Medicare Bulletin
Jurisdiction 15

HOME HEALTH

CMS Guidance for No Matching OASIS ........................................ 3
MM11272: Home Health (HH) Patient-Driven Groupings Model (PDGM) – Additional Manual Instructions ....................................... 3
Update to CGS Home Health PDGM Web Page .......................... 5

HOME HEALTH AND HOSPICE

CGS Website Updates ............................................................... 6
Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) Screen Changes ............................. 7
January 1, 2020: Seven Months To Go and Counting! ..................... 8
July 2019 Changes to Common Working File (CWF) Eligibility Systems ELGA, ELGH, HIQA and HIQH ............................ 9
Medicare Credit Balance Quarterly Reminder ................................ 10
MLN Connects® Weekly News .................................................. 11
MM11171: Documentation of Evaluation and Management Services of Teaching Physicians .................. 12
MM11252: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update ............ 13
MM11289: Additional Processing Instructions to Update the Standard Paper Remit (SPR) ................. 14
MM11292: Claim Status Category and Claim Status Codes Update .................. 16
MM11293: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2019 Update ........................................ 17
Provider Contact Center (PCC) Training ..................................... 22
Quarterly Provider Update ....................................................... 22
Stay Informed and Join the CGS ListServ Notification Service ........ 23
Targeted Probe and Educate Progress Update ......................... 23
Upcoming Educational Events ................................................. 27
What to Expect When Enrolling .............................................. 27

myCGS is a secure Internet-based application where you can view beneficiary eligibility, claims status, online remittances, financial information, and much more!

https://www.cgsmedicare.com/mycgs/index.html

myCGS is a secure Internet-based application where you can view beneficiary eligibility, claims status, online remittances, financial information, and much more!

Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology CPT codes. Descriptions and other data only are copyrighted 2019 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
For Home Health Providers

CMS Guidance for No Matching OASIS

The Centers for Medicare & Medicaid Services (CMS) issued MM11272 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11272.pdf), which includes guidance for home health agencies (HHAs) in cases where a claim is sent to the Return to Provider (RTP) file with reason code 37071 because there is no corresponding OASIS assessment found. In such cases, the HHA may correct any error in the OASIS or claim information to ensure a match and then re-submit the claim (F9) from the RTP file.

No Error – Submit Denial

If there was no error and the HHA determines the claim did not meet the condition of payment, the HHA may bill for denial using the following coding:

- Type of Bill (TOB) 0320 indicating the expectation of a full denial for the billing period.
- Occurrence span code 77 with span dates matching the From/Through dates of the claim, indicating the HHA’s acknowledgement of liability for the billing period.
- Condition code D2, indicating that the HHA is changing the billing for the Health Insurance Prospective Payment System (HIPPS) code to non-covered.

Note: Do not use condition code 21 in this case, since it would result in inappropriate beneficiary liability.

Please refer to MM11272 for additional information.

For Home Health Providers

MM11272: Home Health (HH) Patient-Driven Groupings Model (PDGM) – Additional Manual Instructions

The Centers for Medicare & Medicaid Services (CMS) 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

MLN Matters Number: MM11272
Related CR Release Date: May 3, 2019
Related CR Transmittal Number: R4294CP
Implementation Date: August 7, 2019

Related Change Request (CR) Number: 11272
Effective Date: Claim “From” dates on or after January 1, 2020
Provider Type Affected
This MLN Matters Article is for physicians and Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for Home Health services provided to Medicare beneficiaries.

Provider Action Needed
CR 11272 revises additional sections in Chapter 10 of the Medicare Claims Processing Manual to support the implementation of the Home Health (HH) Patient-Driven Groupings Model (PDGM). Make sure your billing staffs are aware of these revisions.

Background
The Centers for Medicare & Medicaid Services (CMS) finalized an alternative case-mix method now called the Patient-Driven Groupings Model (PDGM), which includes the payment reform requirements set forth in the Bipartisan Budget Act of 2018 (BBA). CMS discussed this model in the Calendar Year (CY) 2019 final Home Health (HH) Prospective Payment System Rate Update final rule. CMS will implement this in CY 2020, effective for claims with From dates on or after January 1, 2020.

CR 11272 revises manual instructions to conform to the final policies of the PDGM. It also further implements the policies of the PDGM, as the CY 2019 HH final rule describes and as Section 51001 of the BBA requires. The complete policy is available in MM11081 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11081.pdf.

The revised Manual sections are part of CR11272. One manual change is that episode is also now a period of care. HHAs should note the following instructions in the revised Medicare Claims Processing Manual, Chapter 10, Section 40.2:

- HH PPS claims must report a 0023 revenue code line on which the first four positions of the HIPPS code match the code submitted on the RAP. This HIPPS code is used to match the claim to the corresponding RAP that was previously paid. After this match is completed, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems. At that time, the submitted HIPPS code on the claim will be replaced with the system-calculated code.

- Principal Diagnosis Code
  - For claim “From” dates before January 1, 2020, the ICD code and principal diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).
  - For claim “From” dates on or after January 1, 2020, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.

- Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment –RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no requirement for the HHA to complete another follow-up (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment.

- Other Diagnosis Codes
  - For claim “From” dates before January 1, 2020, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses).
  - For claim “From” dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.
HHAs may also want to review the revised Sections 70.3 (Decision Logic Used by the Pricer on RAPs) and 70.4 (Decision Logic Used by the Pricer on Claims). These revised sections are part of the manual revision that is attached to CR 11272.

