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Administration

2015 Provider Contact Center (PCC) Training

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). The list below indicates when the CGS Part A PCC (1.866.590.6703) will be closed for CSR training and staff development. The Interactive Voice Response (IVR) unit will be available during these scheduled training sessions for automated customer service transactions.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 16, 2015, President’s Day</td>
<td>9:00 a.m. - 5:30 p.m. Eastern Time</td>
</tr>
</tbody>
</table>


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.
Administration
MLN Connects™ Provider eNews

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


Administration
MM8901: Incorporation of Certain Provider Enrollment Policies in CMS-4159-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15

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: MM8901 Related Change Request (CR) #: CR 8901
Related CR Release Date: December 12, 2014 Effective Date: March 18, 2015
Related CR Transmittal #: R561PI Implementation Date: March 18, 2015

Provider Types Affected
This MLN Matters® Article is intended for physicians and eligible professionals who prescribe Medicare Part D drugs, and for providers and suppliers that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know
CR 8901 incorporates into Chapter 15 of the “Program Integrity Manual” (PIM) several provider enrollment policies in the final rule titled, “Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs.”

Key Points of CR 8901
The key points of the updated Chapter 15 of the “Medicare Program Integrity Manual” are as follows:

- If a MAC approves a provider’s or supplier’s Form CMS-855 reactivation application or Reactivation Certification Package (RCP) for a Part B non-certified supplier, the reactivation effective date will be the date the MAC received the application or RCP that
was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the MAC will issue a new Provider Transaction Access Number (PTAN).

- **CMS may deny a physician’s or eligible professional’s Form CMS-855 enrollment application under § 424.530(a)(11) if:**
  - The physician’s or eligible professional’s Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or
  - The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician’s or eligible professional’s ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.

- **CMS may revoke a physician’s or eligible professional’s Medicare enrollment under § 424.535(a)(13) if:**
  - The physician’s or eligible professional’s DEA Certificate of Registration is suspended or revoked; or
  - The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician’s or eligible professional’s ability to prescribe drugs.

- **CMS may revoke a physician’s or eligible professional’s Medicare enrollment under § 424.535(a)(14) if CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:**
  - The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.
  - The pattern or practice of prescribing fails to meet Medicare requirements.

**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.
MM8950 (Revised): Correction to Remittance Information When Health Insurance Prospective Payment System (HIPPS) Codes are Re-Coded by Medicare Systems

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

MLN Matters® Number: MM8950 Revised
Related CR Release Date: December 17, 2014
Related CR Transmittal #: R3151CP
Related Change Request (CR) #: CR 8950

Effective Date: April 1, 2015 (Effective for claims received on or after April 1, 2015)
Implementation Date: April 6, 2015

Note: This article was revised on December 19, 2014, to reflect the revised CR 8950 issued on December 17. In the article, all references to CARC 169 have been replaced with CARC 186. In addition, the CR release date, transmittal number, and the Web address for accessing CR 8950 are revised. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for Inpatient Rehabilitation Facilities (IRFs), Home Health Agencies (HHAs), and Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for services provided to Medicare beneficiaries.

Provider Action Needed
CR 8950 contains no new payment policy. CR 8950 improves the implementation of existing policies.

CR 8950:
1. Provides approved remittance advice code pairs to apply to claims in which only a Remittance Advice Remark Code (RARC) is currently used. This correction is required for compliance with operating rules of the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE).
2. Reflects changes to the Home Health (HH) Pricer logic that were implemented as part of the 2015 Home Health Prospective Payment System (HH PPS) payment update.

Make sure that your billing personnel are aware of these changes.

Background
The Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set was implemented by January 1, 2014, as the Affordable Care Act required. In order to be compliant with these Operating Rules, the processing of Original Medicare claims must use remittance advice code combinations that are included in this list that CAQH CORE developed.

Recently, MACs informed CMS of two situations in which past instructions specified only a single code for a payment adjustment, rather than a compliant pair.
1. Since 2000, Medicare systems have re-coded the Health Insurance Prospective Payment System (HIPPS) code submitted on home HH PPS claims in various circumstances. Under prior instructions, Medicare systems applied only RARC N69 (PPS code changed by claims processing system) without a corresponding claim adjustment reason code (CARC).

2. In 2012, CR 7760 began the implementation of a process to validate HIPPS codes against the assessment records submitted to the Quality Improvement Evaluation System (QIES). This process currently applies to inpatient rehabilitation facility claims and will be expanded to HH and skilled nursing facility claims in the future. CR 7760 only required Medicare systems to apply RARC N69 to claims recoded based on QIES data, also without a corresponding Claim Adjustment Reason Code (CARC). You can find the associated MLN Matters® Article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7760.pdf on the CMS website.

CR 8950 seeks to correct these oversights. However, CAQH CORE has not yet assigned approved code pairs for RARC N69. Medicare will request the approval of RARC N69 to be paired with CARC 186, Medicare systems will apply CARC 186 with RARC N69 in both situations described above.

Your MAC will:

1. Apply the following remittance advice codes on claims with Type of Bill (TOB) 032x (Home Health Services under a Plan of Treatment) when the output HIPPS code returned by the HH Pricer is different from the input HIPPS code:
   - Group code: CO
   - CARC: 186
   - RARC: N69

2. Apply the following remittance advice codes on claims with TOBs 011x (Hospital Inpatient (Part A)) with CMS Certification Numbers (CCNs) XX3025 - XX3099, XXXXX, or XXRXXX, or TOBs 018x (Hospital Swing Bed), 021x (SNF Inpatient) or 032x (Home Health) when a HIPPS code is changed due to response file information received from QIES:
   - Group code: CO
   - CARC: 186
   - RARC: N69

HIPPS codes changed on the basis of validation with QIES data are not currently displayed to providers on Direct Data Entry (DDE) screens and are not being sent to the remittance advice.

CR 8950 also reflects changes to the HH Pricer logic that were implemented as part of the 2015 HHPPS payment update. You can find these changes in the updated "Medicare Claims Processing Manual," Chapter 10 (Home Health Agency Billing), Section 70.4 (Decision Logic Used by the Pricer on Claims), which is attached to CR 8950.

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.
MM8969 (Revised): Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2015

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

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

Provider Action Needed
CR 8969 informs MACs about the changes and updates to the 60-day national episode rates, the national per-visit amounts, Low-Utilization Payment Adjustment (LUPA) add-on amounts, and the non-routine medical supply payment amounts under the HH PPS for Calendar Year (CY) 2015. Make sure that your billing staffs are aware of these changes.

Background
The Affordable Care Act of 2010 mandated several changes to Section 1895(b) of the Social Security Act (or the Act) and hence the HH PPS Update for CY 2014.

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

Also, Section 3131(c) of the Affordable Care Act amended Section 421(a) of the Medicare Modernization Act (MMA), which was amended by Section 5201(b) of the Deficit Reduction Act (DRA). The amended Section 421(a) of the MMA provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under Section 1895 of the Act applicable to home health services.
furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

**Market Basket Update**

The Multi-Factor Productivity (MFP) adjusted Home Health (HH) market basket update for CY 2015 is 2.1 percent. HHAs that do not report the required quality data will receive a 2-percentage point reduction to the MFP adjusted HH market basket update of 2.1 percent for CY 2015.

**National, Standardized 60-Day Episode Payment**

As described in the CY 2015 final rule, to determine the CY 2015 national, standardized 60-day episode payment rate, CMS starts with the CY 2014 national, standardized 60-day episode rate ($2,869.27). CMS applies a wage index budget neutrality factor of 1.0024 and a case-mix weight budget neutrality factor of 1.0366. CMS then applies an $80.95 reduction (which is 3.5 percent of the CY 2010 national, standardized 60-day episode rate of $2,312.94). Lastly, the national, standardized 60-day episode payment rate is updated by the CY 2015 MFP adjusted HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. The updated CY 2015 national standardized 60-day episode payment rate for HHAs that do submit the required quality data is shown in Table 1 below and for HHAs that do not submit the required quality data are shown in Table 2 below. These payments are further adjusted by the individual episode’s case-mix weight and wage index.

| Table 1: For HHAs that DO Submit Quality Data — National 60-Day Episode Amounts Updated by the MFP adjusted Home Health Market Basket Update for CY 2015 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| $2,869.27 | X 1.0024 | X 1.0366 | -$80.95 | X 1.021 | = $2,961.38 |

| Table 2: For HHAs that DO NOT Submit Quality Data — National 60-Day Episode Amounts Updated by the MFP adjusted Home Health Market Basket Update for CY 2015 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| $2,869.27 | X 1.0024 | X 1.0366 | -$80.95 | X 1.001 | = $2,903.37 |

**National Per-Visit Rates**

To calculate the CY 2015 national per-visit payment rates, CMS starts with the CY 2014 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0012 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2014 wage index, and then applies the maximum rebasing adjustments to the 2014 per-visit rates. The per-visit rates for each discipline are then updated by the MFP adjusted CY 2015 HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. The CY 2015 national per-visit rates per discipline for HHAs that do submit the required quality data are shown in Table 3 below and for HHAs that do not submit the required quality data are shown in Table 4 below.
### Table 3: For HHAs that DO Submit Quality Data — CY 2015 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2014 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2015 Rebasing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage</th>
<th>CY 2015 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$54.84</td>
<td>X 1.0012</td>
<td>$1.79</td>
<td>X 1.021</td>
<td>$57.89</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$194.12</td>
<td>X 1.0012</td>
<td>$6.34</td>
<td>X 1.021</td>
<td>$204.91</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$133.30</td>
<td>X 1.0012</td>
<td>$4.35</td>
<td>X 1.021</td>
<td>$140.70</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$132.40</td>
<td>X 1.0012</td>
<td>$4.32</td>
<td>X 1.021</td>
<td>$139.75</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$121.10</td>
<td>X 1.0012</td>
<td>$3.96</td>
<td>X 1.021</td>
<td>$127.83</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$143.88</td>
<td>X 1.0012</td>
<td>$4.70</td>
<td>X 1.021</td>
<td>$151.88</td>
</tr>
</tbody>
</table>

### Table 4: For HHAs that DO NOT Submit Quality Data – CY 2015 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2014 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2015 Rebasing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage Minus 2 Percentage Points</th>
<th>CY 2015 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$54.84</td>
<td>X 1.0012</td>
<td>$1.79</td>
<td>X 1.001</td>
<td>$56.75</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$194.12</td>
<td>X 1.0012</td>
<td>$6.34</td>
<td>X 1.001</td>
<td>$200.89</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$133.30</td>
<td>X 1.0012</td>
<td>$4.35</td>
<td>X 1.001</td>
<td>$137.95</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$132.40</td>
<td>X 1.0012</td>
<td>$4.32</td>
<td>X 1.001</td>
<td>$137.02</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$121.10</td>
<td>X 1.0012</td>
<td>$3.96</td>
<td>X 1.001</td>
<td>$125.33</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$143.88</td>
<td>X 1.0012</td>
<td>$4.70</td>
<td>X 1.001</td>
<td>$148.90</td>
</tr>
</tbody>
</table>

**Low-Utilization Payment Adjustment Add-On Payments**

Low-Utilization Payment Adjustment (LUPA) episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. Beginning in CY 2014, CMS calculates the payment for the first visit in a LUPA episode by multiplying the per-visit rate by a LUPA add-on factor specific to the type of visit (skilled nursing, physical therapy, or speech-language pathology). The specific requirements for the new LUPA add-on calculation are described in Transmittal 2796 dated September 27, 2013. The CY 2015 LUPA add-on adjustment factors are displayed in Table 5.

