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For Home Health Providers

CMS Launches Jimmo Settlement Agreement Web Page


- Background on the settlement
- Links to resources
- Frequently asked questions (FAQs)

The Centers for Medicare & Medicaid Services (CMS) reminds the Medicare community of the Jimmo Settlement Agreement (January 2013), which clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare’s skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the Jimmo Settlement required manual revisions to restate a “maintenance coverage standard” for both skilled nursing and therapy services under these benefits:

- Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

- Skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist (“skilled care”) are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.

The Jimmo Settlement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The Settlement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.
For Home Health Providers

Home Health Physician Recertification Estimate

The Home Health Provider Contact Center often receives calls from providers asking about the recertification requirement for physician to include an estimate of how much longer the skilled services will be required.

The physician’s recertification estimate should be included on the recertification document along with other required elements of the recertification and not on any separate form or order. As indicated in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.5.2 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf), the physician must include an estimate of how much longer the skilled services will be required and must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1;
2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased. Where a patient’s sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the recertification, or as a signed addendum to the recertification;
3. A plan of care has been established and is periodically reviewed by a physician; and
4. The services are or were furnished while the patient is or was under the care of a physician.

Below are examples of statements that may assist in your understanding of this requirement.

<table>
<thead>
<tr>
<th>Acceptable Estimate Statement</th>
<th>Not Acceptable Estimate Statement</th>
</tr>
</thead>
</table>
| • I estimate John Doe will qualify for home health services for another 15 days.  
• I estimate John Doe will qualify for home health services for another 4 weeks.  
• I estimate John Doe will qualify for home health services until October 1, 2017. | • The patient will be on our services until the patient can walk safely.  
• The patient will need home care until the wound heals. |
For Home Health Providers

MM10167: Revisions to the Home Health Pricer to Support Value-Based Purchasing and Payment Standardization

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: MM10167
Change Request (CR) #: CR 10167
Related CR Release Date: August 4, 2017
Effective Date: January 1, 2018
Related CR Transmittal #: R3629CP
Implementation Date: January 2, 2018

Provider Type Affected
This MLN Matters Article is intended for Home Health Agency (HHA) providers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need To Know
Change Request (CR) 10167 revises the Medicare’s Home Health Pricer to implement value-based purchasing (in nine states – see below) and payment standardization. It also adds consistency editing to ensure the accurate reporting of site-of-service G-codes on home health visit line items.

Background
In the Calendar Year (CY) 2016 Home Health Prospective Payment System (HH PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its proposal to implement the Home Health Value-Based Purchasing (HHVBP) Model in nine states representing each geographic area in the United States.

For all Medicare-certified HHAs that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington, payment adjustments will be based on each HHA’s total performance score on a set of measures already reported via the Outcome and Assessment Information Set (OASIS) and the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) for all patients serviced by the HHA, or determined claims data, in addition to three new measures where performance points are achieved for reporting data.

The HHVBP Model, as finalized, will be tested by CMS’ Center for Medicare & Medicaid Innovation (CMMI) under Section 1115A of the Social Security Act. CR 10167 makes the revisions needed to the HH Pricer program to accept the necessary adjustment factor to apply HHVBP adjustment and to capture the adjusted amount on the claim record.

Additionally, as part of many of its quality and program improvement initiatives, CMS utilizes standardized claims payment amounts and standardized beneficiary payment amounts. Standardized allowed amounts are actual payment amounts adjusted to remove sources of variation not directly related to decisions to utilize care, such as variation due to the application of hospital wage indexes and geographic practice cost indexes (GPCIs). Incentive payment and penalty adjustments are also not included in the standardized payment amounts. In other words, standardized amounts reflect a standard Medicare payment as though the incentive programs were not in effect. To facilitate accurate calculation of standardized claim amounts for HHAs and to facilitate their use by multiple CMS components,
CR 10167 requires that standardized amounts be calculated by Medicare systems and passed on to claims history databases using the field created for hospital standardized payment amounts. These amounts do not affect the payment made to the HHA.

Finally, CR 10167 requires system changes to make HH and hospice claims processing more consistent. CR 6440 created edits on hospice claims to ensure that G-codes for service visits are reported with the corresponding revenue code for the service discipline. Similar editing does not exist for HH claims, even though the same G-codes and revenue codes are required. The requirements of CR 10167 create these edits for HH claims.


HHAs in the nine HHVBP states will have their payments adjusted (upward or downward) in the following manner:

- A maximum payment adjustment of 3 percent in CY 2018
- A maximum payment adjustment of 5 percent in CY 2019
- A maximum payment adjustment of 6 percent in CY 2020
- A maximum payment adjustment of 7 percent in CY 2021
- A maximum payment adjustment of 8 percent in CY 2022

Providers should be aware that MACs will return to the HHA:

- Home health claims (TOB 032x other than 0322) reporting revenue code 042x if the HCPCS code is other than Q5001, Q5002, Q5009, G0151, G0157, or G0159
- Home health claims (TOB 032x other than 0322) reporting revenue code 043x if the HCPCS code is other than Q5001, Q5002, Q5009, G0152, G0158, or G0160
- Home health claims (TOB 032x other than 0322) reporting revenue code 044x if the HCPCS code is other than Q5001, Q5002, Q5009, G0153, or G0161
- Home health claims (TOB 032x other than 0322) reporting revenue code 055x if the HCPCS code is other than Q5001, Q5002, Q5009, G0162, G0299, G0300, G0493, G0494, G0495, G0496
- Home health claims (TOB 032x other than 0322) reporting revenue code 056x if the HCPCS code is other than Q5001, Q5002, Q5009, or G0155
- Home health claims (TOB 032x other than 0322) reporting revenue code 057x if the HCPCS code is other than Q5001, Q5002, Q5009, or G0156

MACs will place the HH VBP adjustment amount on the claim as a value code QV amount. This may be a positive or a negative amount.

