Medicare Bulletin
Jurisdiction 15

Reaching Out to the Medicare Community

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Official CMS Information for Medicare Fee-For-Service Providers  
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Administration

2014 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 CGS Part A PCC (1.866.590.6703) will be closed for CSR training and staff development as indicated below. The Interactive Voice Response (IVR) unit will be available during these scheduled training sessions for automated customer service transactions.

Listed below are the training closure dates and time for July.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Closed</th>
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<tbody>
<tr>
<td>Thursday, August 14, 2014</td>
<td>PCC Closed 9:00 a.m. – 11:00 a.m. ET</td>
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<tr>
<td>Thursday, August 28, 2014</td>
<td>PCC Closed 9:00 a.m. – 11:00 a.m. ET</td>
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To subscribe to the CGS Listserv Notification Service, go to http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp and complete the required information.
Contact Information for CGS Medicare Part A

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.866.590.6703 and choose Option 1. For additional contact information, please access the Kentucky & Ohio Part A "Contact Information" Web page at http://www.cgsmedicare.com/parta/cs/contact_info.html for information about the myCGS Web portal, the Interactive Voice Response (IVR) system, as well as telephone numbers, fax numbers, and mailing addresses for other CGS departments.

Medicare Learning Network®: A Valuable Educational Resource!


MLN Connects™ Provider e-News

The MLN Connects™ Provider e-News contains a week’s worth of Medicare-related messages issued by the Centers of Medicare & Medicaid Services (CMS). These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. The following provides access to the weekly messages. Please share with appropriate staff. If you wish to receive the listserv directly from CMS, please contact CMS at LearnResource-L@cms.hhs.gov.

- June 26, 2014 - http://go.usa.gov/9m3B
- July 3, 2014 - http://go.cms.gov/1mKmUD3
- July 10, 2014 - http://go.usa.gov/Xn9x
**Administration**

**MM8711 (Revised): Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE - June 1, 2014 version 3.1.0**

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: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html)

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**MLN Matters® Number:** MM8711 Revised  
**Related Change Request (CR) #:** CR 8711  
**Related CR Release Date:** June 25, 2014  
**Effective Date:** September 2, 2014  
**Related CR Transmittal #:** R1392OTN  
**Implementation Date:** September 2, 2014

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**Note:** This article was revised on July 9, 2014, to reflect the revised CR 8711 issued on June 25. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are changed. Also, the CAQH CORE version number in the above title is revised to 3.1.0. All other information remains the same.

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**Provider Types Affected**

This MLN Matters® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

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**What You Need to Know**

This article is based on CR 8711, which instructs the MACs to update the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule. If you use Medicare's PC Print or Medicare Remit Easy Print (MREP) software, you will need to obtain the new version after it is updated on October 6, 2014. Make sure that your billing staffs are aware of these changes.

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**Background**

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act.

Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

CAQH CORE will publish the next version of the Code Combination List on or about June 1, 2014. This update is based on March 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. (Visit 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: Per 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/Group Code for a minimum set of four Business Scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios but for the four 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 1.866.590.6703 and choose Option 1.

Administration

News Flash Messages from the Centers for Medicare & Medicaid Services (CMS)

- Products from the Medicare Learning Network® (MLN)
  - REVISED “Improving Quality of Care for Medicare Patients: Accountable Care Organizations” Fact Sheet, ICN 907407, downloadable at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Quality_Factsheet_ICN907407.pdf
Billing

MM8775: Clarification of Billing Instructions Related to the Home Health Benefit

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: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8775
Related CR Release Date: June 20, 2014
Related CR Transmittal #: R2977CP
ICD-10: Upon Implementation of ICD-10

Provider Types Affected
This MLN Matters® article is intended for physicians, home health agencies, and suppliers of durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) submitting claims to Medicare administrative contractors (MACs) for services and supplies to Medicare beneficiaries in a home health period of coverage.

Provider Action Needed
This article is based on CR 8775, which updates the "Medicare Claims Processing Manual," to specify the physician specialty codes that are excluded from home health consolidated billing, to make conforming changes related to the retirement of the home health advance beneficiary notice, and to make miscellaneous changes to conform term and code usage to national standards. This CR contains no new policy. Make sure your billing staffs are aware of these updates.

Background
CR 8775 makes a variety of small changes to the "Medicare Claims Processing Manual." These changes do not reflect any new policy. These changes fall into one of three categories.