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2015 LUPA Add-On Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>1.8451</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>1.6700</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>1.6286</td>
</tr>
</tbody>
</table>

**Non-Routine Supply Payments**

Payments for Non-Routine Supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor. To determine the CY 2015 NRS conversion factor, CMS starts with the CY 2014 NRS conversion factor ($53.65) and applies a 2.82 percent rebasing adjustment calculated in the CY 2015 final rule (1 - 0.0282 = 0.9718). CMS then updates the conversion factor by the MFP adjusted HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. CMS does not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final claim payment amount is computed. The NRS conversion factor for CY 2015 payments for HHAs that do submit the required quality data is shown in Table 6a and the payment amounts for the various NRS severity.
The NRS conversion factor for CY 2015 payments for HHAs that do not submit quality data is shown in Table 7a and the payment amounts for the various NRS severity levels are shown in Table 7b.

### Table 6a: CY 2015 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2014 NRS Conversion Factor</th>
<th>2015 Rebasjing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage</th>
<th>CY 2015 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.65</td>
<td>X 0.9718</td>
<td>X 1.021</td>
<td>$53.23</td>
</tr>
</tbody>
</table>

### Table 6b: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2015 NRS Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.36</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$51.86</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$142.19</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$211.25</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$325.76</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$560.27</td>
</tr>
</tbody>
</table>

### Table 7a: CY 2015 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2014 NRS Conversion Factor</th>
<th>2015 Rebasjing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage minus 2 Percentage Points</th>
<th>CY 2015 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.65</td>
<td>X 0.9718</td>
<td>X 1.001</td>
<td>$52.19</td>
</tr>
</tbody>
</table>

### Table 7b: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2015 NRS Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.08</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$50.84</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$139.41</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$207.12</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$319.39</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$549.32</td>
</tr>
</tbody>
</table>

### Rural Add-on

Section 3131(c) of the Affordable Care Act applies a 3 percent rural add-on to the national standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The following tables show the CY 2015 rural payment rates.

### Table 8a: CY 2015 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area before Case-Mix and Wage Index Adjustment for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2015 National, Standardized 60-Day Episode Payment Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural National, Standardized 60-Day Episode Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,961.38</td>
<td>X 1.03</td>
<td>$3,050.22</td>
</tr>
</tbody>
</table>

### Table 8b: CY 2015 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area before Case-Mix and Wage Index Adjustment for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2015 National Standardized 60-Day Episode Payment Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural National, Standardized 60-Day Episode Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,903.37</td>
<td>X 1.03</td>
<td>$2,990.47</td>
</tr>
</tbody>
</table>
Table 9a: CY 2015 Per-Visit Amounts for Services Provided in a Rural Area, Before Wage Index Adjustment for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Home Health Discipline Type</th>
<th>CY 2015 Per-visit rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural per-visit rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$57.89</td>
<td>X 1.03</td>
<td>$59.63</td>
</tr>
<tr>
<td>MSS</td>
<td>$204.91</td>
<td>X 1.03</td>
<td>$211.06</td>
</tr>
<tr>
<td>OT</td>
<td>$140.70</td>
<td>X 1.03</td>
<td>$144.92</td>
</tr>
<tr>
<td>PT</td>
<td>$139.75</td>
<td>X 1.03</td>
<td>$143.94</td>
</tr>
<tr>
<td>SN</td>
<td>$127.83</td>
<td>X 1.03</td>
<td>$131.66</td>
</tr>
<tr>
<td>SLP</td>
<td>$151.88</td>
<td>X 1.03</td>
<td>$156.44</td>
</tr>
</tbody>
</table>

Table 9b: CY 2015 Per-Visit Amounts for Services Provided in a Rural Area, Before Wage Index Adjustment for HHAs that DO NOT submit quality data

<table>
<thead>
<tr>
<th>Home Health Discipline Type</th>
<th>CY 2015 Per-visit rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural per-visit rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$56.75</td>
<td>X 1.03</td>
<td>$58.45</td>
</tr>
<tr>
<td>MSS</td>
<td>$200.89</td>
<td>X 1.03</td>
<td>$206.92</td>
</tr>
<tr>
<td>OT</td>
<td>$137.95</td>
<td>X 1.03</td>
<td>$142.09</td>
</tr>
<tr>
<td>PT</td>
<td>$137.02</td>
<td>X 1.03</td>
<td>$141.13</td>
</tr>
<tr>
<td>SN</td>
<td>$125.33</td>
<td>X 1.03</td>
<td>$129.09</td>
</tr>
<tr>
<td>SLP</td>
<td>$148.90</td>
<td>X 1.03</td>
<td>$153.37</td>
</tr>
</tbody>
</table>

Table 10a: CY 2015 Conversion Factor for Services Provided in Rural Areas for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2015 Conversion Factor</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.23</td>
<td>X 1.03</td>
<td>$54.83</td>
</tr>
</tbody>
</table>

Table 10b: CY 2015 Conversion Factor for Services Provided in Rural Areas for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2015 Conversion Factor</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.19</td>
<td>X 1.03</td>
<td>$53.76</td>
</tr>
</tbody>
</table>

Table 10c: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for Services Provided in Rural Areas for HHAs that DO submit quality data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>Total CY 2015 NRS Payment Amount for Rural Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.79</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$53.42</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$146.46</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$217.60</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$335.55</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$577.11</td>
</tr>
</tbody>
</table>

Table 10d: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for Services Provided in Rural Areas for HHAs that DO NOT submit quality data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>Total CY 2015 NRS Payment Amount for Rural Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.50</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$52.37</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$143.60</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$213.35</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$329.00</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$565.85</td>
</tr>
</tbody>
</table>

These changes are to be implemented through the Home Health Pricer software found in Medicare contractor standard systems.
HHAs should remember to:

- Submit the Core Based Statistical Area (CBSA) code or special wage index code corresponding to the state and county of the beneficiary's place of residence in value code 61 on home health Requests for Anticipated Payments (RAPs) and claims;
- Use the wage index table attached to CR 8969, which associates states and counties to CBSA codes (codes in the range 10020 – 49780 and 999xx rural state codes) to determine the code to report in value code 61;
- Use the codes in the range 50xxx in the wage index table attached to CR 8969 to determine the code to report in value code 61 if the provider serves beneficiaries in areas where there is more than one unique CBSA due to the wage index transition.

Additional Information


Administration

MM9005: January 2015 Integrated Outpatient Code Editor (I/OCE) Specifications Version 16.0

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

MLN Matters® Number: MM9005 Related CR Release Date: December 19, 2014 Related CR Transmittal #: R3135CP Related Change Request (CR) #: CR 9005 Effective Date: January 1, 2015 Implementation Date: January 5, 2015

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for outpatient services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System (HH PPS) or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider Action Needed

This article is based on CR 9005 which informs MACs about the changes to the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that will be utilized under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes.

Background

CR 9005 instruction informs the MACs and the Fiscal Intermediary Shared System (FISS) that the I/OCE is being updated for January 1, 2015. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims)
through a single integrated OCE, which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis. The full list of I/OCE specifications can now be found at [http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html](http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html) on the CMS website. There is a summary of the changes for January 2015 in Appendix O (located in Appendixes M or N of prior releases) of Attachment A of CR 9005 and that summary is captured in the following table.