Also, CMS added guidance for HHAs in case the MAC returns a claim because there is no corresponding OASIS assessment in Medicare’s systems related to the claim. In such cases, the HHA may correct any errors in the OASIS or claim information to ensure a match and then re-submit the claim. If there was no error and the HHA determines the claim did not meet the condition of payment, the HHA may bill for denial using the following coding:

- Type of Bill (TOB) 0320 indicating the expectation of a full denial for the billing period
- Occurrence span code 77 with span dates matching the From/Through dates of the claim, indicating the HHA’s acknowledgment of liability for the billing period
- Condition code D2, indicating that the HHA is changing the billing for the Health Insurance Prospective Payment System (HIPPS) code to non-covered.

Do not use condition code 21 in these instances, since it would result in inappropriate beneficiary liability.

The MACs will use the following remittance advice messages and associated codes when processing billings for denial under this policy. This Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) combination is compliant with Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Business Scenario Three.

- Group Code: CO
- CARC: 272
- RARC: N211

Additional Information


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 3, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

For Home Health Providers

Update to CGS Home Health PDGM Web Page

CGS first told you about the new Home Health Patient-Driven Groupings Model (PDGM) Web page at https://www.cgsmedicare.com/hhh/education/materials/pdgm.html in a listserv email message on April 11, 2019. In addition to the resources provided by the Centers for Medicare & Medicaid Services (CMS), this page now includes a link to the CGS Overview: Home Health Patient-Driven Groupings Model (PDGM) Web page at https://www.cgsmedicare.com/hhh/education/materials/pdgm_overview.html. This new resource includes the following information.

- Home Health Prospective Payment System (HH PPS) vs PDGM
Claim Filing Elements
Health Insurance Prospective Payment System (HIPPS) Code
Low Utilization Payment Adjustment (LUPA)
Partial Payment Adjustment
Outlier Payment

Please share this information with your appropriate staff.

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 Claims Processing Issues Log Web page at [https://www.cgsmedicare.com/hhh/claims/fiss_claims_processing_issues.html](https://www.cgsmedicare.com/hhh/claims/fiss_claims_processing_issues.html) was updated with the most recent updates.
- The Top Claim Submission Errors (Reason Codes) and How to Resolve Web page at [https://www.cgsmedicare.com/hhh/education/materials/cses.html](https://www.cgsmedicare.com/hhh/education/materials/cses.html) has been updated with the most recent data.
- The HHH Recorded Webinars Web page at [https://www.cgsmedicare.com/hhh/education/recorded_webinars.html](https://www.cgsmedicare.com/hhh/education/recorded_webinars.html) was updated with the most recent home health and hospice related educational events.
- The Home Health Change of Care Notice (HHCC) Web page at [https://www.cgsmedicare.com/hhh/coverage/hh_coverage_guidelines/hhccn.html](https://www.cgsmedicare.com/hhh/coverage/hh_coverage_guidelines/hhccn.html) was updated to provide a link to the HHCCN form and form instructions located on the Centers for Medicare & Medicaid Services (CMS) website. Effective July 1, 2019, home health agencies must use the renewed form showing the expiration date of 4/30/2022 on the bottom.
- The Hospice Billing Frequently Asked Questions (FAQs) Web page at [https://www.cgsmedicare.com/medicare_dynamic/faqs/display_faqs_j15hhh.asp?117](https://www.cgsmedicare.com/medicare_dynamic/faqs/display_faqs_j15hhh.asp?117) was updated to include a new question/answer (#31) about what to do when a Notice of Termination/Revocation (NOTR) was submitted by mistake.
- The Medical Review Additional Development Request (ADR) Process Web page at [https://www.cgsmedicare.com/hhh/medreview/adr_process.html](https://www.cgsmedicare.com/hhh/medreview/adr_process.html) has been updated to include information about using the myCGS MR Dashboard to check for medical review ADRs and submit documentation.
- The Additional Development Request Timeliness Calculator at [https://www.cgsmedicare.com/medicare_dynamic/J15/adrcalc/adrcalc.aspx](https://www.cgsmedicare.com/medicare_dynamic/J15/adrcalc/adrcalc.aspx) and the Appeals Timeliness Calculator at [https://www.cgsmedicare.com/medicare_dynamic/J15/HHH_time_limit_calculator/HHH_time_limit_calculator.aspx](https://www.cgsmedicare.com/medicare_dynamic/J15/HHH_time_limit_calculator/HHH_time_limit_calculator.aspx) have been updated. Instead of having to select the month, day and year from a drop down menu, a monthly calendar can display where you scroll to the correct month and click on the date.
- The Submitting a Hospice Notice of Termination/Revocation of Election (TOB 8XB) quick resource tool at [https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_not_tob8xb.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_not_tob8xb.pdf) has been updated to provide additional information about correcting a discharge date on a previously submitted NOTR and removing a revocation date established by an NOTR submitted in error.
- A new frequently asked question (FAQ) was added to the Beneficiary Eligibility Information FAQ topic at [https://www.cgsmedicare.com/medicare_dynamic/faqs/display_faqs_j15hhh.asp?109](https://www.cgsmedicare.com/medicare_dynamic/faqs/display_faqs_j15hhh.asp?109) that addressed the requirement that the National
Provider Identifier (NPI) is now a required field when accessing eligibility information via ELGA and ELGH.


For Home Health and Hospice Providers

Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) Screen Changes

The July 2019 quarterly system release, which will be implemented on July 1, 2019, includes changes to the following FISS DDE screens. The home health and hospice FISS DDE Guide at https://www.cgsmedicare.com/hhh/education/materials/fiss.html has been updated to reflect these changes.

DDE Inquiry Screen Changes

Effective July 1, 2019, the FISS DDE screens MAP1781 and MAP178B will display the new field INIT. The INIT field identifies the initial Diagnosis Related Group (DRG) code assigned. This field is used in the event a Hospital Acquired Condition (HAC) impacts the final MS-DRG assignment. This field is not used for home health and hospice claims processing.