1. Clarification to Home Health Consolidated Billing (HH CB) Instructions:
   In 2003, CR 2705 made changes to Medicare systems to bypass services from Home Health Consolidated Billing (HH CB) editing when provided by a physician. CR 2705 provided a list of physician specialty codes that are used in this bypass, but the list was never included in the "Medicare Claims Processing Manual". CR 8775 adds the list to the HH CB section of Chapter 10 of the manual. It also makes some wording clarifications to better reflect how Medicare system edits currently enforce HH CB. The modifications to the manual are attached to CR 8775, and you will find a link to that CR in the "Additional Information" section of this article.

2. Removal of References to the Home Health Advance Beneficiary Notice (HHABN):
   CR 8404 described the use of the Advance Beneficiary Notice of Noncoverage (ABN) as a replacement for the HHABN. CR 8775 makes conforming changes to Chapter 10 to remove references to the HHABN.
3. **Conforming to National Standards:** CR 8775 makes detailed changes throughout many sections of Chapter 10 to ensure that references to type of bill and revenue code values mirror the way these values are used in the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual. Additionally, one remittance advice code pair is updated to comply with the Council for Affordable Quality Healthcare’s Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules for code usage on remittance advices.

**Note:** MACs use claim adjustment reason code 97 when rejecting or denying claims due to HH CB.

**Additional Information**


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

**Billing**

**SE1422: Medically Unlikely Edits (MUE) and Bilateral Procedures**


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<th>MLN Matters® Number</th>
<th>Related CR Release Date</th>
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<th>Related Change Request (CR) #</th>
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<td>SE1422</td>
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**Provider Types Affected**

This MLN Matters® Special Edition article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare administrative contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries.

**Provider Action Needed**

**STOP - Impact to You**

Claims filed using noncompliant coding for bilateral surgical procedures may have been paid in the past. The purpose of this article is to inform providers that MUE changes may now render those claim lines unpayable.

**CAUTION - What You Need to Know**

Providers and suppliers, other than ambulatory surgical centers (ASCs), are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a -50 modifier and one unit of service (UOS).

**GO – What You Need to Do**

Make sure your billing staffs examine their process for filing claims for bilateral procedures and services to ensure the -50 modifier is used in accordance with Medicare correct coding and claims submission instructions.
**Background**

There are several ways that claims for bilateral procedures could be coded, but different methods are only correct in specific situations. The most common methods involve reporting

- a single UOS on one line using the -50 modifier;
- one UOS on each of two lines using modifiers RT and LT; and
- two UOS on a single line with no modifier.

For Medicare claims, when reporting bilateral surgical procedures using codes where the term bilateral is not included in the descriptor, both the “Medicare Claims Processing Manual” and the National Correct Coding Initiative (NCCI) manual specify that these bilateral surgical procedures should be reported using a single UOS and the -50 modifier. The NCCI manual goes on to warn that MUE edits are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently many bilateral procedures have an MUE value of 1, and have had that MUE value for some time.

At the recommendation of the Office of the Inspector General (OIG), CMS has examined its claims data relative to MUE levels and has confirmed a pattern of inappropriate billing using multiple lines to bypass the MUEs. Agreeing with the OIG that this practice overcharges both beneficiaries and the Medicare program, CMS is converting most MUEs into per day edits. The MUE Adjudication Indicator (MAI) indicates the type of MUE and its basis. Effective with the July 1, 2014 update, published per day edits are identified on the CMS NCCI website (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html) by their MAI value of 2 or 3.

**MAI of 3**

An MAI of 3, the most common per day edit, indicates an edit for which the MUE is based on clinical information such as

- billing patterns;
- prescribing instructions; or
- other information.

It acknowledges that exceptions could occur but they would be sufficiently rare that the abnormally high units of service value should be considered to be a billing error.

Providers should carefully assess any denials based on these edits and consider the denial to be an indication of incorrect reporting due to such things as clerical errors or errors in the interpretation or application of coding instructions. It is also possible some provider reporting errors could be associated with a lack of medical necessity for the excess units, although the MUE itself does not address medical necessity, but only the medically unlikely nature of the reported value.

In the rare instance where the provider has verified all information, including the correct interpretation of coding instructions, and still believes that the correctly coded medically necessary service exceeds the MUE, the provider should submit a clearly supported appeal.

**MAI of 2**

An MAI of 2 indicates an edit for which the MUE is based on regulation or subregulatory instruction (“policy”), including the instruction that is inherent in the code descriptor or its applicable anatomy.
Examples:

1. The MUE of a “per cervical vertebra” code cannot exceed 7 based on anatomic considerations, that is, the number of cervical vertebrae. The MUE of 7 is therefore inherent in the code descriptor, an integral part of the code set specified for use by Health Insurance Portability & Accountability Act of 1996 (HIPAA).