<table>
<thead>
<tr>
<th>Summary of Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
</tr>
<tr>
<td>Logic</td>
</tr>
</tbody>
</table>
| Logic | 1/1/2015 | Status Indicator (SI) changes:  
• New SI - J1 (Hospital Part B services paid through a comprehensive APC)  
• Deactivate SI X  
Modify description for SI Q1 to remove reference to SI X (STV – Packaged Codes) |
| Logic | 1/1/2015 | 92 | Implement new edit 92 (Device-dependent procedure reported without device code)  
Edit criteria:  
• A device-dependent procedure is reported without a device code - Return to Provider (RTP) |
| Logic | 1/1/2015 | Implement Comprehensive Ambulatory Payment Classification (APC) logic (new Appendix L):  
• Specified device-dependent procedures (SI = J1) are assigned to a comprehensive APC  
• Multiple J1 procedures may be subject to a complexity adjustment which assigns a different comprehensive APC  
• Package all other procedures (change the SI to N) present on the same claim, with exceptions for services that are not covered under OPPS (SI = B, E, M) and services that are excluded by statute |
| Logic | 1/1/2015 | Add new payment adjustment flag value 11 (Multiple units of service present paid at single comprehensive APC rate) and update Appendix G to include new value. |
| Logic | 1/1/2015 | Updates to Appendix F(a) for January 2015:  
• Add edit 86 for home health bill type 32x  
• Add new edit 92 for applicable bill types |
| Logic | 1/1/2015 | Updates Appendix F(a): Remove edits 61 and 72 from hospice bill types (81x, 82x), effective retroactively to 1/1/2014. |
| Logic | 1/1/2015 | Deactivate edits 71 and 77 (procedure/device; device/procedure). |
| Logic | 1/1/2015 | Deactivate special logic for CRT-D (Cardioverter Defibrillator with Pacing Electrode) which conditionally packaged procedure 33225 with 33249. |
| Logic | 1/1/2015 | Remove code pairs associated with 33225 from the edit logic for edit 84. |
| Logic | 1/1/2015 | Revise program logic to remove reference to SI X from conditional packaging (STVX-packaging). |
| Logic | 1/1/2015 | Updates to Appendix K on page 39 to note the deactivation of composite APC 8000. |
| Logic | 1/1/2015 | Update to the sex conflict list by adding codes 0357T and 89337 to the female only list. |
| Logic | 10/1/2014 | Modify the Federally Qualified Health Clinic (FQHC) PPS logic to ignore modifier 59 when reported with an established patient mental health visit (G0469). |
| Logic | 10/1/2014 | Update the following for FQHC PPS:  
• Add HCPCS Q0091 as a qualifying visit code for new and established patient visits  
• Add HCPCS G0472 as a preventive service-  
• Remove HCPCS M0064 from qualifying visit code pair (Appendix M) for G0467; code is deleted. |
<table>
<thead>
<tr>
<th>Type</th>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>22</td>
<td>Add new modifiers to the valid modifier list:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PO: Serv/proc off-campus pbd</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>XE: Separate Encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>XP: Separate Practitioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>XS: Separate Structure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>XU: Unusual Non-Overlapping Service</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Note: XE, XP, XS, XU are designated as National Correct Coding Initiative (NCCI) modifiers</td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>75</td>
<td>Edit 75 (Incorrect billing of modifier FB or FC) is deactivated.</td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>87</td>
<td>Updated skin substitute product lists (Lists A and B in Appendix P).</td>
</tr>
<tr>
<td>Logic</td>
<td>6/2/2014</td>
<td>68</td>
<td>Implement mid-quarter approval for G0472.</td>
</tr>
<tr>
<td>Logic</td>
<td>1/9/2014</td>
<td>68</td>
<td>Implement mid-quarter approval for G0276.</td>
</tr>
<tr>
<td>Logic</td>
<td>8/1/2014</td>
<td>67</td>
<td>Implement mid-quarter approval for 90687.</td>
</tr>
<tr>
<td>Content</td>
<td>1/1/2015</td>
<td></td>
<td>Make HCPCS/APC/SI changes as specified by CMS (data change files).</td>
</tr>
<tr>
<td>Content</td>
<td>1/1/2015</td>
<td>20, 40</td>
<td>Implement version 21.0 of the NCCI (as modified for applicable institutional providers).</td>
</tr>
<tr>
<td>Doc</td>
<td>1/1/2015</td>
<td></td>
<td>Rename Appendices from Appendix L forward, to accommodate new Comprehensive APC Processing Logic (new Appendix L); Appendix M</td>
</tr>
<tr>
<td>Doc</td>
<td>1/1/2015</td>
<td></td>
<td>Update to Appendix D to include notes regarding modifier 50 and comprehensive APCs.</td>
</tr>
<tr>
<td>Doc</td>
<td>1/1/2015</td>
<td></td>
<td>Update Appendix E (Payment Method Flag) to add SI = J1 and note deactivation of SI = X.</td>
</tr>
<tr>
<td>Doc</td>
<td>1/1/2015</td>
<td></td>
<td>Updated IOCE specification document to remove any reference to Fiscal Intermediary or “FI” (includes edit descriptions for edits 11 and 72, and any field description that included a reference to Fi/MAC).</td>
</tr>
<tr>
<td>Doc</td>
<td>10/1/2014</td>
<td></td>
<td>Updates related to FQHC PPS:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Correct the output buffer placement of edit 90 from the Procedure Edits Buffer to the Revenue Edits Buffer (only a change to IOCE output placement in the mainframe software)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Added documentation to the specifications regarding bill type 770 (no payment claim), all claim lines are assigned line item action flag 5 but edit 91 is not returned (Appendix M)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Added documentation to the specifications regarding the use of SI of E for FQHC non-covered services (Appendix M)</td>
</tr>
<tr>
<td>Other</td>
<td>1/1/2015</td>
<td></td>
<td>Create 508-compliant versions of the specifications &amp; Summary of Data Changes documents for publication on the CMS website.</td>
</tr>
<tr>
<td>Other</td>
<td>1/1/2015</td>
<td></td>
<td>Deliver quarterly software update &amp; all related documentation and files to users via electronic means.</td>
</tr>
</tbody>
</table>

**Additional Information**


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

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

- Subscribe to the MLN Connects™ Provider eNews at https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819; a weekly electronic publication with the latest Medicare program information, including MLN Connects™ National Provider Call announcements, claim and PRICER information, and Medicare Learning Network® educational product updates.


- MLN Matters® Articles Index: Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/ on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search for a keyword(s) and you will find articles that contain those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.


- Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLNProducts_listserv.pdf and start receiving updates immediately!


Quarterly Provider Update

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

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

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

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

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

Seasonal Flu Vaccinations


While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community. The HealthMap Vaccine Finder (http://vaccine.healthmap.org/) is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the
HealthMap Vaccine Finder database, register for an account to submit your information in the database (http://vaccine.healthmap.org/admin/signup/). Also, visit the CDC Influenza (Flu) Web page at http://www.cdc.gov/flu/ for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.

**Administration**

**Self-Service Tools Available to Check Eligibility and Claim Status**

The most common questions CGS receives from health care providers are about beneficiary eligibility and checking the status of submitted claims. To assist providers, CGS offers self-service options, which allows providers access to this information at their own convenience.

Please use the IVR or myCGS before contacting the Part A Customer Service Representatives (CSRs) for beneficiary eligibility and/or claim status information. The CSRs are available to answer complex questions; however, unless providers cannot access the self-service tools (due to system outages), the CSR may refer them back to the IVR when asking for eligibility and claim status.

The following provides an overview of the self-service options available. Please share this with your billing staff.

**Interactive Voice Response (IVR): 1.866.289.6501**

Obtain the following information via the CGS IVR:

- Patient eligibility;
- Claim status and deductible;
- Redetermination status;
- Checks issued; and
- General information.

To access the IVR, you must provide the following information:

- National Provider Identifier
- Provider Transaction Access Number (PTAN)
- Provider Tax Identification Number (TIN) (last 5 digits)


**myCGS**

The following information is available through myCGS:

- Patient eligibility;
- Claim status;
- View and print Remittance Advices (RAs);
- Payment information (payment floor) and recently issued check data; and
- Submit Redetermination requests, and check the status of submitted requests.

For additional information, refer to the myCGS Web page at http://www.cgsmedicare.com/parta/mycgs/index.html. The “myCGS User Manual” provides detailed information about accessing and obtaining information. Additional myCGS self-service tools include:
IVR and myCGS Availability

Both the IVR and myCGS are available 24 hours a day, seven days a week; however, information that can only be obtained by accessing other systems may not be available 24/7.

Administration

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 interact 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.

Administration

Unsolicited/Voluntary Refunds

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

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

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

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

**Administration**

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

According to the *Medicare Claims Processing Manual*, (Pub 100-04, Ch. 1, §80.2.2), interest is paid on clean claims, not paid under the periodic interim payment (PIP) method, if payment is not made within 30 days after the date of receipt. The interest rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. Effective, January 1, 2015, the interest amount is 2.125%.


**Clinical Trials**

**2015 Changes to the Category A & B Investigational Device Exemption (IDE) Process**

Beginning in January 2015, there are some changes to the Investigational Device Exemption (IDE) submission process.

**What Is Changing**

Effective for Category A and B IDE studies approved by the FDA on or after January 1, 2015, interested parties (i.e., study sponsors) that wish to seek Medicare coverage must submit a request for review and approval to CMS.

- The CMS Medicare Benefit Policy Manual (Pub. 100-02), chapter 14, contains detailed instructions on seeking CMS approval of Category A and B IDE studies for purposes of Medicare coverage.
- Additional information regarding submission of Category A and B IDE study review requests, along with the list of CMS-approved studies, is available on the CMS website at [http://www.cms.gov/Medicare/Coverage/IDE/index.html](http://www.cms.gov/Medicare/Coverage/IDE/index.html).

**J15 Medicare Providers will continue to submit requests to CGS.**

CMS approvals will be the responsibility of your study sponsor; prior to submitting to CGS for approval, check the Medicare Coverage IDE database to verify that your study has been approved by CMS. The CGE IDE Submission form has been updated to include a field to indicate whether the study has been approved by CMS.

**Reference:**

Coverage

**MM9002: Transcatheter Mitral Valve Repair (TMVR)-National Coverage Determination (NCD)**

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)

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**Related CR Transmittal #:** R178NCD and R3142CP  
**Related Change Request (CR) #:** CR 9002  
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**Implementation Date:** April 6, 2015

**Provider Types Affected**

This MLN Matters Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for Transcatheter Mitral Valve Repair (TMVR) services provided to Medicare beneficiaries.

**Provider Action Needed**

Effective for claims with dates of service furnished on or after August 7, 2014, CMS will reimburse claims for TMVR for Mitral Regurgitation (MR) when furnished under Coverage with Evidence Development (CED).

TMVR is non-covered for the treatment of MR when not furnished under CED according to the above-noted criteria. TMVR used for the treatment of any non-MR indications are non-covered by Medicare.

**Background**

TMVR is a new technology for use in treating MR. MR occurs when the leaflets of the mitral valve do not close properly and blood flows from the left ventricle back into the left atrium, causing the heart to work harder to pump. This, in turn, causes enlargement of the left ventricle and can lead to potential heart failure.

Abbott’s MitraClip, the only U.S. Food and Drug Administration (FDA)-approved TMVR device, involves clipping together a portion of the mitral valve leaflets. This is performed under general anesthesia, with delivery of the device typically through a percutaneous transvenous approach, via echocardiographic and fluoroscopic guidance. The procedure is performed in a cardiac catheterization laboratory or hybrid operating room/cardiac catheterization laboratory with advanced quality imaging. TMVR is covered for uses not listed as an FDA-approved indication when performed in approved clinical studies which meet certain study question requirements. The TMVR procedure must be performed by an interventional cardiologist or cardiac surgeon, or they may jointly participate in the intraoperative technical aspects, as appropriate.
On August 7, 2014, CMS issued a final decision memorandum covering TMVR for MR under CED for the treatment of MR when furnished for an FDA-approved indication with an FDA-approved device as follows:

- Treatment of significant, symptomatic, degenerative MR when furnished according to an FDA-approved indication, and all CMS coverage criteria are met; and
- TMVR for MR uses not expressly listed as FDA-approved indications but only within the context of an FDA-approved, randomized clinical trial that meets all CMS coverage criteria.

CED requires that each patient be entered into a qualified national registry. In addition, prior to receiving TMVR, face-to-face examinations of the patient are required by a cardiac surgeon and a cardiologist experienced in mitral valve surgery to evaluate the patient’s suitability for TMVR and determination of prohibitive risk, with documentation of their rationale.

The NCD lists the criteria that must be met prior to beginning a TMVR program and after a TMVR program is established. No NCD existed for TMVR for MR prior to August 7, 2014, and TMVR is non-covered outside CED or for non-MR indications. The Web address for accessing the NCD transmittal is available in the “Additional Information” section at the end of this article.


Based on the NCD, TMVR must be furnished in a hospital with the appropriate infrastructure that includes but is not limited to:

- On-site active valvular heart disease surgical program with >2 hospital-based cardiothoracic surgeons experienced in valvular surgery;
- Cardiac catheterization lab or hybrid operating room/catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering catheterization laboratory-quality imaging;
- Non-invasive imaging expertise including transthoracic/transesophageal/3D echocardiography, vascular studies, and cardiac CT studies;
- Sufficient space, in a sterile environment, to accommodate necessary equipment for cases with and without complications;
- Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures;
- Adequate outpatient clinical care facilities; and
- Appropriate volume requirements per the applicable qualifications below.