- **MAP1781 - DRG (Pricer/Grouper)**

```
MAP1781  COG J15 MAC - XXX REGION  ACMPAR052 MM/DD/YY
XXXXXXX SC  XXXX XXXX DDE INQUIRY C014204 MM:MM:SS
DIAGNOSES:  1  2  3  4  5
   1   6  7  8  9
   1   6  7  8  9
PROCESSES:  1  2  3  4  5
   1   6  7  8  9
SEX C-I DISCHARGE STATUS DT PROV
REVIEW CODE TOTAL CHARGES DOB OR AGE
APPROVED LOS LTR DAYS PAT LIAB
RETURNED FROM GROUPER DRG INIT MAJOR DIAG CAT RETURN CODE
RETURN CODE
RETURNED FROM PRICER PRICER VERSION
RTN CD WAGE INDEX OUTLIER DAYS
AVG # LENGTH OF STAY OUTLIER DAYS THRESHOLD
OUTLIER COST THRESH
TOTAL BLENDED PAYMENT HOSPITAL SPECIFIC PORTION
FEDERAL SPECIFIC PORTION DISP cost shares HOSPITAL Amt
PASS OUTLIER PORTION OUTLIER PORTION
PFH + TEF STANDARD DATED USED
LTR DAYS USED PROV REIMB

PLEASE ENTER DATA, PF3-EXIT, PF6-FWD, PF8-COST DISCLOSURE, ENTER-PROCESS
```

- **MAP178B - DRG/PPS Inquiry**

```
MAP178B  COG J15 MAC - XXX REGION  ACMPAR052 06/10/19
XXXXXXX SC  XXXX XXXX DRE/PPS INQUIRY A019309 14:15:36
DIAGNOSES:  1  2  3  4  5
   1  67  8  9
   1  67  8  9
PROCESSES:  1  2  3  4  5
   1  67  8  9
SEX C-I DISCHARGE STATUS DT PROV
REVIEW CODE TOTAL CHARGES DOB OR AGE
APPROVED LOS LTR DAYS PAT LIAB
RETURNED FROM GROUPER DRG INIT MAJOR DIAG CAT RETURN CODE
RETURN CODE
RETURNED FROM PRICER PRICER VERSION
UNCOMP CARE Amt
BUNDLE Amt
VAL FURC Amt
READMS Amt
PRs STNDR VALUE
PRs HAC PAY Amt
PRs FLX Amt
EHR PAY Amt
```

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 https://www.cgsmedicare.com. © 2019 Copyright, CGS Administrators, LLC.
Effective July 1, 2019, the new field INIT DRG will display on Claim Page 06 screen. The INIT DRG field identifies the initial DRG code assigned. This field is used in the event a Hospital Acquired Condition (HAC) impacts the final MS-DRG assignment. This field is not used for home health and hospice claims processing.

The field GRAMM RUDMAN ORIG REIMBURSEMENT AMT field name was changed to display as GRH ORIG REIMB AMT.

The following FISS DDE chapters have been updated with this information.

  - Chapter Four: Claims and Attachments Menu - https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_4-claims_and_attachments_menu.pdf

For Home Health and Hospice Providers

January 1, 2020: Seven Months To Go and Counting!

Beginning January 1, 2020, you MUST submit your home health and hospice billing transactions using the Medicare Beneficiary Identifier (MBI) regardless of the dates of service. Billing transactions include home health requests for anticipated payments (RAPs), final claims, hospice notice of elections (NOEs) and claims. Refer to information below about the few exceptions that apply, allowing you to submit either the HICN or the MBI.

CGS encourages home health and hospice providers to begin submitting the MBI before the end of the transition period, December 31, 2019. For information about how to get the MBI, refer to the “Don’t Wait: Submit Your Patients’ MBIs on Claims Now!” article at https://www.cgsmedicare.com/hhh/pubs/news/2019/0319/cope11891.html.

CGS is monitoring MBI submissions to ensure providers are ready for this transition. The data below shows the percentage of home health and hospice claims submitted in April with the MBI for each of our primary states.
Exceptions

Below are the few exceptions when you can use either the Health Insurance Claim Number (HICN) or the MBI on or after January 1, 2020. For additional information about the exceptions, refer to the SE18006 Medicare Learning Network article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18006.pdf.

- **Appeals** – You can use either the HICN or MBI for claim appeals and related forms. This includes the CGS Jurisdiction 15 Redetermination Request Form at https://www.cgsmedicare.com/hhh/appeals/pdf/hhh_redetermination_form.pdf.

- **Claim Status Query** – You can use the HICN or MBI to check the status of a claim (276 transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.

- **Span-Date Claims** – You can use the HICN or the MBI for home health claims and request for anticipated payments (RAPs) (type of bill 32X) if the “From” date is before the end of the transition period (December 31, 2019). If the Medicare beneficiary is admitted to home health care before December 31, 2019, you can submit the episode’s RAP with either the HICN or the MBI; however, you must use the MBI when you submit the final claim that corresponds with the RAP.

Don’t wait till January 1, 2020, to start submitting your patient’s MBI on your claims! If you have it, submit it! If you don’t have it, get it!

Refer to the CMS New Medicare Card Project Web page at https://www.cms.gov/medicare/new-medicare-card/nmc-home.html for additional information regarding this initiative.

If you have questions, please contact the Home Health and Hospice Provider Contact Center at 1.877.299.4500 and select Option 1.

---

**For Home Health and Hospice Providers**

**July 2019 Changes to Common Working File (CWF) Eligibility Systems ELGA, ELGH, HIQA and HIQH**

Effective July 1, 2019, ELGA, ELGH, HIQA and HIQH will display a message before beneficiary eligibility information is made available. This message will notify you that beginning in the fall of 2019, the Centers for Medicare & Medicaid Services (CMS) plans to terminate access to ELGA, ELGH, HIQA and HIQH for those who already use the HIPAA.
Eligibility Transaction System (HETS). This will affect clearinghouses, third-party billers, providers and other users.