**Additional Information**


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

**Document History**

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<th>Description</th>
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<tr>
<td>August 7, 2017</td>
<td>Initial article released.</td>
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For Hospice Providers

CMS Releases Hospice Compare Website to Improve Consumer Experiences, Empower Patients

On August 16, as part of our continuing commitment to greater data transparency, CMS unveiled the Hospice Compare website (https://www.medicare.gov/hospicecompare/). The site displays information in a ready-to-use format and provides a snapshot of the quality of care each hospice facility offers to its patients. CMS is working diligently to make healthcare quality information more transparent and understandable for consumers to empower them to take ownership of their health. By ensuring patients have the information they need to understand their options, CMS is helping individuals make informed healthcare decisions for themselves and their families based on objective measures of quality.

The Hospice Compare site allows patients, family members, caregivers, and healthcare providers to compare hospice providers based on important quality metrics. Currently, the data on Hospice Compare is based on information submitted by approximately 3,876 hospices.

For More Information:

- Fact Sheet - https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-16.html

See the full text of this excerpted Press Release (issued August 16) at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-08-16.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending.

For Hospice Providers

Hospice Billing Resources

The CGS Home Health & Hospice (HH&H) website at http://www.cgsmedicare.com/hhh/index.html offers a wide variety of resources to assist providers billing hospice services. CGS encourages you to use these resources to research questions prior to calling the Provider Contact Center. Please review the following resources, and share this with your appropriate staff.

HH&H educational resources can be accessed by selecting the Educational Resources link at https://www.cgsmedicare.com/hhh/education/resources.html, which is found under the Education & Resources tab on the left side navigation menu at https://www.cgsmedicare.com/hhh/education/index.html of the CGS website. Select Educational Materials to access specific hospice billing resources at https://www.cgsmedicare.com/hhh/education/materials/index.html.
Hospice Claims Filing and Special Claims Filing Situations
[Link]

This resource is beneficial if you enter your billing transactions via the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE). It provides screen prints and field descriptions for each FISS claim page for Notice of Elections (NOEs)/Transfer NOEs, hospice claims, and Notice of Termination/Revocation (NOTR). In addition, under the heading Special Hospice Claims Filing Situations you will find information about hospice physician and nurse practitioner services, sequential billing requirements, and much more.

Hospice Sequential Billing
[Link]

This resource provides information about the sequential billing requirement. This billing requirement is consistently one of the top claim submission errors for hospice providers. Review this resource for steps you can follow to ensure compliance and avoid sequential billing errors.

Hospice Quick Resource Tools
[Link]

A variety of HH&H resource tools are available that cover general, billing and clinical topics. Print a copy of the Hospice Medicare Billing Codes Sheet for a quick reference of all the billing elements (revenue codes, HCPCS, etc.), and the Hospice Prescription Drug Reporting Table for guidance on reporting prescription drugs.

Online Education Center
[Link]

Enter your email address, or if you’re a new user create a profile, to access a variety of computer based training modules. The following hospice billing courses, and more, are available under the J15 Courses heading.

- Hospice Beginner Billing, Part 1
- Hospice Beginner Billing, Part 2
- Top Claim Submission Errors (Reason Codes) and How to Resolve
Click on a specific reason code to learn the reason for the error and what you can do to avoid future billing errors. Additional resources are also available.

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

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

For Hospice Providers

MM10131: Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2018

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: MM10131  Change Request (CR) #: CR 10131
Related CR Release Date: August 4, 2017  Effective Date: October 1, 2017
Related CR Transmittal #: R3628CP  Implementation Date: October 2, 2017

Provider Types Affected

This MLN Matters® Article is intended for physicians and providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 10131 updates the hospice payment rates, hospice wage index, and Pricer for Fiscal Year (FY) 2018. The CR also updates the hospice cap amount for the cap year ending October 31, 2017. Make sure your billing staffs are aware of these changes.

Background

Payment rates for hospice care, the hospice aggregate cap amount, and the hospice wage index are updated annually.

The law governing the payment for hospice care requires annual updates to the hospice payment rates. Payment rates are updated annually according to Section 1814(i)(1)(C)(ii)(VII) of the Social Security Act (the Act), which requires the Centers for Medicare & Medicaid Services (CMS) to use the inpatient hospital market basket, adjusted for multifactor productivity and other adjustments as specified in the Act, to determine the hospice payment update percentage.

The hospice aggregate cap amount is updated annually in accordance with §1814(i)(2)(B) of the Act and provides for an increase (or decrease) in the hospice cap amount. For accounting years that end after September 30, 2016, and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage.