There are institutional and operator requirements for performing TMVR. The hospital must have the following:

- A surgical program that performs ≥25 total mitral valve surgical procedures for severe MR per year of which at least 10 must be mitral valve repairs;
- An interventional cardiology program that performs ≥1000 catheterizations per year, including ≥400 Percutaneous Coronary Interventions (PCIs) per year, with acceptable outcomes for conventional procedures compared to National Cardiovascular Data Registry (NCDR) benchmarks;
- The heart team must include:
  1. An interventional cardiologist(s) who:
     > performs ≥50 structural procedures per year including Atrial Septal Defects (ASD), Patent Foramen Ovale (PFO) and trans-septal punctures; and,
     > must receive prior suitable training on the devices to be used; and
must be board-certified in interventional cardiology or board-certified/eligible in pediatric cardiology or similar boards from outside the United States;

2. Additional members of the heart team, including cardiac echocardiographers, other cardiac imaging specialists, heart valve and heart failure specialists, electrophysiologists, cardiac anesthesiologists, intensivists, nurses, nurse practitioners, physician assistants, data/research coordinators, and a dedicated administrator.

> All cases must be submitted to a single national database;
> Ongoing continuing medical education (or the nursing/technologist equivalent) of 10 hours per year of relevant material; and
> The cardiothoracic surgeon(s) must be board-certified in thoracic surgery or similar foreign equivalent.
> The heart team’s interventional cardiologist or a cardiothoracic surgeon must perform the TMVR. Interventional cardiologist(s) and cardiothoracic surgeon(s) may jointly participate in the intra-operative technical aspects of TMVR as appropriate.

The heart team and hospital must be participating in a prospective, national, audited registry that: 1) consecutively enrolls TMVR patients; 2) accepts all manufactured devices; 3) follows the patient for at least one year; and, 4) complies with relevant regulations relating to protecting human research subjects, including 45 Code of Federal Regulations (CFR) Part 46 and 21 CFR Parts 50 & 56. For complete details on the outcomes that must be tracked by the registry and the data that must be provided to the registry, see the CR9002 NCD transmittal. The Web address for that transmittal is in the “Additional Information” section at the end of this article.

**Coding Requirements/Claims Processing Requirements**

**Coding Requirements for TMVR for MR Claims Furnished on or After August 7, 2014**

The Current Procedural Terminology (CPT) Codes for TMVR for MR Claims are:

- **0343T** - Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; initial prosthesis. (Note: 0343T will be replaced by CPT code 33418 effective January 1, 2015.)

- **0344T** - Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure). (Note: 0344T will be replaced by CPT code 33419 effective January 1, 2015.)

- **0345T** - Transcatheter mitral valve repair percutaneous approach via the coronary sinus

- **33418** - Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis. (Note: CPT code 33418 is effective January 1, 2015.)

- **33419** - Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session. (List separately in addition to code for primary procedure.) (Note: CPT code 33419 is effective January 1, 2015.)

**ICD-9/ICD-10 Codes for TMVR for MR Claims**

The ICD-9 (and upon ICD-10 implementation)/ ICD-10 codes are:

- ICD-9 Procedure Code - 35.97 - Percutaneous mitral valve repair with implant - and
  ICD-10 procedure code is 02UG3JZ – Supplement mitral valve with synthetic substitute, percutaneous approach
Professional Claims Place of Service (POS) Codes for TMVR for MR Claims

Effective for claims with dates of service on and after August 7, 2014, place of service (POS) code 21 is valid for use for TMVR for MR services. All other POS codes will be denied. MACs will supply the following messages when MACs denying TMVR for MR claims for invalid POS:

- Claim Adjustment Reason Code (CARC) 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file.)

Professional Claims Modifiers for TMVR for MR Claims

Effective for claims with dates of service on or after August 7, 2014, MACs will pay TMVR for MR claim lines billed with CPT codes 0343T, 0344T, and 00345T when billed for two surgeons/co-surgeons only when the claim includes modifier -62. (Effective January 1, 2015, CPT codes 33418 and 33419 replace CPT codes 0343T and 0344T, respectively.) Claim lines for two surgeons/co-surgeons billed without modifier -62 shall be returned as unprocessable.

MACs will supply the following messages when returning TMVR for MR claim lines for two surgeons/co-surgeons billed without modifier -62 as unprocessable:

- CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- Remittance Advice Remarks Code (RARC) N517: “Resubmit a new claim with the requested information.”
- Group Code: CO

Professional Clinical Trial Diagnostic Coding for TMVR for MR Claims

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with CPT codes 0343T, 0344T, and 0345T in a clinical trial when billed with modifier -Q0. (Effective January 1, 2015, CPT codes 33418 and 33419 replace CPT codes 0343T and 0344T, respectively.) TMVR for MR claim lines in a clinical trial billed without modifier -Q0 will be returned as unprocessable. MACs will supply the following messages when returning TMVR for MR claim lines in a clinical trial billed without modifier -Q0 as unprocessable:

- CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N517: “Resubmit a new claim with the requested information”
- Group Code: CO
MACs will supply the following messages when denying TMVR for MR claim lines in a clinical trial billed without secondary ICD-9 diagnosis code V70.7(ICD-10=Z00.6) as unprocessable:

- CARC 50: “These are non-covered services because this is not deemed a “medical necessity” by the payer.”
- RARC N386: “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [http://www.cms.hhs.gov/mcd/search.asp](http://www.cms.hhs.gov/mcd/search.asp). If you do not have Web access, you may contact the contractor to request a copy of the NCD.”
- Group Code: CO

**Mandatory National Clinical Trial (NCT) Number for TMVR for MR Claims**

Effective for claims with dates of service on or after August 7, 2014, contractors shall pay TMVR for MR claim lines billed with CPT codes 0343T, 0344T, and 0345T in a clinical trial only when billed with an 8-digit National Clinical Trial (NCT) number. (Effective January 1, 2015, CPT codes 33418 and 33419 replace CPT codes 0343T and 0344T, respectively.) MACs shall accept the numeric, 8-digit NCT number preceded by the two alpha characters of “CT” when placed in Field 19 of paper Form CMS-1500, or when entered WITHOUT the “CT” prefix in the electronic 837P in Loop 2300 REF02 (REF01=P4). **NOTE:** The “CT” prefix is required on a paper claim, but it is not required on an electronic claim. TMVR for MR claim lines in a clinical trial billed without an 8-digit NCT number shall be returned as unprocessable. MACs will supply the following messages when returning TMVR for MR claim lines as unprocessable when billed without an 8-digit NCT number:

- CARC 16: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)”
- RARC MA50: “Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.”
- Group Code: CO

**Claims Processing Requirements for TMVR for MR on Inpatient Hospital Claims**

Inpatient hospitals shall bill for TMVR for MR on a 11X Type of Bill (TOB) effective for discharges on or after August 7, 2014. In addition to the ICD-9/10 procedure and diagnosis codes mentioned above, inpatient hospital discharges for TMVR for MR shall be covered when billed with the following clinical trial coding:

- Secondary ICD-9 diagnosis code V70.7/ICD-10 diagnosis code Z00.6;
- Condition Code 30; and
- An 8-digit NCT Number assigned by the National Library of Medicine (NLM) and displayed at [https://clinicaltrials.gov](https://clinicaltrials.gov) on the Internet.

Inpatient hospital discharges for TMVR for MR will be rejected when billed without the ICD-9/10 diagnosis and procedure codes and clinical trial coding mentioned above. Claims that do not include these required codes shall be rejected with the following messages:

- CARC: 50 - “These are non-covered services because this is not deemed a “medical necessity” by the payer.”
- RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [http://www.cms.hhs.gov/mcd/search.asp](http://www.cms.hhs.gov/mcd/search.asp). If you do not have Web access, you may contact the contractor to request a copy of the NCD.”
- Group Code - Contractual Obligation (CO)
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.

End-Stage Renal Disease

MM8978 (Revised): Implementation of Changes in the End-Stage Renal Disease Prospective Payment System (ESRD PPS) for Calendar Year (CY) 2015

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

MLN Matters® Number: MM8978
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Related Change Request (CR) #: CR 8978
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Implementation Date: January 5, 2015

Note: This article was revised on December 8, 2014, to reflect the revised CR 8978 issued on December 2. In the article, the CR release date, transmittal numbers, and the Web addresses for accessing CR 8978 are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for End Stage Renal Disease (ESRD) facilities submitting claims to Medicare Administration Contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8978 which implements the CY 2015 rate updates for the ESRD Prospective Payment System (PPS). Make sure that your billing staffs are aware of these changes for CY 2015.

Background

In accordance with the Medicare Improvements for Patients and Providers Act (MIPPA; section 153(b)), CMS implemented the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) effective January 1, 2011. You may review MIPPA (section 153(b)) at http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf on the Internet.

The Affordable Care Act (section 3401(h) amended MIPPA (section 153(b)); see http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf), and states that for 2012 and each subsequent year, CMS will reduce the ESRD bundled (ESRDB) market basket increase factor by a productivity adjustment described in the Social Security Act (section 1886(b)(3)(B)(xi)(II); see http://www.ssa.gov/OP_Home/ssact/title18/1886.html). The ESRDB market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate.
For CY 2015, CMS rebased and revised the ESRDB market basket so that the cost weights and price proxies reflect the mix of goods and services that underlie ESRD bundled operating and capital costs for CY 2012. A payment provision for CY 2015 that is affected by the rebase and revision is an increase in the labor-related share, which is used when adjusting payments for geographic locality. CMS is implementing a 2-year transition under which a 50/50 blended labor-related share will apply to all ESRD facilities.

In addition, the Protecting Access to Medicare Act of 2014 (PAMA; section 217; see http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf on the Internet) includes several provisions that apply to the ESRD PPS. The most significant provisions for CY 2015 are the elimination of the drug utilization adjustment transition, a 0.0 percent update to the ESRD PPS base rate, and a delay in the inclusion of oral-only drugs used for the treatment of ESRD into the bundled payment until January 1, 2024.

The CY 2015 ESRD PPS final rule adopts the most recent core-based statistical area (CBSA) delineations as described in the February 28, 2013, Office of Management and Budget (OMB) Bulletin No. 13-01. In addition, CMS is implementing a 2-year transition under which a 50/50 blended wage index will apply to all ESRD facilities. As a result, several counties now have new CBSA numbers. In addition, for CY 2015 only, there are several special wage index values that need to be sent to the ESRD PPS pricer in order to apply correct payments to certain ESRD facilities.