Background

In December 2012, CMS announced plans to discontinue the CWF beneficiary health insurance eligibility transactions (MLN Matters® Special Edition Article SE1249 - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1249.pdf). These transactions include the eligibility systems ELGA, ELGH, HIQA, and HIQH. In that same article, CMS also announced the HIPAA Eligibility Transaction System (HETS) would be the single source for this data.

What Providers Need to Know

Effective July 1, 2019, once you enter the required information to access beneficiary eligibility in ELGA, ELGH, HIQA and HIQH, a new screen will display the new message. You will need to press the “ENTER” key to acknowledge the message before eligibility information displays. If you use screen-scraping and/or other automation methods to obtain beneficiary eligibility information via ELGA, ELGH, HIQA and HIQH, you may need to modify your program in order to accept the message.

If you currently use both the CWF eligibility transactions and HETS to obtain Medicare beneficiary eligibility information, it is recommended that you begin using HETS exclusively. For additional information about HETS, refer to the HIPAA Eligibility Transaction System (HETS) Web page at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html on the CMS website. CGS also recommends contacting your clearinghouse/vendor to notify them of this change, and ask if they offer the HETS application.

myCGS

As a reminder, you can access Medicare beneficiary eligibility information by using myCGS, the free CGS website portal. Learn more about what myCGS offers by accessing the following resources.


For Home Health and Hospice Providers

Medicare Credit Balance Quarterly Reminder

This article is a reminder to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by July 30, 2019, for the quarter ending June 30, 2019. 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>

<table>
<thead>
<tr>
<th>Reports may be faxed to (do not send duplicate faxes):</th>
<th>1.615.664.5987</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MCBR Receipts</td>
</tr>
<tr>
<td></td>
<td>Attn: Credit Balance Reporting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regular and Certified Mail:</th>
<th>CGS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Attn: HHH Credit Balance Reporting</td>
</tr>
<tr>
<td></td>
<td>PO Box 20014</td>
</tr>
<tr>
<td></td>
<td>Nashville, TN 37202</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fed Ex/UPS/Overnight Courier:</th>
<th>CGS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>J15 Credit Balance Reporting</td>
</tr>
<tr>
<td></td>
<td>2 Vantage Way</td>
</tr>
<tr>
<td></td>
<td>Nashville, TN 37228</td>
</tr>
</tbody>
</table>

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...
MM11171: Documentation of Evaluation and Management Services of Teaching Physicians

The Centers for Medicare & Medicaid Services (CMS) 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

MLN Matters Number: MM11171
Related CR Release Date: April 26, 2019
Related CR Transmittal Number: R4283CP

Related Change Request (CR) Number: CR 11171
Effective Date: January 1, 2019
Implementation Date: July 29, 2019

Provider Type Affected
This MLN Matters Article is for teaching physicians billing Medicare Administrative Contractors (MACs) for Evaluation and Management (E/M) services provided to Medicare beneficiaries.

Provider Action Needed
CR 11171 represents a change in policy of documentation for teaching physicians providing evaluation and management (E/M) services. It clarifies existing language in the Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Section 100.1.1 (Evaluation and Management (E/M) Services) to bring it in line with current documentation policy for teaching physicians and E/M services.

Background
This manual revision clarifies existing language for the documentation policy for teaching physicians and E/M services.

The following provides these policy clarifications:

- For the purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate: 1) that the teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and 2) the participation of the teaching physician in the management of the patient.

- The patient medical record must document the extent of the teaching physician’s participation in the review and direction of the services furnished to each beneficiary. The extent of the teaching physician’s participation may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

Note that MACs will not search their files to reprocess claims impacted by this change. However, they will adjust such claims that you bring to their attention.
Additional Information

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 3, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

For Home Health and Hospice Providers

**MM11252**: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

The Centers for Medicare & Medicaid Services (CMS) 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

**Provider Types Affected**

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

**Provider Action Needed**

CR 11252 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the maintainers of the ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and PC Print software. Make sure your billing staffs are aware of these changes and obtain the new MREP or PC Print software if they use that software.

**Background**

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

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

CR 11252 is a code update notification indicating when updates to CARC and RARC lists are available on the Washington Publishing Company (WPC) website. Shared System Maintainers (SSMs) are responsible for implementing code deactivation, making sure...
they do not use any deactivated codes in original business messages, and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date later than the implementation date in CR11252, MACs must implement on the date specified at [http://wpc-edi.com/Reference/](http://wpc-edi.com/Reference/).

A discrepancy between the dates may arise as the WPC only updates the website three times per year and the dates may not match the CMS release schedule. For CR 11252, MACs and SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are on the code list since the last code update (CR 11204; [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11204.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11204.pdf)).

**Additional Information**


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

**Document History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 17, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**For Home Health and Hospice Providers**

**MM11289: Additional Processing Instructions to Update the Standard Paper Remit (SPR)**

The Centers for Medicare & Medicaid Services (CMS) 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](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles).

**MLN Matters Number:** MM11289  
**Related CR Release Date:** May 21, 2019  
**Related CR Transmittal Number:** R2307OTN  
**Related Change Request (CR) Number:** 11289  
**Effective Date:** October 1, 2019  
**Implementation Date:** October 7, 2019

**Provider Type Affected**

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

**Provider Action Needed**

CR 11289 is to provide additional instructions to the MACs to update the SPR to ensure that no SPR is mailed out after the implementation of this CR with a Health Insurance Claim Number (HICN) or Social Security Number per the Social Security Number (SSN) Fraud Prevention Act of 2017. Make sure your billing staffs are aware of these changes.
Background
The Social Security Number Fraud Prevention Act of 2017 restricts the inclusion of Social Security Numbers (SSNs) on documents sent by mail no later than September 15, 2022.