2. The MUE of a “first 15 minutes” session code for a practitioner cannot exceed 1 since any time beyond that would require a different “subsequent” code, and that limitation is inherent in the code descriptor and its annual incorporation by CMS.

CMS expects all claims reporting services in excess of the MUE for edits with an MAI of 2 will represent either clerical errors or errors in the interpretation of instructions. CMS has not identified any instances in which a higher value would be correct and payable. MACs have therefore been instructed that this subregulatory instruction is binding on the MAC for both initial determinations and redeterminations, as is all subregulatory instruction.

Request for Reopening of a Claim

For all MUE edit denials, including both MAI of 2 and 3, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening to correct its billing of the claim as an alternative to filing an appeal. Providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral service because it was billed with two UOS instead of being billed with one UOS and a -50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the -50 modifier to avoid future denials and delays in payment.

Additional Information

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

CMHC

**MM8784: Submission of Community Mental Health Center (CMHC) Certifications of Compliance with Section 485.918(b)(1)**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8784  
**Related Change Request (CR) #:** CR 8784  
**Related CR Release Date:** June 13, 2014  
**Effective Date:** July 15, 2014  
**Related CR Transmittal #:** R521PI  
**Implementation Date:** July 15, 2014

**Provider Types Affected**

This MLN Matters® article is intended for community mental health centers (CMHCs) submitting institutional claims to Medicare administrative contractors (MACs) for CMHC services to Medicare beneficiaries.
What You Need to Know

This article is based on CR 8784, which informs MACs about the processing of CHMC certifications of compliance.

Background

Effective October 29, 2014, under 42 CFR 485.918(b)(1) a CMHC must provide at least 40 percent of its items and services to individuals who are not eligible for benefits under title XVIII of the Social Security Act, as measured by the total number of CMHC clients treated by the CMHC for whom services are not paid by Medicare, divided by the total number of clients treated by the CMHC in the applicable timeframe. Pursuant to this requirement, a newly enrolling or revalidating CMHC must submit to CMS, via its MAC, a certification statement provided by an independent entity (such as an accounting technician). The document must certify that:

- The entity has reviewed the CMHC’s client care data; and
- For:
  - Initial enrollments: The CMHC meets the 40 percent requirement for the prior 3 months.
  - Revalidations: The CMHC meets the 40 percent requirement for each of the intervening 12-month periods between initial enrollment and revalidation.

The statement must be submitted as part of any initial enrollment or revalidation (including off-cycle revalidations).

Special Guidelines

1. An appropriate official of the certifying entity must sign the document. (Notarization is not required unless CMS requests it.) Such persons may include accounting technicians, CEOs, officers, directors, etc.
2. The certification should be on the certifying entity’s letterhead or should otherwise indicate that the document is clearly from the entity.

Additional Information


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

Coverage

Change Request 8825: Invalidation of National Coverage Determination
140.3 – Transsexual Surgery

The Centers for Medicare & Medicaid Services (CMS) has issued the following Change Request (CR). This CR and other CMS CRs can be found on the CMS website at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals.html.

<table>
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<tr>
<th>Pub 100-02</th>
<th>Transmittal 189</th>
<th>Date: June 27, 2014</th>
<th>Change Request: 8825</th>
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EFFECTIVE DATE: May 30, 2014
Implementation Date: June 29, 2014 – (For clarification, 6/29/14 was referred to as the ‘effective’ date in recent communication; 6/29/14 is the ‘implementation’ date)

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to inform you that the Department of Health and Human Services Departmental Appeals Board (DAB) has invalidated National Coverage Determination (NCD) 140.3 “Transsexual Surgery” pursuant to section 1869(f)(1)(A)(iii) of the Social Security Act (SSA). (Docket #A-13-47, Decision #2576) dated May 30, 2014. As a consequence of this decision, NCD 140.3 is no longer valid. Implementation of this decision shall be June 29, 2014.

B. Policy: Because the NCD is no longer valid as of the effective date, its provisions are no longer a basis for denying claims for Medicare coverage of “transsexual surgery” under 42 CFR §405.1060. Moreover, any local coverage determinations used to adjudicate such claims may not be based on or rely on the provisions or reasoning from section 140.3 of Pub. 100-03, Medicare NCD Manual. In the absence of an NCD, contractors and adjudicators should consider whether any Medicare claims for these services are reasonable and necessary under §1862(a)(1)(A) of the SSA consistent with the existing guidance for making such decisions when there is no NCD.

Therefore, the Centers for Medicare & Medicaid Services will implement the DAB decision with this CR consistent with 42 CFR §426.560(b)(2). Section 140.3 will be removed from the Medicare NCD Manual.