The hospice wage index is used to adjust payment rates to reflect local differences in wages. The hospice wage index is updated annually as discussed in hospice rulemaking.
Section 3004 of the Affordable Care Act (ACA) amended the Act to authorize a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act requires that beginning with Fiscal Year (FY) 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data reporting requirements with respect to that FY.

**FY 2018 Hospice Payment Rates**

Section 411(d) of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015, Pub. L. 114-10 (April 16, 2015) (MACRA) amended Section 1814(i)(1)(C) of the Act such that for hospice payments for FY 2018, the market basket percentage increase, after application of the productivity adjustment and the 0.3 percent reduction, if applicable, shall be 1 percent. Therefore, for FY 2018, the hospice payment update percentage will be 1 percent.

The FY 2018 hospice payment rates are effective for care and services furnished on or after October 1, 2017, through September 30, 2018. The hospice payment rates are discussed further in the “Medicare Claims Processing Manual”, Chapter 11, Processing Hospice Claims, Section 30.2.

The updated payment rates are shown in Tables 1 and 2.

| Table 1: FY 2018 Hospice Payment Rates for RHC for Hospices that Submit the Required Quality Data |
|-------------------------------------------------|-----------------|-----------------|-----------------|
| Code   | Description                                             | FY 2017 Payment Rate | Labor Share | Non-Labor Share |
| 651    | Routine Home Care (days 1-60)                           | $192.78              | $132.46    | $60.32          |
| 651    | Routine Home Care (days 61+)                            | $151.41              | $104.03    | $47.38          |
| 652    | Continuous Home Care Full Rate = 24 hours of care Hourly Rate -$40.68 | $976.42              | $670.90    | $305.52         |
| 655    | Inpatient Respite Care                                  | $172.78              | $93.53     | $79.25          |
| 656    | General Inpatient Care                                  | $743.55              | $475.95    | $267.60         |

| Table 2: FY 2018 Hospice Payment Rates for Hospices that DO NOT Submit the Required Quality Data |
|-------------------------------------------------|-----------------|-----------------|-----------------|
| Code   | Description                                             | FY 2017 Payment Rate | Labor Share | Non-Labor Share |
| 651    | Routine Home Care (days 1-60)                           | $188.97              | $129.84    | $59.13          |
| 651    | Routine Home Care (days 61+)                            | $148.41              | $101.97    | $46.44          |
| 652    | Continuous Home Care Full Rate = 24 hours of care Hourly Rate -$39.88 | $957.08              | $657.61    | $299.47         |
| 655    | Inpatient Respite Care                                  | $169.36              | $91.67     | $77.69          |
| 656    | General Inpatient Care                                  | $728.83              | $466.52    | $262.31         |

**Hospice Inpatient and Aggregate Caps**

In the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142), CMS finalized aligning the cap accounting year, for both the inpatient cap and the hospice aggregate cap, with the federal FY beginning in 2017. Therefore, the 2017 cap year will start on October 1, 2016, and end on September 30, 2017. See Table 3 for the timeframes used to count beneficiaries and payments for the hospice aggregate cap in the 2017 and 2018 cap years.

| Table 3: Hospice Aggregate Cap Timeframes for Counting Beneficiaries and Payments for the Alignment of the Cap Accounting Year with the Federal Fiscal Year |
|-------------------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Cap Year | Streamlined Method | Patient-by-Patient Proportional Method | Streamlined Method | Patient-by-Patient Proportional Method |
| 2017 (Transition Year) | 9/28/16-9/30/17 | 11/1/16-9/30/17 | 11/1/16-9/30/17 | 11/1/16-9/30/17 |
For the inpatient cap for the 2017 cap year, CMS will calculate the percentage of all hospice days of care that were provided as inpatient days (General Inpatient (GIP) and Respite care) from November 1, 2016, through September 30, 2017 (11 months). For the inpatient cap for the 2018 cap year, CMS will calculate the percentage of all hospice days that were provided as inpatient days (GIP care and Respite care) from October 1, 2017, through September 30, 2018.

The hospice cap amount for the 2017 cap year is equal to the 2016 cap amount ($27,820.75) updated by the FY 2017 hospice payment update percentage of 2.1 percent. As such, the 2017 cap amount is $28,404.99.

The hospice cap amount for the 2018 cap year is equal to the 2017 cap amount ($28,404.99) updated by the FY 2018 hospice payment update percentage of 1 percent. As such, the 2018 cap amount is $28,689.04.

Hospice Wage Index
Following publication of the FY 2018 Hospice Wage Index and Payment Rate Update final rule, the revised payment rates and wage index will be incorporated in the Hospice Pricer and forwarded to the Medicare contractors. The wage index will not be published in the Federal Register but will be available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.

Additional Information

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

Document History

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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>August 14, 2017</td>
<td>Initial Article Released</td>
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</table>

For Home Health and Hospice Providers

Announcing The Provider Enrollment Interactive Help Tool!

CGS has released the Provider Enrollment Interactive Help Tool at https://www.cgsmedicare.com/hhh/enrollment/helptool/index.html for HH&H providers. This tool is designed to walk you through the application process simply by asking you a series of questions.