Effective October 1, 2019, MACs will mask the Patient Control Number field (also named the Patient CNTRL Number) or the Patient Account Number (ACNT) field on any print file used to create an SPR for mailing if it contains a HICN or SSN.

Notes: The Patient Control Number field is a “free format” field and the HICN or SSN could be present anywhere in the field. This direction does not affect SPRs used for the portal process.

MACs will check the Patient Control Number field or the ACNT field to see if there is a HICN or SSN anywhere within the field and, if so, the MACs will replace the first five digits of the HICN or SSN with capital Xs on any print file used to create an SPR for mailing. MACs shall follow the RRB HICN masking criteria defined in CR11112 to mask the Patient Control Number field or the ACNT field. Examples for reference are below.

HICN Examples
- XXXXX7777A
- XXXXX7777C1

RRB HICN Examples
- AXXXXX1370
- WCAXXXXX2388
- CAXXXXX1

Note 1: This masking requirement does not apply to RRB numbers issued before March 1964, which included an alpha prefix and 6 digits; for example, A000000.

SSN Examples
- XXXXX1234
- XXX-XX-1234

MACs will not mask the Medicare Beneficiary Identifier (MBI).

Additional Information

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 21, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
MM11292: Claim Status Category and Claim Status Codes Update

The Centers for Medicare & Medicaid Services (CMS) 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

MLN Matters Number: MM11292
Related Change Request (CR) Number: 11292
Related CR Release Date: May 17, 2019
Effective Date: October 1, 2019
Related CR Transmittal Number: R4304CP
Implementation: October 7, 2019

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

Provider Action Needed
CR11292 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). Do not use proprietary codes in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee allows the industry 6 months for implementation of newly added or changed 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 June 2019 committee meeting are available on these sites on or about July 1, 2019.

The Centers for Medicare & Medicaid Services (CMS) will issue future updates to these codes as needed. MACs must update their claims systems to ensure they use the current version of these codes in their claim status responses.

MACs use these code changes in editing all ASC X12 276 transactions the MACs process on or after the implementation date and are in the ASC X12 277 transactions issued on and after the implementation date of CR11292.

MACs must comply with the requirements in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. The MACs must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses. They must also use valid Claim Status Category Codes...
and Claim Status Codes when sending ASC X12 277 Healthcare Claim Acknowledgments. References in CR11292 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 questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

**Document History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 17, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**For Home Health and Hospice Providers**

**MM11293: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2019 Update**

The Centers for Medicare & Medicaid Services (CMS) 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](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles).

**MLN Matters Number:** MM11293  
**Related Change Request (CR) Number:** 11293  
**Related CR Release Date:** May 3, 2019  
**Effective Date:** January 1, 2019  
**Related CR Transmittal Number:** R4292CP  
**Implementation Date:** July 1, 2019

**Provider Types Affected**

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

**Provider Action Needed**

CR 11293 informs providers that the Centers for Medicare & Medicaid Services (CMS) has issued payment files to the MACs based upon the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule. CR 11293 amends those payment files, to be effective for services furnished between January 1, 2019, and December 31, 2019. Be sure your billing staffs are aware of these updates.

**Background**

Below is a summary of the changes for the July update to the 2019 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2019.

**HCPCS Codes and Actions**

<table>
<thead>
<tr>
<th>CODE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>27369</td>
<td>Multiple Procedure indicator = 2, Bilateral Surgery = 1, Assistant Surgery = 1</td>
</tr>
<tr>
<td>28740</td>
<td>Bilateral Surgery indicator = 1</td>
</tr>
</tbody>
</table>
Revised MP RVU and HCPCS
The malpractice relative value unit (MP RVU) has been revised for numerous HCPCS codes. These MP RVU changes have minimal impact on payment. The complete list of the revised MP RVUs is a part of the CR, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4292CP.pdf.

J and Q Code Changes
The MPFSDB file will reflect the changes below effective for dates of service July 1, 2019, and after. Other instructions convey the implementation of these “J” and “Q” code changes are being communicated via other instructions. The descriptors and more information are available at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html.

<table>
<thead>
<tr>
<th>CODE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9031</td>
<td>Procedure Status = I</td>
</tr>
<tr>
<td>J9355</td>
<td>Short Descriptor = Inj trastuzumab excl biosimi</td>
</tr>
<tr>
<td>J1444</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>J7208</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>J7677</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>J9030</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>J9036</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>J9356</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q5112</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q5113</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q5114</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q5115</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
</tbody>
</table>

New CPT Codes
The new CPT codes listed below (0543T through 0562T, and 90619) are effective for dates of service July 1, 2019, and after. On the MPFSDB file, codes 0543T through 0562T are all Procedure Status C and have no RVUs. The Global Days are YYY for 0543T through 0546T and 0548T through 0553T; XXX for 0547T, 0554T through 0559T, and 0561T; and ZZZ for 0560T and 0562T. Code 90619 is Procedure Status N; there are no RVUs and payment policy indicators do not apply.

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0543T</td>
<td>TA MV RPR WARTIF CHORD TEND</td>
<td>Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae</td>
</tr>
<tr>
<td>0544T</td>
<td>TCAT MV ANNUlus RCNSTJ</td>
<td>Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture</td>
</tr>
<tr>
<td>0545T</td>
<td>TCAT TV ANNUlus RCNSTJ</td>
<td>Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach</td>
</tr>
<tr>
<td>0546T</td>
<td>RF SPECTRSC NTRAOP MRGN ASMT</td>
<td>Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report</td>
</tr>
<tr>
<td>0547T</td>
<td>B1 MATRL QUAL TST MCRIND TIB</td>
<td>Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score</td>
</tr>
<tr>
<td>0548T</td>
<td>TPRNL BALO CNTNC DEV BI</td>
<td>Transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy</td>
</tr>
<tr>
<td>0549T</td>
<td>TPRNL BALO CNTNC DEV UNI</td>
<td>Transperineal periurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy</td>
</tr>
<tr>
<td>0550T</td>
<td>TPRNL BALO CNTNC DEV RMVL EA</td>
<td>Transperineal periurethral balloon continence device; removal, each balloon</td>
</tr>
</tbody>
</table>
### Table: CPT Codes Effective for dates of service July 1, 2019, and After