Medicare Benefit Policy Manual

Chapter 1 – Inpatient Hospital Services Covered under Part A

120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

(Rev. 189, Issued: 06-27-14, Effective: 05-30-14, Implementation: 06-29-14)

Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services “related to” non-covered services (e.g., cosmetic surgery, non-covered organ transplants, non-covered artificial organ implants, etc.), including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay in which the non-covered service was performed, are not covered services under Medicare. Services “not related to” non-covered services are covered under Medicare.

Following are examples of services “related to” and “not related to” non-covered services while the beneficiary is an inpatient:

- A beneficiary was hospitalized for a non-covered service and broke a leg while in the hospital. Services related to care of the broken leg during this stay is a clear example of “not related to” services and are covered under Medicare.

- A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a non-covered transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a
recommendation for a non-covered transplant or implant, the services related to the admitting condition would be covered.

- A beneficiary was admitted to the hospital for covered services related to a condition which ultimately led to identification of a need for transplant and receipt of a transplant during the same hospital stay. If, on the basis of the nature of the services and a comparison of the date they are received with the date on which the beneficiary is identified as a transplant candidate, the services could reasonably be attributed to preparation for the non-covered transplant, the services would be "related to" non-covered services and would also be non-covered.

Following is an example of services received subsequent to a non-covered inpatient stay:

After a beneficiary has been discharged from the hospital stay in which the beneficiary received non-covered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior non-covered services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous non-covered procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, complications from cosmetic surgery, removal of a non-covered bladder stimulator, or treatment of any infection at the surgical site of a non-covered transplant that occurred following discharge from the hospital.

However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered.

Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services “related to” non-covered services (e.g., cosmetic surgery, non-covered organ transplants, non-covered artificial organ implants, etc.), including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay in which the non-covered service was performed, are not covered services under Medicare. Services “not related to” non-covered services are covered under Medicare.

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- A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a non-covered transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a recommendation for a non-covered transplant or implant, the services related to the admitting condition would be covered.

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Following is an example of services received subsequent to a non-covered inpatient stay:

After a beneficiary has been discharged from the hospital stay in which the beneficiary received non-covered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior non-covered services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous non-covered procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, complications from cosmetic surgery, removal of a non-covered bladder stimulator, or treatment of any infection at the surgical site of a non-covered transplant that occurred following discharge from the hospital.

However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient’s progress, these visits are not covered.

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

Coverage

MM8797: Changes to the Laboratory National Coverage Determination (NCD) Software

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: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8797  Related Change Request (CR) #: CR 8797
Related CR Release Date: June 13, 2014  Effective Date: October 1, 2014
Related CR Transmittal #: R2976CP  Implementation Date: October 6, 2014

Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8797 which informs MACs that the Laboratory National Coverage Determination (NCD) Edit Software will be updated to continue the processing of ICD-9 diagnosis codes. Make sure your billing staffs are aware of these changes.

Background

The Laboratory NCD Edit Software will be updated to continue the processing of the ICD-9 diagnosis codes. On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary of Health and Human Services may not adopt ICD-10 codes prior to October 1, 2015. This requires Health Insurance Portability & Accountability Act of 1996 (HIPAA) covered entities...
Additional Information


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

Coverage

SE1419: Medicare Signature

Requirements - Educational

Resources for Health Care Professionals

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters Special Edition article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: SE1419  Related Change Request (CR) #: N/A
Related CR Release Date: N/A  Effective Date: N/A
Related CR Transmittal #: N/A  Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order or provide Medicare-covered services to Medicare beneficiaries.

Provider Action Needed

STOP - Impact to You

Medicare requires that services provided/ordered be authenticated by the author. The method used should be a handwritten or electronic signature. Under certain circumstances, a rubber stamped signature is acceptable. If you do not have an acceptable signature on services provided/ordered, your Medicare payment may be impacted.

CAUTION - What You Need to Know

Medicare services provided/ordered must be authenticated by the author using an acceptable signature.

GO – What You Need to Do

Use this article as a reference to available educational resources related to signature requirements for Medicare-covered services.

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) offers a variety of educational products to help you understand signature requirements for Medicare-covered services.

1. Medicare Quarterly Compliance Newsletter
   * The Medicare Quarterly Provider Compliance Newsletter (January 2014) at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-
2. Articles


- **MM6100**, [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6100.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6100.pdf): “Physician Signature Requirements for Diagnostic Tests” notes that a physician’s signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

- **MM6261**, [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6261.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6261.pdf): “Signature and Date Stamps for DME Supplies – Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs)” alerts providers that CMS has issued instructions regarding signature requirements for CMNs and DIFs. It states signature and date stamps are not acceptable for use on CMNs and DIFs. Medicare contractors will only accept hand written, facsimiles of original written and electronic signatures and dates on medical documentation for medical review purposes on CMNs and DIFs.