ESRD facilities can confirm their CY 2015 CBSA delineation status and wage index value at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment on the CMS website.

The consolidated billing requirements for drugs and biologicals included in the ESRD PPS will be updated to include Health Care Procedure Coding System (HCPCS) code J3480 (Injection, potassium chloride, per 2 meq). It is a composite rate drug and therefore, is not eligible for outlier consideration.

Regarding the calculation for outlier payments, there is a correction to the mean unit cost associated with the oral equivalent drug, Hectorol (doxercalciferol) 0.5 mcg capsule and 1 mcg capsule, applicable to claims with dates of service in 2014. Facilities that believe the mean unit cost corrections may impact their outlier payments for claims in 2014, should submit adjustments to their claims within 6 months from the effective date of CR 8978. MACs will be instructed to override timely filing if necessary.

Finally, in an effort to enhance the ESRD claims data for possible future refinements to the ESRD PPS, CMS is requiring ESRD facilities to begin reporting composite rate drugs and biologicals on the claim. Specifically, ESRD facilities should only report the composite rate drugs identified on the consolidated billing drug list provided in Attachment B of CR 8978. The ESRD PPS payment policy remains the same for composite rate drugs, therefore, no separate payment is made and these drugs will not be included in the outlier policy.

Calendar year (CY) 2015 ESRD PPS Updates:

ESRD PPS base rate:

A zero percent update to the payment rate results in a CY 2015 ESRD PPS base rate of $239.02 in accordance with section 217(b)(2) of PAMA. With a wage index budget neutrality adjustment factor of 1.001729, the CY 2015 ESRD PPS base rate is $239.43 ($239.02 x 1.001729 = $239.43).

Wage index:

The wage index adjustment will be updated to reflect the latest available wage data. New CBSA delineations are being implemented with a 50/50 blend of wage indices and the wage index floor will be reduced from 0.45 to 0.40.
Labor-related share:
The revised labor-related share is 50.673 percent, an increase from 41.737 percent. CMS will implement the revised labor-related share with a 50/50 blend under a 2-year transition which results in a labor-related share value of 46.205 percent for CY 2015.

Outlier Policy:
CMS will make the following updates to the adjusted average outlier service Medicare Allowable Payment (MAP) amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $51.29.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $43.57.

CMS will make the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:

1. The fixed dollar loss amount is $86.19 for adult patients.
2. The fixed dollar loss amount is $54.35 for pediatric patients.

CMS will make the following changes to the list of outlier services:

1. Renal dialysis drugs, that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the Medicare Prescription Drug Plan Finder, will be updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. See Attachment A of CR8978 which provides a list of 2015 Oral and Other Equivalent Forms of Injectable Drugs.
2. The mean dispensing fee of the National Drug Codes (NDC) qualifying for outlier consideration is revised to $1.15 per NDC per month for claims with dates of service on or after January 1, 2015. See Attachment A of CR8978.

Claims Reporting:
ESRD facilities shall begin reporting the composite rate drugs itemized on the consolidated billing list (see Attachment B of CR 8978) when provided, on ESRD claims with dates of service on or after January 1, 2015.

CR 8978 also revises the “Medicare Benefit Policy Manual” (Chapter 11 (End Stage Renal Disease (ESRD), sections 10, 20, 30, 40, 50, and 60) and the “Medicare Claims Processing Manual (Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), section 50.3 (Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS). These manual revisions are included as attachments to CR 8978.

As part of the manual changes, ESRD facilities are required, effective January 1, 2015, to report on the claim the composite rate drugs identified on the consolidated billing list provided at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDPayment/Consolidated_Billing.html on the CMS website. No other composite rate drugs, items, or services are to be reported on the claim.

Additional Information
Fee Schedule

MM9028: Calendar Year (CY) 2015
Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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: MM9028 Related Change Request (CR) #: CR 9028
Related CR Release Date: December 19, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R3152CP Implementation Date: January 5, 2015

Provider Types Affected
This MLN Matters® article is intended for clinical diagnostic laboratories who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
CR 9028 provides instructions for the CY 2015 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Make sure your billing staffs are aware of these updates.

Background
In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Affordable Care Act of 2010, the annual update to the local clinical laboratory fees for CY 2015 is (-0.25) percent. The annual update to local clinical laboratory fees for CY 2015 reflects an additional multi-factor productivity adjustment and a (-1.75) percentage point reduction as described by the Affordable Care Act.

The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2015 is 2.10 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the National Limitation Amount (NLA).

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key Points of CR 9028

National Minimum Payment Amounts
For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2015 national minimum payment amount is $14.38 ($14.42 plus (-0.25) percent update for CY 2015).
The affected codes for the national minimum payment amount are 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, and P3000.

**National Limitation Amounts (Maximum)**

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

**Access to Data File**

Internet access to the CY 2015 clinical laboratory fee schedule data file is available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html) on the CMS website. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, may use the Internet to retrieve the CY 2015 clinical laboratory fee schedule; available in multiple formats, including Excel, text, and comma delimited.

**Public Comments**

On July 14, 2014, CMS hosted a public meeting to solicit input on the payment relationship between CY 2014 codes and new CY 2015 CPT codes. Notice of the meeting was published in the Federal Register on March 25, 2014, and on the CMS Web site approximately April 1, 2014. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the Web site at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html?redirect=/ClinicalLabFeeSched](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html?redirect=/ClinicalLabFeeSched). Additional written comments from the public were accepted until October 30, 2014. CMS has posted a summary of the public comments and the rationale for the final payment determinations at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2015-CLFS-Codes-Final-Determinations.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2015-CLFS-Codes-Final-Determinations.pdf) on the CMS Web site.

**Pricing Information**

The CY 2015 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated annually. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2015, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2015 clinical laboratory fee schedule also includes codes that have a “QW” modifier to both identify codes and to determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

**Organ or Disease Oriented Panel Codes**

As in prior years, the CY 2015 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

**Mapping Information**

Existing code 83516QW is priced at the same rate as code 83516.

New code 80163 is priced at the same rate as code 80162.

New code 80165 is priced at the same rate as code 80164.
New codes to be gap filled are 81161, 81246, 81287, 81288, 81313, 81410, 81411, 81415, 81416,
81417, 81420, 81425, 81426, 81427, 81430, 81431, 81435, 81436, 81440, 81445, 81450, 81455,
81460, 81465, 81470, and 81471.

New code 83006 is priced at the same rate as code 82777.
New code 87505 is priced at the same rate as code 87631.
New code 87506 is priced at the same rate as code 87632.
New code 87507 is priced at the same rate as code 87633.
New code 87623 is priced at the same rate as code 87621.
New code 87624 is priced at the same rate as code 87621.
New code 87625 is priced at the same rate as code 87621.
New code 87806 is priced at the same rate as code 87389.
New code G6030 is priced at the same rate as code 80152.
New code G6031 is priced at the same rate as code 80154.
New code G6032 is priced at the same rate as code 80160.
New code G6034 is priced at the same rate as code 80166.
New code G6035 is priced at the same rate as code 80172.
New code G6036 is priced at the same rate as code 80174.
New code G6037 is priced at the same rate as code 80182.
New code G6038 is priced at the same rate as code 80196.
New code G6039 is priced at the same rate as code 82003.
New code G6040 is priced at the same rate as code 82055.
New code G6041 is priced at the same rate as code 82101.
New code G6042 is priced at the same rate as code 82145.
New code G6043 is priced at the same rate as code 82205.
New code G6044 is priced at the same rate as code 82520.
New code G6045 is priced at the same rate as code 82646.
New code G6046 is priced at the same rate as code 82649.
New code G6047 is priced at the same rate as code 82651.
New code G6048 is priced at the same rate as code 82654.
New code G6049 is priced at the same rate as code 82666.
New code G6050 is priced at the same rate as code 82690.
New code G6051 is priced at the same rate as code 82742.
New code G6052 is priced at the same rate as code 83805.
New code G6053 is priced at the same rate as code 83840.
New code G6054 is priced at the same rate as code 83858.
New code G6055 is priced at the same rate as code 83887.
New code G6056 is priced at the same rate as code 83925.
New code G6057 is priced at the same rate as code 84022.
New code G6058 is priced at the same rate as code 80102.
New code G0464 is priced at the same rate as sum of codes 81315, 81275, and 82274.
The following existing codes are to be deleted: 80440, 82000, 82055, 82055QW, 82953, 82975, 82980, 83008, 83055, 83071, 83634, 83866, 84127, 87001, 87620, 87621, 87622, 80102, 80152, 80154, 80160, 80166, 80172, 80174, 80182, 80196, 82003, 82101, 82145, 82205, 82520, 82646, 82649, 82651, 82654, 82666, 82690, 82742, 83805, 83840, 83858, 83887, 83925, and 84022.

Laboratory Costs Subject to Reasonable Charge Payment in CY 2011

For outpatients, the following codes are paid under a reasonable charge basis. The reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2015 is 2.1 percent.


When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, the “Medicare Claims Processing Manual,” Chapter 8, Section 60.3, which is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf), instructs that the reasonable charge basis applies. When these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital Outpatient Prospective Payment System (OPPS).

Blood Product Codes


NOTE: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047 should be obtained from the Medicare Part B drug pricing files.

Transfusion Medicine Codes

Transfusion Medicine codes are 86850, 86860, 86870, 86880, 86885, 86886, 86890, 86891, 86900, 86901, 86902, 86904, 86905, 86906, 86920, 86921, 86922, 86923, 86927, 86930, 86931, 86932, 86945, 86950, 86960, 86965, 86970, 86971, 86972, 86975, 86976, 86977, 86978, and 86985.

Reproductive Medicine Procedures

Reproductive Medicine Procedure codes are 89250, 89251, 89253, 89254, 89255, 89257, 89258, 89259, 89260, 89261, 89264, 89268, 89272, 89280, 89281, 89290, 89291, 89335, 89342, 89343, 89344, 89346, 89352, 89353, 89354, and 89356.

MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust claims that you bring to their attention.
Additional Information


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

Fee Schedule

MM9034: Summary of Policies in the Calendar Year (CY) 2015 Medicare Physician Fee Schedule (MPFS) Final Rule and Telehealth Originating Site Facility Fee Payment Amount

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: MM9034 Related CR Release Date: December 24, 2014
Related CR Transmittal #: R3157CP Effective Date: January 1, 2015
Related Change Request (CR) #: CR 9034 Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

This article is based on CR 9034 which provides a summary of the policies in the CY 2015 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. Make sure that your billing staff are aware of these updates for 2015.

Background

The Social Security Act (Section 1848(b)(1); (see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm on the Internet) requires CMS to establish a fee schedule of payment amounts for physicians’ services for the subsequent year. CMS issued a final rule with comment period on October 13, 2014 (see https://www.federalregister.gov/articles/2014/11/13 on the Internet), that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in CY 2015.