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0551T</td>
<td>TPRNL BALO CNTNC DEV ADJMT</td>
<td>Transperineal periurethral balloon continence device; adjustment of balloon(s) fluid volume</td>
</tr>
<tr>
<td>0552T</td>
<td>LOW-LEVEL LASER THERAPY</td>
<td>Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional</td>
</tr>
<tr>
<td>0553T</td>
<td>PERO TCAT IILAC ANAST IMPLT</td>
<td>Percutaneous trans catheter placement of iliac arteriovenous anastomosis implant, inclusive of all radiological supervision and interpretation, intra procedural road mapping, and imaging guidance necessary to complete the intervention</td>
</tr>
<tr>
<td>0554T</td>
<td>B1 STR &amp; FX RSK ANALYSIS</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report</td>
</tr>
<tr>
<td>0555T</td>
<td>B1 STR&amp;FX RSK TRANSMIS DATA</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data</td>
</tr>
<tr>
<td>0556T</td>
<td>B1 STR &amp; FX RSK ASSESSMENT</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density</td>
</tr>
<tr>
<td>0557T</td>
<td>B1 STR &amp; FX RSK I&amp;R</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density</td>
</tr>
<tr>
<td>0558T</td>
<td>CT SCAN F/Biomchn CT ALYS</td>
<td>Computed tomography scan taken for the purpose of biomechanical computed tomography analysis</td>
</tr>
<tr>
<td>0559T</td>
<td>ANTMC MDL 3D PRINT 1ST CMPNT</td>
<td>Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure</td>
</tr>
<tr>
<td>0560T</td>
<td>ANTMC MDL 3D PRINT EA ADDL</td>
<td>Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0561T</td>
<td>ANTMC GUIDE 3D PRINT 1ST GD</td>
<td>Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide</td>
</tr>
<tr>
<td>0562T</td>
<td>ANTMC GUIDE 3D PRINT EA ADDL</td>
<td>Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>90619</td>
<td>MENACWY-TT VACCINE IM</td>
<td>Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use</td>
</tr>
</tbody>
</table>

### Additional Information


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

### Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 3, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
For Home Health and Hospice Providers


The Centers for Medicare & Medicaid Services (CMS) 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

**MLN Matters Number:** MM11296  
**Related Change Request (CR) Number:** 11296  
**Related CR Release Date:** May 17, 2019  
**Effective Date:** July 1, 2019  
**Related CR Transmittal Number:** R4306CP  
**Implementation Date:** July 1, 2019

**Provider Type Affected**

This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for drug and biological services.

**Provider Action Needed**

CR 11296 updates the HCPCS code set for codes related to drugs and biologicals. Please make sure your billing staffs are aware of these updates.

**Background**

The HCPCS code set is updated on a quarterly basis. CR 11296 informs MACs and providers of the updated specific drug/biological HCPCS codes. The April 5, 2019, HCPCS file includes 10 new HCPCS codes. These HCPCS codes will be payable for Medicare, effective for claims with dates of service on or after July 1, 2019:

1. **J1444**  
   a. Short Descriptor: Fe pyro cit pow 0.1 mg iron  
   b. Long Descriptor: Injection, ferric pyrophosphate citrate powder, 0.1 mg of iron  
   c. Type of Service (TOS): 1, L

2. **J7208**  
   a. Short Descriptor: Inj. jivi 1 iu  
   b. Long Descriptor: Injection, factor viii, (antihemophilic factor, recombinant), pegylated-auc1, (jivi), 1 i.u.  
   c. TOS: 1

3. **J7677**  
   a. Short Descriptor: Revefenacin inh non-com 1mcg  
   b. Long Descriptor: Revefenacin inhalation solution, fda-approved final product, non-compounded, administered through DME, 1 microgram  
   c. TOS: 1, P

4. **J9030**  
   a. Short Descriptor: Bcg live intravesical 1mg  
   b. Long Descriptor: BCG live intravesical instillation, 1 mg  
   c. TOS: 1, P

5. **J9036**  
   a. Short Descriptor: Inj., belrapzo/bendamustine
b. Long Descriptor: Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg
   c. TOS: 1

6. J9356
   a. Short Descriptor: Inj. herceptin hylecta, 10mg
   b. Long Descriptor: Injection, trastuzumab, 10 mg and Hyaluronidase-oysk
   c. TOS: 1

7. Q5112
   a. Short Descriptor: Inj ontruzant 10 mg
   b. Long Descriptor: Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg
   c. TOS: 1, P

8. Q5113
   a. Short Descriptor: Inj herzuma 10 mg
   b. Long Descriptor: Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg
   c. TOS: 1, P

9. Q5114
   a. Short Descriptor: Inj ogivri 10 mg
   b. Long Descriptor: Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg
   c. TOS: 1, P

10. Q5115
    a. Short Descriptor: Inj rituximab-abbs bio 10 mg
    b. Long Descriptor: Injection, rituximab-abbs, biosimilar, 10 mg
    c. TOS: 1, P

Medicare will not pay for HCPCS code J9031 (Bcg (intravesical) per instillation), effective for claims with dates of service on or after July 1, 2019.

The long and short descriptors for HCPCS code J9355 will be modified, effective for claims with dates of service on or after July 1, 2019. The TOS and all other indicators will remain the same.