Answering the questions correctly will give you confidence that you are:

- Selecting the correct CMS-855 application
- Completing the sections applicable to your situation
• Including the supporting documentation we need
• Accessing the other forms needed to complete your enrollment

Using the tool is easy! Simply click on the Provider Enrollment Interactive Help Tool link at https://www.cgsmedicare.com/hhh/enrollment/helptool/index.html to get started.

Answering a series of ‘yes’ and ‘no’ questions will display the information you need to facilitate a smooth enrollment process. You also have the option of printing the results for your reference.

The Provider Enrollment Interactive Help Tool is available now. If you have questions, please contact the Provider Contact Center (PCC) at 1.877.299.4500.

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 Jurisdiction 15 Home Health & Hospice Provider Outreach and Education (POE) Advisory Group Web page at https://www.cgsmedicare.com/hhh/education/advisory_groups.html was updated to include the upcoming meeting dates.
• All references to Social Security Number Removal Initiative (SSNRI) were changed to the New Medicare Card Project. A link to the CMS New Medicare Card Project is located under the Hot Topics heading on the J15 HHH home page at https://www.cgsmedicare.com/hhh/index.html.
• References to the Provider Connects eNews were changed to CMS MLN Connects. A link to the CMS MLN Connects® Web page was added to the left side navigation menu on the J15 HHH home page at https://www.cgsmedicare.com/hhh/index.html.
• The Top Claim Submission Errors (Reason Codes) and How to Resolve Web page at https://www.cgsmedicare.com/hhh/education/materials/cses.html was updated to add the new CSE web page, Top Claim Submission Errors for Hospice Providers: Error U5194 at https://www.cgsmedicare.com/hhh/education/materials/3944.html.
• References to the FISS Guide were updated to FISS DDE Guide in order to better identify this resource as a guide for providers who access the Fiscal Intermediary Standard System (FISS) via Direct Data Entry (DDE). The FISS DDE Guide is available under the Claims left side navigation tab and under the Educational Materials & Resources Web page at https://www.cgsmedicare.com/hhh/education/materials/index.html.
• The Adjustments/Cancels Web page at https://www.cgsmedicare.com/hhh/education/materials/adjustments_cancels.html was updated to provide specific type of bill information and instructions indicating that information must be entered in the Remarks field when Claim Change Reason Code D9 is reported.
For Home Health and Hospice Providers

Medicare Credit Balance Quarterly Reminder

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


NOTE: Please do not submit duplicate Credit Balance Reports. To ensure CGS has received your report, consider using the website portal myCGS to submit your report. myCGS provides instant confirmation of receipt and allows you to check the status. Submitting your CBR using certified mail, or other methods that require a signature upon delivery is also an option.

The report must be postmarked by the date indicated above. If the report is received with a postmark date later than the date indicated above, we are required to withhold 100 percent of all payments being sent to your facility. This withholding will remain in effect until the reporting requirements are met. If no credit balance exists for your facility during a quarter, a signed Medicare Credit Balance Report certification is still required. Please include your Medicare provider number on the certification form.

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

To ensure timely receipt and processing, send the CMS-838/Certification within 30 days of the quarter end date using one of the options below. Do not submit duplicate Credit Balance Reports.

<table>
<thead>
<tr>
<th>myCGS, secure Web Portal (preferred method):</th>
<th>myCGS provides instant confirmation of receipt. For details, refer to:</th>
</tr>
</thead>
</table>

Reports may be faxed to (do not send duplicate faxes):
1.615.664.5987
MCBR Receipts
Attn: Credit Balance Reporting

Regular and Certified Mail:
CGS
Attn: HHH Credit Balance Reporting
PO Box 20014
Nashville, TN 37202

Fed Ex/UPS/Overnight Courier:
CGS
J15 Credit Balance Reporting
2 Vantage Way
Nashville, TN 37228
Please note that if you have or will be submitting an adjustment, please send the UB-04 along with the CMS-838 form.

If you are issuing a refund check for a credit balance:
- Send the CMS-838 and a copy of the refund check using one of the options listed above.
- Send the refund check with a copy of the CMS-838 or documentation that indicates the check is for a credit balance, the quarter end date, and provider number associated with the check to the following address:
  
  CGS - J15 Home Health and Hospice
  PO Box 957124
  St. Louis, MO 63195-7124

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

For Home Health and Hospice Providers
MLN Connects’ Weekly News

The MLN Connects® is the official news from the Medicare Learning Network and contains a weeks worth of Medicare-related messages. 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, refer to https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819.

MM10071 (Revised): July Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

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: MM10071 Revised Change Request (CR) #: CR 10071 Related CR Release Date: August 2, 2017 Effective Date: July 1, 2017 Related CR Transmittal #: R3824CP Implementation Date: July 3, 2017

Note: This article was revised on August 3, 2017, to reflect an updated Change Request (CR). That CR updated the policy section on complex rehabilitative power wheelchair accessories & seat and back cushions (page 2 of this article). The CR release date, transmittal number and link to the CR was also changed. All other information is the same.

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

Provider Action Needed
CR 10071 provides the July 2017 quarterly update for the Medicare DMEPOS fee schedule, and it includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

Background
The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf.


Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 (https://www.ecfr.gov/cgi-bin/text-idx?SID=becd20e512ac4c175ad81e37e4583f85&mc=true&node=pt42.3.414&rgn=div5#se42.3.414_1102) for parenteral and enteral nutrition (PEN), splints and casts and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, Section 1834 of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas (CBAs), based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on
adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. 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.