The final rule also addresses interim final values established in the CY 2014 MPFS final rule with comment period. (See http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf on the Internet). The final rule assigns interim final values for new, revised, and
potentially misvalued codes for CY 2015 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until December 30, 2014.

**Sustainable Growth Rate (SGR)**

The Protecting Access to Medicare Act of 2014 (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) provides for a zero percent update from the CY 2014 rates for services furnished between January 1, 2015, and March 31, 2015. Adjusting by .06 percent to achieve required budget neutrality, the conversion factor for this period is $35.8013.

**Under current law, the conversion factor will be adjusted on April 1, 2015.** In the final rule CMS announced a conversion factor of $28.2239 for this period, resulting in an average reduction of 21.2 percent from the CY 2014 rates. In most prior years, Congress has taken action to avert large across-the-board reductions in PFS rates before they went into effect. The Administration supports legislation to permanently change SGR to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

**Screening and Diagnostic Digital Mammography**

To ensure that the higher resources needed for 3D mammography are recognized, Medicare will pay for 3D mammography using add-on codes that will be reported in addition to the 2D mammography codes when 3D mammography is furnished. See MLN Matters® Article MM8874 at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf) for more information.

**Primary Care and Chronic Care Management**

Medicare continues to emphasize primary care by making payment for chronic care management (CCM) services — non-face-to-face services to Medicare beneficiaries who have two or more chronic conditions — beginning January 1, 2015. CCM services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management. CCM can be billed once per month per qualified beneficiary, provided the minimum level of services is furnished. CMS is finalizing its proposal to allow greater flexibility in the supervision of clinical staff providing CCM services. The proposed application of the “incident to” supervision rules was widely supported by the commenters.

Payment for CCM is only one part of a multi-faceted CMS initiative to improve Medicare beneficiaries’ access to primary care. Models being tested through the Innovation Center will continue to explore other primary care innovations.

Finally, CMS will require that in order to bill CCM, a practitioner must use a certified electronic health record (EHR) that meets the requirements for the EHR Incentive Program as of December 31 of the prior calendar year.

**Application of Beneficiary Cost Sharing To Anesthesia Related To Screening Colonoscopies**

The Medicare statute waives the Part B deductible and coinsurance applicable to screening colonoscopy. In the CY 2015 final rule, CMS revised the definition of a “screening colonoscopy” to include separately provided anesthesia as part of the screening service so that the coinsurance and deductible do not apply to anesthesia for a screening colonoscopy, reducing beneficiaries’ cost-sharing obligations under Part B. For more information, review MLN Matters® Article MM8874 at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf) on the CMS website.
Enhanced Transparency in Setting PFS Rates

Since the beginning of the physician fee schedule in 1992, CMS adopted rates for new and revised codes for the following calendar year in the final rule on an interim basis subject to public comment. This policy was necessary because CMS did not receive the codes in time to include in the PFS proposed rule. Until recently, the only services that were affected by this policy were services with new and revised codes. In recent years, CMS began receiving new and revised codes and revaluing existing services under the misvalued codes initiative. Establishing payment in the final rule for misvalued codes often led to implementation of payment reductions before the public had the opportunity to comment. CMS finalized its proposal to change the process for valuing new, revised and potentially misvalued codes for CY 2016, so that payment for the vast majority of these codes goes through notice and comment rulemaking prior to being adopted. After a transition in CY 2016, the process will be fully implemented in CY 2017.

Potentially Misvalued Services

Consistent with amendments to the Affordable Care Act (see http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf on the Internet), CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and to make adjustments where appropriate.

The following are major misvalued code decisions for 2015:

- **Radiation Therapy and Gastroenterology**: Consistent with the final rule policy and in response to public comments, CMS is not adopting the CPT coding changes for CY 2015 for gastroenterology and radiation therapy services so that CMS can propose and obtain comments on the revised coding prior to using them for payment. As a result, CMS will not recognize some new CPT codes, and created G-codes in place of changed and new CPT codes.

- **Radiation Treatment Vault**: CMS proposed to refine the way it accounts for the infrastructure costs associated with radiation therapy equipment, specifically to remove the radiation treatment vault as a direct expense when valuing radiation therapy services. After considering public comments, CMS did not finalize this proposal.

- **Epidural Pain Injections**: CMS reduced payment for these services in 2014 under the misvalued code initiative. In response to concerns from pain physicians regarding the accuracy of the valuation, CMS proposed to raise the values in 2015 based on their prior resource inputs before adopting further changes after considering RUC recommendations. However, because the inputs for these services included those related to image guidance, CMS also proposed to prohibit separate billing for image guidance for CY 2015. CMS finalized the policy as proposed to avoid duplicate payment for image guidance. CMS has asked the RUC to further review this issue and make recommendations to us on how to value epidural pain injections.

- **Film to Digital Substitution**: CMS finalized its proposal to update the practice expense inputs for X-ray services to reflect that X-rays are currently done digitally rather than with analog film.

Global Surgery

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) has identified a number of surgical procedures that include more visits in the global period than are being furnished. CMS is also concerned that post-surgical visits are valued higher than visits that were furnished and billed separately by other physicians such as general internists or family physicians.

CMS finalized a proposal to transform all 10- day and 90-day globals to 0-day globals, beginning with 10-day global services in CY 2017 and following with the 90-day global...
services in 2018. As CMS revalues these services as 0-day global periods, CMS will actively assess whether there is a better construction of a bundled payment for surgical services that incentivizes care coordination and care redesign across an episode of care.

**Access to Telehealth Services**

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

- Annual wellness visits,
- Psychoanalysis,
- Psychotherapy, and
- Prolonged evaluation and management services.

For the list of telehealth services, visit: [http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html](http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html) on the CMS website.

**Telehealth Origination Site Facility Fee Payment Amount Update**

The Social Security Act (Section 1834(m)(2)(B) (see [http://www.ssa.gov/OP_Home/ssact/title18/1834.htm](http://www.ssa.gov/OP_Home/ssact/title18/1834.htm)) establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20.

For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in the Social Security Act (Section 1842(i)(3) (see [http://www.ssa.gov/OP_Home/ssact/title18/1842.htm](http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) on the Internet).

The MEI increase for 2015 is 0.8 percent. Therefore, for CY 2015, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $24.83. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

**Revisions to Malpractice Relative Value Units (RVUs)**

As required by the Medicare law, CMS conducted a five-year review and updated the resource-based malpractice RVUs based on updated professional liability insurance premiums, largely paralleling the methodology used in the CY 2010 update. The final rule indicated that anesthesia RVUs will be updated in CY 2016.

**Revisions to Geographic Practice Cost Indices (GPCIs)**

As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in the cost of operating a medical practice. For CY 2015, CMS is using territory-level wage data to calculate the work GPCI and employee wage component of the PE GPCI for the Virgin Islands.

The CY 2015 GPCIs also reflect the application of the statutorily mandated of 1.5 work GPCI floor in Alaska, and 1.0 work GPCI floor for all other physician fee schedule areas, and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming).

However, given that the statutory 1.0 work GPCI floor is scheduled to expire under current law on March 31, 2015, the GPCIs reflect the elimination of the 1.0 work GPCI floor from April 1, 2015, through December 31, 2015.

**Services Performed in Off-campus Provider-Based Departments**

CMS will collect data on services furnished in off-campus provider-based departments by requiring hospitals to report a modifier for those services furnished in an off-campus provider-based department of the hospital and by requiring physicians and other
billing practitioners to report these services using a new place of service code on professional claims.

Data collection will be voluntary for hospitals in 2015 and required beginning on January 1, 2016. The new place of service codes will be used for professional claims as soon as it is available, but not before January 1, 2016.

**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.

**Hospital**

**MM9014 (Revised): January 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

The Centers for Medicare & Medicaid Services (CMS) issued the following *Medicare Learning Network® (MLN) Matters* article on December 18, 2014. CMS then issued a revision to this article on December 24, 2014. The following reflects the revised 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:** MM9014 *Revised*  
**Related CR Release Date:** December 22, 2014  
**Related CR Transmittal #:** R3156CP  
**Related Change Request (CR) #:** CR9014  
**Effective Date:** January 1, 2015  
**Implementation Date:** January 5, 2015

**Note:** This article was revised on December 23, 2014, based on a revised Change Request (CR) that corrected some values in Table 8, which addressed changes to the Outpatient Provider Specific File. That Table is in Attachment A of the CR, but was not included in this article. The CR Release Date, transmittal number and link to the CR was also changed. All other information remains the same.

**Provider Types Affected**

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

**Provider Action Needed**

CR 9014 describes changes to and billing instructions for various payment policies implemented in the January 2015 OPPS update. Make sure your billing staffs are aware of these changes.

**Background**

CR 9014 describes changes to and billing instructions for various payment policies implemented in the January 2015 Outpatient Prospective Payment System (OPPS) update. The January 2015 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer
will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicators (SIs) and Revenue Code additions, changes, and deletions identified in CR 9014.


Key changes to and billing instructions for various payment policies implemented in the January 2015, OPPS update are as follows:

New Service

The new service listed in Table 1 is assigned for payment under the OPPS, effective January 1, 2015.

Table 1 – New Service Assigned for Payment under OPPS, Effective January 1, 2015

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective Date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Payment</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9742</td>
<td>01/01/2015</td>
<td>T</td>
<td>0073</td>
<td>Laryngoscopy</td>
<td>Laryngoscopy,</td>
<td>$1259.06</td>
<td>$251.82</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>with injection</td>
<td>flexible fiberoptic, with injection into vocal cord(s), therapeutic, including diagnostic laryngoscopy, if performed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

New Device Pass-Through Categories

The Social Security Act (Section 1833(t)(6)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Social Security Act (the Act) requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device pass-through category as of January 1, 2015. Table 2 provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

Table 2 – New Device Pass-Through Code

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective Date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Device Offset from Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2624</td>
<td>01/01/15</td>
<td>H</td>
<td>2624</td>
<td>Wireless pressure sensor</td>
<td>Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components</td>
<td>$310.33</td>
</tr>
</tbody>
</table>

a.  **Device Offset from Payment:** Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8).

CMS has determined that a portion of the APC payment amount associated with the cost of C2624 is reflected in APC 0080, Diagnostic Cardiac Catheterization. The C2624 device should always be billed with procedure code C9741 (Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report), which is assigned to APC 0080 for CY 2015. The device offset from payment represents a deduction from pass-through payments for the device in category C2624. Therefore, CMS is establishing the offset amount for C2624 to be that of APC 0080, $310.33, which will be deducted from pass-through payment.
Comprehensive APCs

For CY 2015, CMS is creating a new category of codes, called “Comprehensive APCs,” for which CMS provides a single claim payment. Through OCE logic, the PRICER will automatically assign payment for a “Comprehensive APC” service reported on a claim. Both the OCE and the PRICER will implement these new policies without any coding change required on the part of hospitals.