- J9355 Short Descriptor: Inj trastuzumab excl biosimi
- J9355 Long Descriptor: Injection, trastuzumab, excludes biosimilar, 10 mg

**Additional Information**


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

**Document History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 20, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). The list below indicates when the home health and hospice PCC at **1.877.299.4500** (option 1) will be closed for training.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Training/Closures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday, July 4, 2019</td>
<td>Office Closed, Independence Day</td>
</tr>
<tr>
<td>Thursday, July 11, 2019</td>
<td>8:00 a.m.– 10:00 a.m. Central Time</td>
</tr>
<tr>
<td>Thursday, July 25, 2019</td>
<td>8:00 a.m.– 10:00 a.m. Central Time</td>
</tr>
</tbody>
</table>

The Interactive Voice Response (IVR) (**1.877.220.6289**) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at [https://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf](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](https://www.cgsmedicare.com/hhh/index.html) and click the “myCGS” button on the left side of the Web page.


**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.

Stay Informed and Join the CGS ListServ Notification Service

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

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

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

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

Targeted Probe and Educate Progress Update


**Findings**

Medical Review initiated complex review edits for specific providers identified through data analysis demonstrating high risk for improper payment. Education has been offered to providers throughout and upon completion of each Round of TPE review. Current TPE Home Health and Hospice Results are as follows:

**Home Health**

**Probes completed January 1, 2019 – March 31, 2019**

<table>
<thead>
<tr>
<th>Eligibility and Medical Necessity edit 5A000</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probes Completed</td>
<td>81</td>
</tr>
<tr>
<td>Providers Compliant after Round 1 Completion</td>
<td>2</td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>79</td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 1</td>
<td>19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligibility and Medical Necessity edit 5B000 (Round 2)</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probes Completed</td>
<td>10</td>
</tr>
<tr>
<td>Providers Compliant after Round 2 Completion</td>
<td>2</td>
</tr>
<tr>
<td>Providers Non-compliant after Round 2 Completion (advancing to Round 3)</td>
<td>8</td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 2</td>
<td>1</td>
</tr>
</tbody>
</table>
Findings by State

CGS is providing an overview of review findings by state for providers who have completed Round 1 and Round 2.

### Home Health

#### Round 1 Review Decisions by State

*January 1, 2019 - March 31, 2019*

#### Round 2 Review Decisions by State

*January 1, 2019 - March 31, 2019*

#### Top Denial Reasons January 1, 2019 – March 31, 2019

1. Face-to-Face missing/incomplete/untimely
2. Initial certification invalid
3. Therapy visits not medically necessary
4. Recert estimate missing/invalid
5. The order(s) are incomplete
   - **FTF Documentation Denials** accounted for approximately 30% of the total Targeted Probe and Educate denials.
     - Actual FTF encounter document not submitted
     - Certifying physician did not document the date of the FTF encounter
     - Community physician was not identified when a physician who would not be following the patient after discharge signed the certification
     - Required elements for initial certification (initial plan of care, initial certification, initial encounter documentation) were not submitted for recertification
Refer to the CGS Home Health Coverage Guidelines Web page at https://www.cgsmedicare.com/hhh/coverage/Home_Health_Coverage_Guidelines.html for a variety of resources on the home health FTE encounter.

- **Initial certification invalid** accounted for approximately 14% of the total Targeted Probe and Educate denials.


- **Documentation did not support medical necessity of therapy services** accounted for approximately 7% of the total Targeted Probe and Educate denials.

Refer to the CGS Physical Therapy Web page at https://www.cgsmedicare.com/hhh/coverage/hh_coverage_guidelines/9a.html for documentation tips, access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7) therapy information and the Local Coverage Determination for physical therapy services.

- **Recertification estimate missing/invalid** accounted for approximately 6% of the total Targeted Probe and Educate denials.

**Dates of Service before January 1, 2019.** The physician’s estimate of how much longer skilled services will be required

- Is the physician’s estimate stated in a measurable unit of time (i.e. days, weeks, months, years)?


- **The orders are incomplete** accounted for approximately 6% of the total Targeted Probe and Educate denials.

Refer to the CGS Physician Orders, Plan of Care and Certification (https://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/1B.html) and Home Health Denial Fact Sheet – Missing/Incomplete/Untimely Plan of Care or Certification (https://www.cgsmedicare.com/hhh/education/materials/pdf/hh_5hpln-Shord_factsheet.pdf) Web pages for documentation tips and access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 Specificity of Orders §30.2.2 and Verbal Orders §30.2.5).

**Hospice**

Probes completed January 1, 2019 – March 31, 2019

<table>
<thead>
<tr>
<th>LOS with Non-Oncologic Diagnosis edit 5D000</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results</td>
<td></td>
</tr>
<tr>
<td>Probes Completed</td>
<td>7</td>
</tr>
<tr>
<td>Providers Compliant after Round 1 Completion</td>
<td>1</td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>6</td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GIP LOC edit 5D006</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results</td>
<td></td>
</tr>
<tr>
<td>Probes Completed</td>
<td>4</td>
</tr>
<tr>
<td>Providers Compliant after Round 1 Completion</td>
<td>2</td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>2</td>
</tr>
<tr>
<td>Providers with Non-Responses to ADR’s for Round 1</td>
<td>0</td>
</tr>
</tbody>
</table>
Findings by State
CGS is providing an overview of review findings by state for providers who have completed Round 1.

Top Denial Reasons January 1, 2019 – March 31, 2019
1. Terminal prognosis not supported
2. Physician Narrative missing/invalid
3. Notice of Election is invalid
   - Terminal prognosis not supported accounted for approximately 47% of the total Targeted Probe and Educate denials.
   - Refer to the CGS Hospice Denial Fact Sheet—Six-Month Terminal Prognosis Not Supported Web page at [https://www.cgsmedicare.com/hhh/education/materials/pdf/Hospice_5pter_factsheet.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/Hospice_5pter_factsheet.pdf) for documentation tips and access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 9).
   - Physician narrative missing/invalid accounted for approximately 17% of the total Targeted Probe and Educate denials.
   - Refer to the CGS Hospice Denial Fact Sheet – Missing/Incomplete/Untimely Certification/Recertification Web page at [https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_5pcer_factsheet.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_5pcer_factsheet.pdf) for documentation tips and access to the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 9) and SE1628 Documentation Requirements for the Hospice Physician Certification/Recertification.
   - Notice of Election is invalid accounted for approximately 11% of the total Targeted Probe and Educate denials.