The Calendar Year (CY) 2017 DMEPOS and PEN fee schedules and the July 2017 DMEPOS Rural ZIP code file public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

**KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back Cushions**

Suppliers should continue to use the KU modifier when billing for wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864) with dates of service on or after July 1, 2017. The fee schedule amounts associated with the KU modifier were not adjusted using information from the competitive bidding program in accordance with Section 2 of Patient Access and Medicare Protection Act (PAMPA) for dates of service January 1, 2016 through December 31, 2016. Section 16005 of the 21st Century Cures Act then extended the effective date through June 30, 2017. Effective for dates of service on or after July 1, 2017, taking into consideration the exclusion at section 1847(a)(2)(A) of the Social Security Act, the policy for these items is revised. As a result, payment for these items furnished in connection with a Group 3 complex rehabilitative power wheelchair and billed with the KU modifier will be based on the unadjusted fee schedule amounts updated in accordance with section 1834(a)(14) of the Act.

The list of HCPCS codes associated with the KU modifier is available in Transmittal 3713, CR 9966, dated February 3, 2017. The updated DMEPOS fee schedule files have been released.

**Therapeutic Continuous Glucose Monitor (CGM)**

As part of this update, the fee schedule amounts for the following therapeutic CGM HCPCS codes are added to the DMEPOS fee schedule file effective for dates of service on or after July 1, 2017:

- K0553 - Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month’s supply
- K0554 - Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system


**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

MM10098: Common Working File (CWF) to Modify CWF Provider Queries to Only Accept National Provider Identifier (NPI) as Valid Provider Number

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: MM10098
Related CR Release Date: July 27, 2017
Related CR Transmittal #: R1877OTN
Change Request (CR) #: CR 10098
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers querying Medicare’s Common Working File (CWF) for checking eligibility and entitlement status for Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 10098, which informs the MACs about modifications to the CWF Provider Queries, ELGA, ELGH, HIQA, HIQH, and HUQA, to only accept the National Provider Identifier (NPI) as a valid Provider Number. Make sure that your billing staffs are aware of these changes.

Background
Providers, clearinghouses, and/or third-party vendors, herein referred to as “Trading Partners," verify an individual’s Medicare eligibility and entitlement status prior to and/or while the individual is receiving services before billing Medicare for services rendered to Medicare beneficiaries using HIPAA Eligibility Transaction System (HETS) and/or CWF.

Within CWF, Trading Partners use CWF Provider Queries, ELGA, ELGH, HIQA, HIQH, and HUQA. Currently, Trading Partners are allowed to use either legacy Provider Numbers (CMS Certification Number (CCN) or Unique Physician Identification Number (UPIN)) or NPI on CWF Provider Queries.

The Centers for Medicare & Medicaid Services (CMS) is requiring CWF to modify CWF Provider Queries to only accept NPI as a valid Provider Number.

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

### Document History

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<td>July 28, 2017</td>
<td>Initial Article Released</td>
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### For Home Health and Hospice Providers

**MM10132: Claim Status Category and Claim Status Codes Update**

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

**MLN Matters® Number:** MM10132  
**Change Request (CR) #:** CR 10132  
**Related CR Release Date:** August 18, 2018  
**Effective Date:** January 1, 2018  
**Related CR Transmittal #:** R3839CP  
**Implementation Date:** January 2, 2018

### Provider Types Affected

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

### Provider Action Needed

Change Request (CR) 10132 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277, Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these updates.

### Background

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

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting, held each year in January or February, June, and in September or October. At these meetings, the Committee makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.

The code sets are available at http://www.wpc-edi.com/reference/codelist/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelist/healthcare/claim-status-codes/. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the September/October 2017 Committee meeting shall be posted on the above websites on or about November 1, 2017.
The Centers for Medicare & Medicaid Services (CMS) will issue instructions to the MACs who then must update their claims systems to ensure that the current version of these codes is used in their claim status responses.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR10132. References in CR10132 to "277 responses," and "claim status responses," encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

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

MM10140: Implement Operating Rules -Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule -Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)

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

MLN Matters® Number: MM10140 Change Request (CR) #: CR 10140
Related CR Release Date: August 18, 2017 Effective Date: January 1, 2018
Related CR Transmittal #: R3841CP Implementation Date: January 2, 2018

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs and Home Health & Hospice MACs for services provided to Medicare beneficiaries.
Provider Action Needed
Change Request (CR) 10140 instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2017.

Background
The Department of Health and Human Services (DHHS) adopted the Phase III CAQH CORE, EFT and ERA Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about July 1, 2017. This will also include updates based on Market Based Review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them. See http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

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

Additional Information

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

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For Home Health and Hospice Providers

MM10141: Healthcare Provider Taxonomy Codes (HPTCs) October 2017 Code Set Update

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

MLN Matters® Number: MM10141
Related CR Release Date: August 18, 2018
Related CR Transmittal #: R3842CP
Change Request (CR) #: CR 10141
Effective Date: October 1, 2017
Implementation Date: January 2, 2018 – Contractors with capability to do so will implement effective October 1, 2017

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

Provider Action Needed
Change Request (CR) 10141 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

You should note that:

1. Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) for current use.
2. Terminated codes are not approved for use after a specific date.
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.
5. Medicare would be guilty of non-compliance with HIPAA if MACs accepted claims that contain invalid HPTCs.