- **MM7337**, [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7337.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7337.pdf): “Hospice Benefit Policy Manual Update: New Certification Requirements and Revised Conditions of Participation” states, if the narrative is part of the certification or recertification form it must be located immediately above the physician’s signature. If the narrative is an addendum to the form, (in addition to the physician’s signature on the certification or recertification form) the physician must also sign immediately following the narrative in the addendum. In addition, it must include a statement directly above the physician’s signature attesting that (by signing), the physician confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his or her examination of the patient.

a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. Under this circumstance, by affixing the rubber stamp, the provider is certifying that they have reviewed the document.


SE1308, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1308.pdf: “Physicians Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)” addresses the authority of nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) to sign orders, certification, and recertification in SNFs and NFs.

SE1405, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1405.pdf: “Documentation Requirements for Home Health Prospective Payment System (HH PPS) Face-to-Face Encounter” notes that the homebound status of the patient and his/her need for skilled services must be written in a brief narrative, signed by a physician, titled “Home Health Face-to-Face Encounter”, and dated.

3. Fact Sheets:


ICN 905364, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf: “Complying With Medicare Signature Requirements” provides answers to questions, as well as a list of resources, about Medicare signature requirements.

ICN 905064, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PAP_DocCvg_FactSheet_ICN905064.pdf: “Continuous and Bi-Level Positive Airway Pressure (CPAP/BPAP) Devices: Complying with Documentation and Coverage Requirements” states the order/prescription must be signed by the treating physician who ordered the device. The description may be written by someone else, but the treating physician must sign the order.

Additional Information


For more information about provider compliance, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html on the CMS website.

The MLN Educational Web Guides’ “MLN Guided Pathways to Medicare Resources” help providers gain knowledge on resources and products related to Medicare and the CMS
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: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html)

**Hospital**

**MM8761: Off-Cycle Release of the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2014 Pricer**

The MLN Matters® article is intended for hospitals who submit claims to Medicare Claims Part A Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

CR 8761 updates the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) PRICER due to the Protecting Access to Medicare Act of 2014 and due to corrections of some uncompensated care per claim amounts. Make sure that your billing staff are aware of these updates.

**Background**

On April 1, 2014, the Protecting Access to Medicare Act of 2014 was signed into law, and the new law includes the extension of certain provisions of the Affordable Care Act. (See [http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf](http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf) on the Internet.) Specifically, the following Medicare fee-for-service policies have been extended through March 31, 2015:

- **Section 105 - Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals**
  The Affordable Care Act provided for temporary changes to the low-volume hospital adjustment for Fiscal Years (FYs) 2011 and 2012. To qualify, the hospital must:
  - Have less than 1,600 Medicare discharges, and
  - Be 15 miles or greater from the nearest like hospital.
  The temporary changes to the low-volume hospital adjustment were extended for FY 2013 by the American Taxpayer Relief Act (see [http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf](http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf)), and from October 1, 2013 through March 31, 2014 by the Pathway for SGR Reform Act (http://www.gpo.gov/fdsys/pkg/BILLS-
The provision of the Protecting Access to Medicare Act of 2014 extends the temporary changes to the low-volume payment adjustment through March 31, 2015.

- **Section 106 - Extension of the Medicare-Dependent Hospital (MDH) Program**

  The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision of the Protecting Access to Medicare Act of 2014 extends the MDH program until March 31, 2015. Prior to this legislation, the MDH program expired March 31, 2014, as provided by the Pathway for SGR Reform Act.

  In addition, consistent with the Centers for Medicare & Medicaid Services (CMS) policy finalized in the FY 2014 IPPS Final Rule (78 FR 50638; see [http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm](http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm)) CMS is making changes to the FY 2014 Factor 3, the total uncompensated care payments and the uncompensated care per claim amount for 38 providers included in Attachment A of CR 8761, whose uncompensated care payments were inadvertently calculated using a cost report that was less than a full year when a cost report that was a full year or closer to being a full year was available.

  The updated payments reflect revisions to Factor 3 such that Medicaid days in the numerator and denominator for all affected providers are based on:

  - A full year cost report from 2011, or if not available or if less than 12 months,
  - A full year cost report from 2010, or
  - The cost report from 2011 or 2010 that is closest to 12 months.

  In addition, CMS is revising the uncompensated care per claim amount for one provider, whose uncompensated care per claim amount was inadvertently overstated, resulting in large interim overpayments. This provider is also included in Attachment A of CR 8761.

**Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2014**

The Affordable Care Act (Sections 3125 and 10314; see [http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf](http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf)) amended the low-volume hospital adjustment in section 1886(d)(12) of the Social Security Act by revising, for FYs 2011 and 2012, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. These amendments were extended for FY 2013 by the American Taxpayer Relief Act (ATRA; see [http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf](http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf)), and subsequently extended for FY 2014 discharges occurring before April 1, 2014, by the Pathway for SGR Reform Act. Prior to the Protecting Access to Medicare Act of 2014, for FY 2014 discharges occurring on or after April 1, 2014, and subsequent years, the low-volume hospital qualifying criteria and payment adjustment returned to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act and subsequent legislation.

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2014 discharges occurring on or after April 1, 2014, provided for by section 105 of the Protecting Access to Medicare Act (quoted above), in accordance with the existing regulations at CFR 412.101(b)(2)(ii) and consistent with current policy, CMS published a notice in the Federal Register (CMS 1599-N).

In that notice, CMS established that for FY 2014 discharges occurring on or after April 1, 2014, through September 30, 2015, the low-volume hospital qualifying criteria and payment adjustment (percentage increase) is determined using FY 2012 Medicare discharge data from the March 2013 update of the MedPAR files (that is, the same discharge data used to identify qualifying low-volume hospitals and calculate the payment adjustment for discharges that occurred during the first half of FY 2014).
Table 14 of the Addendum to that notice, CMS republishes the list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files (originally published in CMS 1599-IFC2). This list of IPPS hospitals with fewer than 1,600 Medicare discharges is not a listing of the hospitals that qualify for the low-volume adjustment for FY 2014 since it does not reflect whether or not the hospital meets the mileage criterion (that is, to qualify for the low-volume adjustment, the hospital must also be located more than 15 road miles from any other IPPS hospital).

In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2014 discharges occurring on or after April 1, 2014, a hospital must meet both the discharge and mileage criteria. In order to receive a low-volume hospital payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, consistent with the previously established procedure, CMS is continuing to require a hospital to notify and provide documentation to its MAC that it meets the mileage criterion. Specifically, a hospital must make its request for low-volume hospital status in writing to its Medicare Contractor and provide documentation that it meets the mileage criterion, so that the applicable low-volume percentage increase is applied to payments for its discharges occurring on or after April 1, 2014. The MAC must be in receipt of the hospital's written request by June 30, 2014, in order for the effective date of the hospital's low-volume hospital status to be April 1, 2014. A hospital that qualified for the low-volume payment adjustment for its FY 2014 discharges occurring on or after October 1, 2013, through March 31, 2014, does not need to notify its MAC and will continue to receive the applicable low-volume payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, without reapplying, provided it continues to meet the Medicare mileage criterion.

A hospital that qualified for the low-volume payment adjustment in FY 2013 but failed to make the required notification to its MAC by the deadline for its discharges occurring during the first half of FY 2014 may begin receiving the applicable low-volume payment adjustment for its FY 2014 discharges occurring on or after April 1, 2014, without reapplying, if it meets the Medicare discharge criterion, based on the FY 2012 MedPAR data (shown in Table 14 of that notice) and the distance criterion. However, the hospital must verify in writing to its MAC that it continues to be more than 15 miles from any other “subsection (d)” hospital no later than June 30, 2014. For requests for low-volume hospital status for FY 2014 discharges occurring on or after April 1, 2014, received after June 30, 2014, if the hospital meets the criteria to qualify as a low-volume hospital, the MAC will establish a low-volume hospital status effective date that will be applicable prospectively within 30 days of the date of the MAC's low-volume status determination, consistent with CMS historical policy. Hospital requests for low-volume hospital status received between the issuance of the Federal Register notice that implements the provisions of section 105 (quoted above) of the Protecting Access to Medicare Act through June 30, 2014, are only applicable for FY 2014 discharges occurring on or after April 1, 2014 (and will not be applied in determining payments for the hospital's FY 2014 discharges occurring before April 1, 2014, since CMS policy does not provide for retroactive effective dates).

MACs will verify that the hospital meets the discharge criteria by using the Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files as shown in Table 14 of the Federal Register Notice (CMS-1599-N) and available on the Acute Inpatient PPS webpage at [http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp](http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp) (click on the link on the left side of the screen titled, "FY 2014 IPPS Final Rule Home Page"). CMS notes that in order to facilitate administrative implementation, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, is the data from the March 2013 update of the FY 2012 MedPAR
The Medicare discharge count includes any billed Medicare Advantage claims in the MedPAR file but excludes any claims serviced in non-IPPS units.