Effective January 1, 2015, comprehensive APCs (Identified by a new Status Indicator, J1) provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service.

CMS is updating the “Medicare Claims Processing Manual,” (Chapter 4, by adding Section 10.2.3 and revising Section 10.4 to reflect comprehensive APC payment policies. The added Section 10.2.3 (Comprehensive APCs) and revised Section 10.4 (Packaging) are included in CR 9014. The added Section 10.2.3 states the following:

HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for the list of HCPCS codes designated with status indicator J1.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

- Major OPPS procedure codes (status indicators P, S, T, V);
- Lower ranked comprehensive procedure codes (status indicator J1);
- Non-pass-through drugs and biologicals (status indicator K);
- Blood products (status indicator R);
- DME (status indicator Y); and
- Therapy services (HCPCS codes with status indicator A reported on therapy revenue centers).

The following services are excluded from comprehensive APC packaging:

- Brachytherapy sources (status indicator U);
- Pass-through drugs, biologicals and devices (status indicators G or H);
- Corneal tissue, CRNA services, and Hepatitis B vaccinations (status indicator F);
- Influenza and pneumococcal pneumonia vaccine services (status indicator L);
- Ambulance services;
- Mammography; and
- Certain preventive services

The single payment for a comprehensive claim is based on the rate associated with the J1 service. When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service. When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family. Note that complexity adjustments will not be applied to discontinued services (reported with modifier -73 or -74).

Billing for Corneal Tissue

CMS reminds hospitals that according to the “Medicare Claims Processing Manual” (Chapter 4, Section 200.1 at http://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c04.pdf), the corneal tissue is paid on a cost
basis and not under the OPPS. To receive cost based reimbursement for corneal tissue, hospitals must bill charges for corneal tissue using HCPCS code V2785.

**Billing for Mobile Cardiac Telemetry Monitoring Services**

Current Procedural Terminology (CPT) code 93229 describes wearable mobile cardiovascular telemetry services. As instructed in the CY 2015 OPPS/ASC final rule, CPT code 93229 should be used to report continuous outpatient cardiovascular monitoring that includes **up to 30 consecutive days** of real-time cardiac monitoring. In particular, the 2015 CPT Code Book defines CPT code 93229 as:

> Mobile Cardiovascular Telemetry (MCT): continuously records the electrocardiographic rhythm from external electrodes placed on the patient’s body. Segments of the ECG data are automatically (without patient intervention) transmitted to a remote surveillance location by cellular or landline telephone signal. The segments of the rhythm, selected for transmission, are triggered automatically (MCT device algorithm) by rapid and slow heart rates or by the patient during a symptomatic episode. There is continuous real time data analysis by preprogrammed algorithms in the device and attended surveillance of the transmitted rhythm segments by a surveillance center technician to evaluate any arrhythmias and to determine signal quality. The surveillance center technician reviews the data and notifies the physician or other qualified health care professional depending on the prescribed criteria (2015 CPT Professional Edition; page 578).

CMS expects that hospitals will report CPT code 93229 on hospital claims only when they have provided the mobile telemetry service as described above.

For information on the APC assignment, OPPS status indicator, and payment rate for CPT code 93229 effective January 1, 2015, refer to Addendum B of the January 2015 OPPS Update that is posted at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) on the CMS website.

**Billing for “Sometimes Therapy” Services that May be Paid as Non-Therapy Services for Hospital Outpatients**

The Social Security Act (Section 1834(k); see [http://www.ssa.gov/OP_Home/ssact/title18/1834.htm](http://www.ssa.gov/OP_Home/ssact/title18/1834.htm), as added by Section 4541 of the Balanced Budget Act (BBA), allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Act, a therapy code list was created based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the Medicare Physician Fee Schedule (MPFS).

The list of therapy codes, along with their respective designation, can be found at [http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage](http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage) on the CMS website. Two of the designations that are used for therapy services are: “always therapy” and “sometimes therapy.” An “always therapy” service must be performed by a qualified therapist under a certified therapy plan of care, and a “sometimes therapy” service may be performed by physician or a non-physician practitioner outside of a certified therapy plan of care.

Under the OPPS, separate payment is provided for certain services designated as “sometimes therapy” services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPPS for a non-therapy service, hospitals SHOULD **NOT** append the therapy modifier GP (physical therapy), GO (occupational therapy), or...
GN (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the “sometimes therapy” codes listed in Table 3 below.

To receive payment under the MPFS, when “sometimes therapy” services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy modifier GP, GO, or GN, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to claims for “sometimes therapy” codes furnished as non-therapy services in the hospital outpatient department and paid under the OPPS.

Effective January 1, 2015, two HCPCS codes designated as “Sometimes Therapy” services, G0456 (Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters) and G0457 (Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters) would be terminated and replaced with two new CPT codes 97607 (Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters) and 97608 (Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters).

The list of HCPCS codes designated as “sometimes therapy” services that may be paid as non-therapy services when furnished to hospital outpatients is displayed in Table 3.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>92520</td>
<td>Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)</td>
</tr>
<tr>
<td>97597</td>
<td>Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (for example, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters</td>
</tr>
<tr>
<td>97598</td>
<td>Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (for example, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters</td>
</tr>
<tr>
<td>97602</td>
<td>Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (for example, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session</td>
</tr>
<tr>
<td>97605</td>
<td>Negative pressure wound therapy (for example, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters</td>
</tr>
<tr>
<td>97606</td>
<td>Negative pressure wound therapy (for example, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters</td>
</tr>
</tbody>
</table>
Table 3 – Services Designated as “Sometimes Therapy” that May be Paid as Non-Therapy Services for Hospital Outpatients

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>97607</td>
<td>Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters</td>
</tr>
<tr>
<td>97608</td>
<td>Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters</td>
</tr>
<tr>
<td>97610</td>
<td>Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day</td>
</tr>
</tbody>
</table>

New Laboratory HCPCS G-codes Effective January 1, 2015

For the CY 2015 update, the CPT Editorial Panel deleted several laboratory services on December 31, 2014, and replaced them with new CPT codes effective January 1, 2015. Because the laboratory services described by the 2014 CPT codes (which are being deleted) will continue to be paid under the Clinical Lab Fee Schedule (CLFS) in 2015, Medicare has established the following HCPCS G-codes to replace the deleted CPT codes for these laboratory services. Under the hospital OPPS, the HCPCS G-codes are assigned to status indicator “N” (packaged) effective January 1, 2015. In addition, the new laboratory CY 2015 CPT codes that replaced the deleted laboratory CY 2014 CPT codes have been assigned to status indicator “B” to indicate that another code should be reported under the hospital OPPS. The list of the new HCPCS G-codes and their predecessor CPT codes are in Table 4.

Table 4—New HCPCS G-codes and their Predecessor CPT codes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>80102</td>
<td>Drug confirmation, each procedure</td>
<td>G6058</td>
<td>Drug confirmation, each procedure</td>
<td>N</td>
</tr>
<tr>
<td>80152</td>
<td>Amitriptyline</td>
<td>G6030</td>
<td>Amitriptyline</td>
<td>N</td>
</tr>
<tr>
<td>80154</td>
<td>Benzodiazepines</td>
<td>G6031</td>
<td>Benzodiazepines</td>
<td>N</td>
</tr>
<tr>
<td>80160</td>
<td>Desipramine</td>
<td>G6032</td>
<td>Desipramine</td>
<td>N</td>
</tr>
<tr>
<td>80166</td>
<td>Doxepin</td>
<td>G6034</td>
<td>Doxepin</td>
<td>N</td>
</tr>
<tr>
<td>80172</td>
<td>Gold</td>
<td>G6035</td>
<td>Gold</td>
<td>N</td>
</tr>
<tr>
<td>80174</td>
<td>Imipramine</td>
<td>G6036</td>
<td>Imipramine</td>
<td>N</td>
</tr>
<tr>
<td>80182</td>
<td>Nortriptyline</td>
<td>G6037</td>
<td>Nortriptyline</td>
<td>N</td>
</tr>
<tr>
<td>80196</td>
<td>Salicylate</td>
<td>G6038</td>
<td>Salicylate</td>
<td>N</td>
</tr>
<tr>
<td>82003</td>
<td>Acetaminophen</td>
<td>G6039</td>
<td>Acetaminophen</td>
<td>N</td>
</tr>
<tr>
<td>82055</td>
<td>Alcohol (ethanol); any specimen except breath</td>
<td>G6040</td>
<td>Alcohol (ethanol); any specimen except breath</td>
<td>N</td>
</tr>
<tr>
<td>82101</td>
<td>Alkaloids, urine, quantitative</td>
<td>G6041</td>
<td>Alkaloids, urine, quantitative</td>
<td>N</td>
</tr>
<tr>
<td>82145</td>
<td>Amphetamine or methamphetamine</td>
<td>G6042</td>
<td>Amphetamine or methamphetamine</td>
<td>N</td>
</tr>
<tr>
<td>82205</td>
<td>Barbiturates, not elsewhere specified</td>
<td>G6043</td>
<td>Barbiturates, not elsewhere specified</td>
<td>N</td>
</tr>
<tr>
<td>82520</td>
<td>Cocaine or metabolite</td>
<td>G6044</td>
<td>Cocaine or metabolite</td>
<td>N</td>
</tr>
<tr>
<td>82646</td>
<td>Dihydrocodeinone</td>
<td>G6045</td>
<td>Dihydrocodeinone</td>
<td>N</td>
</tr>
<tr>
<td>82649</td>
<td>Dihydromorphinone</td>
<td>G6046</td>
<td>Dihydromorphinone</td>
<td>N</td>
</tr>
<tr>
<td>82651</td>
<td>Dihydropyrostosterone (DHT)</td>
<td>G6047</td>
<td>Dihydropyrostosterone (DHT)</td>
<td>N</td>
</tr>
<tr>
<td>82654</td>
<td>Dimethyladione</td>
<td>G6048</td>
<td>Dimethyladione</td>
<td>N</td>
</tr>
<tr>
<td>82666</td>
<td>Epiandrosterone</td>
<td>G6049</td>
<td>Epiandrosterone</td>
<td>N</td>
</tr>
<tr>
<td>82690</td>
<td>Ethchlorvynol</td>
<td>G6050</td>
<td>Ethchlorvynol</td>
<td>N</td>
</tr>
<tr>
<td>82742</td>
<td>Flurazepam</td>
<td>G6051</td>
<td>Flurazepam</td>
<td>N</td>
</tr>
<tr>
<td>83805</td>
<td>Meprobamate</td>
<td>G6052</td>
<td>Meprobamate</td>
<td>N</td>
</tr>
</tbody>
</table>
Coding Guidance for Intraocular or Periocular Injections of Combinations of Anti-Inflammatory Drugs and Antibiotics

Intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics are being used with increased frequency in ocular surgery (primarily cataract surgery). One example of combined or compounded drugs includes triamcinolone and moxifloxacin with or without vancomycin. Such combinations may be administered as separate injections or as a single combined injection. Because such injections may obviate the need for post-operative anti-inflammatory and antibiotic eye drops, some have referred to cataract surgery with such injections as “dropless cataract surgery.”