The HPTC set is maintained by the NUCC for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view from the Washington Publishing Company (WPC) website at http://www.wpc-edi.com/codes and can be downloaded from the NUCC’s website http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40.

Although the NUCC generally posts their updates on the WPC Web page 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each.
update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by color code:

- New items are green
- Modified items are orange
- Inactive items are red.

Additional Information

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

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**For Home Health and Hospice Providers**

**MM10151: Suppression of the Standard Paper Remittance Advice (SPR) in 45 days if also Receiving Electronic Remittance Advice (ERA)**

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: MM10151  
Change Request (CR) #: CR 10151  
Related CR Release Date: August 4, 2017  
Effective Date: January 1, 2018  
Related CR Transmittal #: R1890OTN  
Implementation Date: January 2, 2018

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 10151 provides notice that beginning January 2, 2018, Medicare’s Shared System Maintainers (SSMs) must eliminate issuance of Standard Paper Remittance Advice (SPRs) to those providers/suppliers (or a billing agent, clearinghouse, or other entity representing those providers/suppliers) who also have been receiving Electronic Remittance Advice (ERA) transactions for 45 days or more. The shared system changes to suppress the distribution of SPRs were implemented in January 2006 per CR3991 (issued August 12, 2005, Transmittal 645). Make sure your billing staffs are aware of the suppression of the SPR.

Background

The SPR is the hard copy version of an ERA. MACs, including Durable Medical Equipment (DME) MACs must be capable of producing SPRs for providers/suppliers who
are unable or choose not to receive an ERA. The MACs and the DME MACs suppress distribution of SPRs if an Electronic Data Interchange (EDI) enrolled provider/supplier is also receiving ERAs for more than 31 days for Institutional Health Care Claims (837I) and 45 days for DME and Professional Health Care Claims (837P). Internet-Only-Manuals (IOMs), MLN Matters Article MM4376 provided information to the MACs regarding the receipt of SPR and ERA distribution time lines.

Beginning February 14, 2018, the SSMs shall suppress the delivery of SPR to the MACs EDI enrolled providers/suppliers who are also receiving both the ERA and SPR. In rare situations (such as natural or man-made disasters) exceptions to this policy may be allowed at the discretion of the Centers for Medicare & Medicaid Services (CMS). MACs will not send a SPR/hard copy version to a particular provider/supplier unless this requirement causes hardship and CMS has approved a waiver requested by your MAC.


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

**MM10196 (Revised): Quarterly Influenza Virus Code Update – January 2018**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. CMS then issued a revised article. The following reflects the revised information. 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: MM10196 Revised
Related CR Release Date: August 4, 2017
Effective Date: August 1, 2017
Implementation Date: January 2, 2018

**Note:** This article was revised on August 9, 2017, to correctly show in all appropriate places the code of Q2039. In the original article, Q0239 was mistakenly referenced in two places and that is corrected to show Q2039. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 10196, from which this article was developed, provides instructions for payment and edits for the Common Working File (CWF) and the Fiscal Intermediary
Shared System (FISS) to include and update new or existing influenza virus vaccine codes. The influenza virus vaccine code set is updated on a quarterly basis. This update will include one new influenza virus vaccine code: 90756. Please make sure your billing staffs are aware of this update.

**Background**

Effective for claims processed with dates of service (DOS) on or after January 1, 2018, influenza virus vaccine code 90756 (Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use) will be payable by Medicare. This new code will be included on the 2018 Medicare Physician Fee Schedule Database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

During the interim period of August 1, 2017, through December 31, 2017, MACs will use code Q2039 (Influenza virus vaccine, not otherwise specified) to handle bills for this new influenza virus vaccine product (Influenza virus vaccine, quadrivalent (ccIIV4)). Q2039 is already an active code.

The new influenza virus vaccine code 90756 will then be implemented with the January 2018 release for DOS on or after January 1, 2018.

Effective for dates of service on or after August 1, 2017, MACs will use the CMS Seasonal Influenza Vaccines Pricing website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) to determine the payment rate for influenza virus vaccine code Q2039 and 90756.

Medicare will issue further instructions on how to handle claims using Q2039 for the new influenza virus vaccine product between August 1, 2017, and December 31, 2017. MACs will use existing processes to handle these claims.

The new influenza virus vaccine code (90756) is not retroactive to August 1, 2017. Claims will not be accepted for influenza virus vaccine code 90756 between the DOS August 1, 2017, and December 31, 2017. If claims are received in January 2018 with code 90756 for DOS between August 1, 2017, and December 31, 2017, claims will be rejected or returned as unprocessable.