In order to implement this policy for FY 2014, the Pricer will continue to include the table containing the provider number and discharge count determined from the March 2013 update of the FY 2012 MedPAR file. The table in the Pricer includes IPPS providers with fewer than 1,600 Medicare discharges but does not consider whether the IPPS hospital meets the mileage criterion (that is, located more than 15 road miles from the nearest IPPS hospital).

The applicable low-volume payment adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, Disproportionate Share Hospital (DSH), uncompensated care, Indirect Medical Education (IME) and outliers. For Sole-Community Hospitals (SCHs) and MDHs, the applicable low-volume percentage increase is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Reinstatement of Medicare Dependent Hospital (MDH) Status

Under the Affordable Care Act (Section 3124), the MDH program authorized by the Social Security Act (Section 1886(d)(5)(G)) was set to expire at the end of FY 2012. These amendments were extended for FY 2013 by section 606 of the American Taxpayer Relief Act, and from October 1, 2013, through March 31, 2014, by the Pathway for SGR Reform Act. As part of the Protecting Access to Medicare Act, Congress reinstated the MDH program through March 31, 2015.

CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in:

- The regulations at 42 CFR 412.108 (see http://www.ecfr.gov/cgi-bin/text-id?SID=cb24df348324f83565afefe0ef321163&node=42:2.0.1.2.12&rgn=divy5#42:2.0.1.2.12.7:50.13);
- The FY 2011 IPPS/LTCH PPS final rule (75 FR 50287; see http://www.gpo.gov/fdsys/pkg/FR-2010-08-16/html/2010-19092.htm);
- The FY 2014 IPPS/LTCH PPS final rule (78 FR 50647 through 50649; see http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm); and

Consistent with the CMS implementation of previous MDH program extensions, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective April 1, 2014, with no need to reapply for MDH classification. There are the following two exceptions:

A. MDHs that classified as Sole-Community Hospitals (SCHs) on or after April 1, 2014

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by March 1, 2014, to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification received SCH status as of April 1, 2014. Additionally, some hospitals that had MDH status as of the March 31, 2014, expiration of the MDH program may have missed the March 1, 2014, application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than April 1, 2014.
B. MDHs that requested a cancellation of their rural classification under 42 CFR 412.103(b)

In order to meet the criteria to become an MDH, a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at 42 CFR 412.103. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification. You can review 42 CFR 412.103 at http://www.ecfr.gov/cgi-bin/text-idx?SID=cb24df348324f83565afe0ef321163&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.7.50.8 on the Internet.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to April 1, 2014. All other former MDHs will be automatically reinstated as MDHs effective April 1, 2014. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). Specifically, the regulations at 412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (412.108(b)(2)).
2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the contractor’s written notification to the hospital (412.108(b)(4)).


Cancellation of MDH Status

As required by the regulations at 42 CFR 412.108(b)(5), MACs must “evaluate on an ongoing basis” whether or not a hospital continues to qualify for MDH status. Therefore, as required by the regulations at 412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at 412.108(a) and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the contractor provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2013, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

Attachment B of CR8761 outlines the various possible actions to be followed for each former MDH and the corresponding examples for each scenario.

Hospital Specific (HSP) Rate Update for MDHs

For the payment of FY 2014 discharges occurring on or after April 1, 2014, the Hospital Specific (HSP) amount for MDHs in the Provider Specific File will continue to be entered in FY 2012 dollars (just as was done for SCHs as instructed in CR 8241 (Transmittal 2778; August 30, 2013)). PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond.

Uncompensated Care Payment

There is no change to the existing policy.
ICD-10

ICD-10: Accessing a List of Local Coverage Determinations (LCDs) Converted to ICD-10

During the question and answer session of the June 4, 2014, Centers for Medicare & Medicaid Services (CMS) MLN Connects™ Call on More ICD-10 Coding Basics, there was a question about where to find a list of Local Coverage Determinations (LCDs) converted to ICD-10. Follow the steps below to access this information.

1. Go to the LCDs by Contractor Index Web page at http://www.cms.gov/medicare-coverage-database/indexes/lcd-contractor-index.aspx?LCntrctr=All&DocType=Future&bc=AgACAAAAAAA%3d%3d#ResultsAnchor
2. Use the scroll box to find CGS Administrators, LLC and select the appropriate contractor as follows.
   - 15004 – HHH MAC
   - 15101 – Kentucky Part A
   - 15102 – Ohio Part A
   - 15201 – Kentucky Part B
   - 15202 – Ohio Part B
3. Click the “Submit” button to access a link for that specific Medicare administrative contractor (MAC).
4. Click on the “CGS Administrators, LLC” link to view future translated LCDs.