Education
Providers with a moderate to high error rate will be offered an individualized education session where each claim found in error will be discussed and any questions will be answered. CGS offers education sessions via webinar, web-based presentation, or traditional teleconferences. Other methods may also be available. Providers may also submit questions or request education via the home health and hospice TPE email box at J15HPROBEANDEDUCATION@CGSADMIN.COM.
Next Steps

Providers found to be non-compliant at the completion of Round 1/2 will advance to Round 2/3 of TPE at least 45 days from completion of the 1:1 post probe education call date. CGS offers education at any time for providers. Providers do not have to be identified for TPE to request education. CGS encourages providers to request education and conduct self-monitoring based on our posted Medical Review Activity Log at [https://www.cgsmedicare.com/hhh/medreview/activitylog.html](https://www.cgsmedicare.com/hhh/medreview/activitylog.html) and using tools such as Comparative Billing Reports (CBRs) at [https://www.cgsmedicare.com/hhh/education/materials/pdf/mycgs_comparative_billing_reports_hhh.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/mycgs_comparative_billing_reports_hhh.pdf) offered through our web portal.

References


For Home Health and Hospice Providers

Upcoming Educational Events

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

If you have a topic that you would like the CGS POE department to present, send us your suggestion to J15_HHH_Education@cgsadmin.com.

For Home Health and Hospice Providers

What to Expect When Enrolling

To better serve the provider community, CGS Provider Enrollment Management Team created an informational guide to the enrollment process that explains what happens after a CMS Medicare enrollment application is submitted. The “What to Expect When Enrolling” guide at [https://www.cgsmedicare.com/enrollment/pdf/what_to_expect_when_enrolling.pdf](https://www.cgsmedicare.com/enrollment/pdf/what_to_expect_when_enrolling.pdf) delivers the answer as well as needed information for every step of the enrollment process.

This guide explains the provider enrollment process from the contractor’s perspective and gives providers an easy to follow guideline to the enrollment process. This tool will:

- Simplify the enrollment process by eliminating industry jargon
- Use easy to understand terms to explain steps within the process
Convey general processing timeframes to minimize status inquiries early on in the application processing period.

This guide also introduces CGS’ 4R-s of enrollment and provides an interactive view of both provider and contractor actions in the order they are performed.

**CGS’ 4Rs of Enrollment – RECEIVE, REVIEW, RECONCILE, RESOLVE**

Although complex, the enrollment process can be summarized in these four basic categories - RECEIVE, REVIEW, RECONCILE, RESOLVE. These categories are common terms whose meanings rarely change regardless of the industry or context they are used. To draw a comparison, we give an explanation of what each one means as it relates to the Medicare enrollment.

### What to Expect When ENROLLING

CGS 4R’s of Enrollment gives providers an idea of what to expect during the enrollment process. This Job Aid consists of provider’s and contractor’s actions and general time-frames.

<table>
<thead>
<tr>
<th>RECEIVE</th>
<th>REVIEW</th>
<th>RECONCILE</th>
<th>RESOLVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers can submit applications to CGS via standard mail, email, or fax. Within 10 days of receipt, providers can expect to receive a letter acknowledging receipt of the application.</td>
<td>≤ 20 days after receipt, applications are reviewed for missing or clarifying information. If additional information is needed, providers can expect to receive a letter requesting additional information. Providers have 30 days to submit additional information or the application will be rejected and closed. If no additional information is needed, no request letter is sent; the application continues processing.</td>
<td>≤ 30 days of receipt of a complete application and/or additional information, providers can expect the enrollment to be updated. Site visits, address validation, and CMS requirements can cause delays during this stage. Promptly responding to contractor’s request will ensure your application if completed faster.</td>
<td>Application is resolved and a final letter is issued. Click the applicable link to see average processing times for your application type.</td>
</tr>
</tbody>
</table>
| | | | Part B: [https://www.cgsmedicare.com/medicare_dynamic/cyctime/j15b.asp](https://www.cgsmedicare.com/medicare_dynamic/cyctime/j15b.asp)
| | | | HHH: [https://www.cgsmedicare.com/medicare_dynamic/cyctime/j15hhh.asp](https://www.cgsmedicare.com/medicare_dynamic/cyctime/j15hhh.asp)

The guide offers timelines for the various application types:

- When your CMS application is a Paper application that does not require clarification, corrections, or a response to the contractor’s request for more information
- When your CMS application is a Paper application that does require clarification, corrections, or a response to the contractor’s request for more information
- When your CMS application is a Web application that does not require clarification, corrections, or a response to the contractor’s request for more information
- When your CMS application is a Web Paper application that does require clarification, corrections, or a response to the contractor’s request for more information
- When your CMS application is a Paper or Web 855A or 855B Initial or CHOW for certified providers and requires approval from CMS regional office.

As we continue to share this new tool with our provider community, we anticipate an increase in applications that do not require clarification, corrections, or a response to the contractor’s request for more information. Moreover, we foresee usage of this tool causing a decrease in calls to our provider contact center, as well as a decrease in status inquiries.

To view the average processing times for your application type, refer to the Home Health and Hospice Average Provider Enrollment Applications Processing Time at [https://www.cgsmedicare.com/medicare_dynamic/cyctime/j15hhh.asp](https://www.cgsmedicare.com/medicare_dynamic/cyctime/j15hhh.asp) on the CGS website.