**New Vaccine Description**

**Code 90756** – Long Description: Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use TOS Code: V

- **Short Description:** CCIIV4 VACC ABX FREE IM
- **Medium Description:** CCIIV4 VACCINE ANTIBIOTIC FREE 0.5 ML DOS IM USE Long

**Payment Basis**

Based on reasonable cost, MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:

- Hospitals (Type of Bill 12X and 13X)
- Skilled Nursing Facilities (22X and 23X)
- Home Health Agencies (34X)
- Hospital-based renal dialysis facilities (72X) and
- Critical Access Hospitals (85X)

Based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP), MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:
• Indian Service Hospitals (IHS) (12X and 13X)
• HS Hospices (81X and 82X) and
• IHS Critical Access Hospitals (85X)
• Comprehensive Outpatient Rehabilitation Facilities (CORFs) (75X), and
• Independent RDFs (72X)

**Note:** In all cases, coinsurance and deductible to not apply.

MACS will suspend and manually price claims when the HCPC File rate is blank for:

• IHS Hospitals (12X, 13X), hospices (81X and 82X), and IHS CAHs (85X)
• CORFs (75X) and
• Independent RDFs (72X)

**Messages for Denied Claims**

MACs will return as unprocessable claims submitted with Q2039 for the DOS January 1, 2018, through July 31, 2018, when code 90756 should have been submitted, using the following messages:

• **Claims Adjustment Reason Code (CARC):** 181 – “Procedure code was invalid on the date of service.”
• **Remittance Advice Remark Code (RARC):** N56 – “Procedure code billed is not correct/valid for the services billed or the date of service billed.”
• **Group Code:** CO (Contractual Obligation)

**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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<td>August 7, 2017</td>
<td>Article initially released</td>
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MM10224: Influenza Vaccine Payment Allowances - Annual Update for 2017-2018 Season

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: MM10224  Effective Date: August 1, 2017
Related CR Release Date: August 18, 2018  Implementation Date: No later than October 2, 2017
Related CR Transmittal #: R3837CP  Change Request (CR) #: CR 10224

Provider Type Affected
This MLN Matters Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for influenza vaccines provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 10224 informs MACs about the payment allowances for seasonal influenza virus vaccines, which are updated on August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved after the release of CR10224 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html. Make sure your billing staffs are aware that the payment allowances are being updated.

Background
The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

The Medicare Part B payment allowances for the following Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2017-July 31, 2018:

- CPT 90653 Payment allowance is $50.217.
- CPT 90655 Payment allowance is pending.
- CPT 90656 Payment allowance is $19.247.
- CPT 90657 Payment allowance is pending.
- CPT 90661 Payment allowance is pending.
- CPT 90685 Payment allowance is $21.198.
- CPT 90686 Payment allowance is $19.032.
- CPT 90687 Payment allowance is $9.403.
- CPT 90688 Payment allowance is $17.835.
- HCPCS Q2035 Payment allowance is $17.685.
- HCPCS Q2036 Payment allowance is pending.
• HCPCS Q2037 Payment allowance is $17.685.
• HCPCS Q2038 Payment allowance is pending.

Payment for the following CPT or HCPCS codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2017 - July 31, 2018:

• CPT 90630 Payment allowance is $20.343.
• CPT 90654 Payment allowance is pending.
• CPT 90662 Payment allowance is $49.025.
• CPT 90672 Payment allowance is pending.
• CPT 90673 Payment allowance is $40.613.
• CPT 90674 Payment allowance is $24.047.
• CPT 90682 Payment allowance is $46.313. (New code)
• CPT 90756 Payment allowance is $22.793. Effective dates: 1/1/2018-7/31/2018

Note: Providers and Medicare Administrative Contractors shall use HCPCS Q2039 for dates of service from 8/1/2017 – 12/31/2017. See special note under HCPCS Q2039 for payment amounts for this product prior to 1/1/2018.

• HCPCS Q2039 Flu Vaccine Adult -Not Otherwise Classified. Payment allowance is to be determined by your MAC with effective dates of 8/1/2017 -7/31/2018.

Special note: Until CPT code 90756 is implemented on 1/1/2018, Q2039 shall be used for products described by the following language: influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. The payment allowance for these products, effective for dates of service 8/1/2017 -12/31/2017 is $22.793.

CMS will post payment limits for influenza vaccines that are approved after the release date of CR10224 on the CMS Seasonal Influenza Vaccines Pricing Web page at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html as information becomes available. Effective dates for these vaccines shall be the date of Food and Drug Administration (FDA) approval.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the Quarterly Average Sales Price (ASP) Drug Pricing Files.

Providers should note that:

• All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
• The annual Part B deductible and coinsurance amounts do not apply.
• Your MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust such claims that you bring to their attention.

Additional Information


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

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, October 9, 2017 (Columbus Day)</td>
<td>PCC Closed 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 https://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 https://www.cgsmedicare.com/hhh/index.html and click the “myCGS” button on the left side of the Web page.

For your reference, access the “Home Health & Hospice 2017 Holiday/Training Closure Schedule” at https://www.cgsmedicare.com/hhh/help/pdf/2017_hhh_calendar_FINAL.pdf for a complete list of PCC closures.

For Home Health and Hospice Providers

Quarterly Provider Update

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

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

To receive notification when regulations and program instructions are added throughout the quarter, go to https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Quarterly-Provider-Updates-Email-Updates.html to sign up for the Quarterly Provider Update (electronic mailing list).
We encourage you to bookmark the Quarterly Provider Update website at https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html and visit it often for this valuable information.