As a reminder, the compliance date for the transition to ICD-10 is October 1, 2015. To keep up to date on ICD-10, visit the CMS ICD-10 website at http://www.cms.gov/Medicare/Coding/ICD10/index.html for the latest news and resources to help you prepare. In addition, sign up CMS ICD-10 Industry Email updates at http://www.cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html.

ICD-10

ICD-10, Dual Coding, and Dual Processing

Discussions of ICD-9 and ICD-10 often include mention of the terms dual processing and dual coding. Different people use these terms to mean different things, but in general, dual coding or processing refers to the use of ICD-9 and ICD-10 codes at the same time. So, when can you expect to use dual coding and processing and when can’t you?

Testing to Prepare for ICD-10

Dual coding and dual processing can be useful tools to prepare for ICD-10 by testing whether you are able to prepare, send, receive, and process transactions with ICD-10.
However, ICD-10 can be used for testing purposes only before the compliance date; providers and payers cannot use ICD-10 in “live” transactions for dates of service before the ICD-10 compliance date.

**Dual Coding and Dual Processing After the Compliance Date**
Following the ICD-10 compliance date, providers and payers must use:
- ICD-9 in transactions for services provided before the compliance date
- ICD-10 in transactions for services provided on or after the compliance date

While providers and payers must be able to use both ICD-9 and ICD-10 codes after the compliance date to accommodate backlogs in claims and other transactions, they will not be able to choose to use either ICD-9 or ICD-10 for a given transaction. The date of service determines whether ICD-9 or ICD-10 is to be used.

**When is the ICD-10 Compliance Date?**
The Department of Health & Human Services (HHS) expects to release a final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The new compliance date would give providers an extra year to prepare. The final rule would also require the continued use of ICD-9 for services provided through September 30, 2015.

**Keep Up to Date on ICD-10**

**ICD-10**

**SE1421: How to Access Updates to ICD-10 Local Coverage Determinations in the CMS Medicare Coverage Database**


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**Provider Types Affected**
This article is intended for all physicians, providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**
This MLN Matters® Special Edition article is intended to convey information on how to access updates to International Classification of Diseases, 10th Edition (ICD-10) Local Coverage Determinations (LCDs) in the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database (MCD).
Background
MACs may develop an LCD to further define a National Coverage Determination (NCD) or in the absence of a specific NCD. An LCD is a coverage decision made at a MAC’s own discretion to provide guidance to the public and the medical community within a specified geographic area. An LCD cannot conflict with an NCD. An LCD is an administrative and educational tool that can assist you in submitting correct claims for payment by:

- Outlining coverage criteria;
- Defining medical necessity; and
- Providing references upon which a policy (LCD) is based and codes that describe covered and/or noncovered services when the codes are integral to the discussion of medical necessity.

The MCD

Use the following steps to access the list of LCDs with ICD-10 codes:

1. On the CMS MCD Homepage, click on the “Indexes” tab at the top of the page;
2. Select “Local Coverage;”
3. Select one of the three display options for LCDs (“LCDs by Contractor,” “LCDs by State,” or “LCDs Listed Alphabetically”);
4. If you choose LCDs by Contractor, click on that link;
5. Select a MAC;
6. In the Document types, checkmark the square for “Future LCDs/Future Contract Number LCDs;”
7. Click the “Submit” button;
8. Click on the Contractor name; and
9. A list of Future Effective LCDs will display. Those LCDs with a 10/01/2014 Effective Date are ICD-10 LCDs.

Note: 1. The ICD-10 updates are labeled “future” as the policies are not yet in effect. These updates are subject to change as necessitated by code updates and policy revisions.
2. It is expected that the 10/01/2014 Effective Dates will be changed to 10/01/2015 in mid-2014.

Printing Documents on the CMS MCD
All documents on the CMS MCD may be printed. Use the following steps to print a document:

1. Open the document; and
2. In the upper right-hand corner, click on the “Print” button or use “Control + P.” Alternatively, click on the “Need a PDF?” button and click on the “Save a Copy” icon on the bottom of your screen or use “Shift + Control + S.”

Additional Information
For an in-depth review on how to use the CMS MCD, refer to the Medicare Learning Network® publication titled “How to Use the Medicare Coverage Database” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-
This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters are available at no cost from our website at http://www.cgsmedicare.com. © 2014 Copyright, CGS Administrators, LLC.

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

Network-MLN/MLNProducts/Downloads/MedicareCvrgeDatabase_ICN901346.pdf on the CMS website.