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

For Home Health and Hospice Providers

Return to Provider Reason Code 34961: Present on Admission Indicator

Recently the home health and hospice Provider Contact Center has received calls regarding claims being returned to the provider (RTP) with reason code 34961. Effective August 7, 2017, the Fiscal Intermediary Standard System (FISS) no longer accepts information entered in the POA indicator field for home health and hospice claims. The POA Indicator is a one position field that follows the DIAG CODES field on FISS Claim Page 03. If your claim is in the RTP file (T B9997) with reason code 34961, remove any character that appears in that field. The example below shows the character ‘W’ in the POA indicator field. We encourage home health and hospice providers to work with their vendor to ensure information is not submitted in the POA indicator field.

For Home Health and Hospice Providers

SE1128: Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

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: SE1128 Revised
Effective Date: N/A
Implementation Date: N/A

Note: This article was revised on August 23, 2017, to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.

Provider Types Affected
This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in Original Medicare or a Medicare Advantage (MA) plan.

Provider Action Needed
This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers and suppliers that they may not bill
beneficiaries enrolled in the QMB program for Medicare cost-sharing. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Look for new information and messages in CMS’ HIPAA Eligibility Transaction System (HETS) and the Provider Remittance Advice (RA) to identify patients’ QMB status and exemption from cost-sharing prior to billing. If you are an MA provider, contact the MA plan for more information about verifying the QMB status of plan members.

Implement key measures to ensure compliance with QMB billing requirements. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the States in which you practice. Refer to the Background and Additional Information Sections below for further details and important steps to promote compliance.

Background

All original Medicare and MA providers and suppliers—not only those that accept Medicaid—must refrain from charging individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances.

Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program. See the chart at the end of this article for more information about the QMB benefit.

Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)


Refer to the Important Reminders Concerning QMB Billing Requirements Section below for key policy clarifications.

Inappropriate Billing of QMB Individuals Persists

Despite Federal law, improper billing of individuals enrolled in the QMB program persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information,
Ways to Promote Compliance with QMB Billing Rules

Take the following steps to ensure compliance with QMB billing prohibitions:

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.
   - Starting October 3, 2017, original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions from the Medicare Provider RA, which will contain new notifications and information about a patient’s QMB status. Refer to Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System ([https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9911.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9911.pdf)) for more information about these improvements.
   - MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.
   - Providers and suppliers may also verify a patient’s QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid identification cards and documents issued by the State proving the patient is enrolled in the QMB program.

2. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid.

3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the States in which you operate. Different processes may apply to Original Medicare and MA services provided to individuals enrolled in the QMB program. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.
   - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.
   - Understand the processes you need to follow to request payment for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.

Important Reminders Concerning QMB Billing Requirements

Be aware of the following policy clarifications on QMB billing requirements:

1. All original Medicare and MA providers and suppliers—not only those that accept Medicaid—must abide by the billing prohibitions.
2. Individuals enrolled in the QMB program retain their protection from billing when they cross State lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is provided by a different State than the State in which care is rendered.

3. Note that individuals enrolled in QMB cannot choose to “waive” their QMB status and pay Medicare cost-sharing. The Federal statute referenced above supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect.

### QMB Eligibility and Benefits

<table>
<thead>
<tr>
<th>Program</th>
<th>Income Criteria*</th>
<th>Resources Criteria*</th>
<th>Medicare Part A and Part B Enrollment</th>
<th>Other Criteria</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB Only</td>
<td>≤100% of Federal Poverty Line (FPL)</td>
<td>≤3 times SSI</td>
<td>Part A***</td>
<td>Not Applicable</td>
<td>• Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)</td>
</tr>
<tr>
<td>QMB Plus</td>
<td>≤100% of FPL</td>
<td>Determined by State</td>
<td>Part A***</td>
<td>Meets financial and other criteria for full Medicaid benefits</td>
<td>• Full Medicaid coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)</td>
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</tbody>
</table>

* States can effectively raise these Federal income and resources criteria under Section 1902(r)(2) ([https://www.ssa.gov/OP_Home/ssact/title19/1902.htm](https://www.ssa.gov/OP_Home/ssact/title19/1902.htm)) of the Act.

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a “conditional basis”). For more information on this process, refer to Section HI 00801.140 of the Social Security Administration Program Operations Manual System ([https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140](https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140)).

### Additional Information


### Document History

<table>
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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>August 23, 2017</td>
<td>The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.</td>
</tr>
<tr>
<td>May 12, 2017</td>
<td>This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.</td>
</tr>
<tr>
<td>January 12, 2017</td>
<td>This article was revised to add a reference to MLN Matters article MM9817 (<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf</a>), which instructs Medicare Administrative Contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.</td>
</tr>
<tr>
<td>Date of Change</td>
<td>Description</td>
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<tr>
<td>February 4, 2016</td>
<td>The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3.</td>
</tr>
<tr>
<td>February 1, 2016</td>
<td>The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table on page 4.</td>
</tr>
<tr>
<td>March 28, 2014</td>
<td>The article was revised on to change the name of the Coordination of Benefits Contractor (COBC) to BCRC.</td>
</tr>
</tbody>
</table>

For Home Health and Hospice Providers

Stay Informed and Join the CGS ListServ Notification Service

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

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

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

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

For Home Health and Hospice Providers

Upcoming Educational Events

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