As stated in Chapter VIII, Section D, Item 20 of the CY 2015 “National Correct Coding Initiative (NCCI) Policy Manual,” injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable. Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.

According to the “Medicare Claims Processing Manual” (Chapter 17, Section 90.2; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf), the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code J3490 (Unclassified drugs), regardless of the site of service of the surgery, and are packaged as surgical supplies in both the HOPD and the ASC. Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399. According to the “Medicare Claims Processing Manual” (Chapter 30, Section 40.3.6; http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf on the CMS website) physicians or facilities should not give Advance Beneficiary Notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare. Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2015 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2015, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 5.

### Table 4—New HCPCS G-codes and their Predecessor CPT codes

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>83840</td>
<td>Methadone</td>
<td>G6053</td>
<td>Methadone</td>
<td>N</td>
</tr>
<tr>
<td>83858</td>
<td>Methsuximide</td>
<td>G6054</td>
<td>Methsuximide</td>
<td>N</td>
</tr>
<tr>
<td>83887</td>
<td>Nicotine</td>
<td>G6055</td>
<td>Nicotine</td>
<td>N</td>
</tr>
<tr>
<td>83925</td>
<td>Opiate(s), drug and metabolites, each procedure</td>
<td>G6056</td>
<td>Opiate(s), drug and metabolites, each procedure</td>
<td>N</td>
</tr>
<tr>
<td>84022</td>
<td>Phenothiazine</td>
<td>G6057</td>
<td>Phenothiazine</td>
<td>N</td>
</tr>
</tbody>
</table>

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Table 5 – New CY 2015 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A9606</td>
<td>Radium ra-223 dichloride, therapeutic, per microcurie</td>
<td>K</td>
<td>1745</td>
</tr>
<tr>
<td>C9027</td>
<td>Injection, pembrolizumab, 1 mg</td>
<td>G</td>
<td>1490</td>
</tr>
<tr>
<td>C9136</td>
<td>Injection, factor vii, fc fusion protein, (recombinant), per i.u.</td>
<td>G</td>
<td>1656</td>
</tr>
<tr>
<td>C9349</td>
<td>FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter</td>
<td>G</td>
<td>1657</td>
</tr>
<tr>
<td>C9442</td>
<td>Injection, belinostat, 10 mg</td>
<td>G</td>
<td>1658</td>
</tr>
<tr>
<td>C9443</td>
<td>Injection, dalbavancin, 10 mg</td>
<td>G</td>
<td>1659</td>
</tr>
<tr>
<td>C9444</td>
<td>Injection, ontavancin, 10 mg</td>
<td>G</td>
<td>1660</td>
</tr>
<tr>
<td>C9446</td>
<td>Injection, tedizolid phosphate, 1 mg</td>
<td>G</td>
<td>1662</td>
</tr>
<tr>
<td>C9447</td>
<td>Injection, phenylephrine and ketorolac, 4 ml vial</td>
<td>G</td>
<td>1663</td>
</tr>
<tr>
<td>J0571</td>
<td>Buprenorphine, oral, 1 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J0572</td>
<td>Buprenorphine/naloxone, oral, less than or equal to 3 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J0573</td>
<td>Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J0574</td>
<td>Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J0575</td>
<td>Buprenorphine/naloxone, oral, greater than 10 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J1826</td>
<td>Injection, interferon beta-1a, 30 mcg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J2704</td>
<td>Injection, Propofol, 10mg</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>J7182</td>
<td>Factor viii, (antihemophilic factor, recombinant), (novoeight), per iu</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J7301</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 13.5mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J7302</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J7327</td>
<td>Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose</td>
<td>K</td>
<td>1747</td>
</tr>
<tr>
<td>J8565</td>
<td>Gefitinib, oral, 250 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Q4150</td>
<td>Allowrap dds or dry, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4151</td>
<td>Amnioband or guardian, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4152</td>
<td>Dermapure, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4153</td>
<td>Dermavest, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4154</td>
<td>Biovance, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4155</td>
<td>Neoxflo or Clarixflo, 1 mg</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4156</td>
<td>Neox 100, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4157</td>
<td>Revitalon, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4158</td>
<td>Marigen, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4159</td>
<td>Affinity, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4160</td>
<td>Nushield, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

b. Other Changes to CY 2015 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have changes in their HCPCS and CPT code descriptors that will be effective in CY 2015. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2014, and replaced with permanent HCPCS codes in CY 2015. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2015 HCPCS and CPT codes.

Table 6 below notes those drugs, biologicals, and radiopharmaceuticals that have changes in their HCPCS/CPT code, their long descriptor, or both. Each product’s CY 2014 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2015 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.
### Table 6 – Other CY 2015 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>J7195</td>
<td>Factor ix (antihemophilic factor, recombinant) per i.u.</td>
<td>J7195</td>
<td>Injection, Factor ix (antihemophilic factor, recombinant) per i.u.</td>
</tr>
<tr>
<td>J7301</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5mg/J</td>
<td>J7301</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 13.5mg</td>
</tr>
<tr>
<td>Q4119</td>
<td>Matristem wound matrix, psmx, rs, or psm, per square centimeter</td>
<td>Q4119</td>
<td>Matristem wound matrix, per square centimeter</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect, extracellular matrix, per square centimeter</td>
<td>Q4147</td>
<td>Architect, architect px, or architect fx, extracellular matrix, per square centimeter</td>
</tr>
<tr>
<td>C9021</td>
<td>Injection, obinutuzumab, 10 mg</td>
<td>J9301</td>
<td>Injection, obinutuzumab, 10 mg</td>
</tr>
<tr>
<td>C9022</td>
<td>Injection, elosulfase alfa, 1mg</td>
<td>J1322</td>
<td>Injection, elosulfase alfa, 1mg</td>
</tr>
<tr>
<td>C9023</td>
<td>Injection, testosterone undecanoate, 1 mg</td>
<td>J3145</td>
<td>Injection, testosterone undecanoate, 1 mg</td>
</tr>
<tr>
<td>C9133</td>
<td>Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.</td>
<td>J7200</td>
<td>Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.</td>
</tr>
<tr>
<td>C9134</td>
<td>Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.</td>
<td>J7181</td>
<td>Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.</td>
</tr>
<tr>
<td>C9135</td>
<td>Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.</td>
<td>J7201</td>
<td>Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.</td>
</tr>
<tr>
<td>J0150</td>
<td>Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)</td>
<td>J0153</td>
<td>Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)</td>
</tr>
<tr>
<td>J0151</td>
<td>Injection, adenosine for diagnostic use, 1 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)</td>
<td>J0153</td>
<td>Injection, adenosine for diagnostic use, 1 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)</td>
</tr>
<tr>
<td>J0170</td>
<td>Injection, testosterone cypionate, up to 100 mg</td>
<td>J1071</td>
<td>Injection, testosterone cypionate, 1mg</td>
</tr>
<tr>
<td>J0180</td>
<td>Injection, testosterone cypionate, 1 cc, 200 mg</td>
<td>J1071</td>
<td>Injection, testosterone cypionate, 1mg</td>
</tr>
<tr>
<td>J2271</td>
<td>Injection, morphine sulfate, 100mg</td>
<td>J2274</td>
<td>Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg</td>
</tr>
<tr>
<td>J2275</td>
<td>Injection, morphine sulfate (preservative-free sterile solution), per 10 mg</td>
<td>J2274</td>
<td>Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg</td>
</tr>
<tr>
<td>J3120</td>
<td>Injection, testosterone enanthate, up to 100 mg</td>
<td>J3121</td>
<td>Injection, testosterone enanthate, 1mg</td>
</tr>
<tr>
<td>J3130</td>
<td>Injection, testosterone enanthate, up to 200 mg</td>
<td>J3121</td>
<td>Injection, testosterone enanthate, 1mg</td>
</tr>
<tr>
<td>J7335</td>
<td>Capsaicin 8% patch, per 10 square centimeters</td>
<td>J7336</td>
<td>Capsaicin 8% patch, per square centimeter</td>
</tr>
<tr>
<td>J9265</td>
<td>Injection, paclitaxel, 30 mg</td>
<td>J9267</td>
<td>Injection, paclitaxel, 1 mg</td>
</tr>
<tr>
<td>Q9970</td>
<td>Injection, ferric carboxymaltose, 1mg</td>
<td>J1439</td>
<td>Injection, ferric carboxymaltose, 1 mg</td>
</tr>
<tr>
<td>Q9972</td>
<td>Injection, epoetin beta, 1 microgram, (For ESRD On Dialysis)</td>
<td>J0887</td>
<td>Injection, epoetin beta, 1 microgram, (for esrd on dialysis)</td>
</tr>
<tr>
<td>Q9973</td>
<td>Injection, Epoetin Beta, 1 microgram, (Non-ESRD use)</td>
<td>J0888</td>
<td>Injection, epoetin beta, 1 microgram, (for non esrd use)</td>
</tr>
<tr>
<td>Q9974</td>
<td>Injection, morphine sulfate (preservative-free sterile solution), per 10 mg</td>
<td>J2274</td>
<td>Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg</td>
</tr>
<tr>
<td>S0144</td>
<td>Injection, Propofol, 10mg</td>
<td>J2704</td>
<td>Injection, Propofol, 10mg</td>
</tr>
</tbody>
</table>

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

**Effective January 1, 2015**

For CY 2015, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2015, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these
pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2015, payment rates for many drugs and biologicals have changed from the values published in the CY 2015 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2014. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2015 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request implementing the January 2015 update of the OPPS. However, the updated payment rates effective January 1, 2015, can be found in the January 2015 update of the OPPS Addendum A and Addendum B at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) on the CMS website.

d. Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 7 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. CMS will implement an OPPS edit that requires hospitals to report all high-cost skin substitute products in combination with one of the skin application procedures described by CPT codes 15271-15278 and to report all low-cost skin substitute products in combination with one of the skin application procedures described by HCPCS codes C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT codes 15271-15278.

<table>
<thead>
<tr>
<th>CY 2015 HCPCS Code</th>
<th>CY 2015 Short Descriptor</th>
<th>CY 2015 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9349</td>
<td>Fortaderm, fortaderm antimic</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>C9358</td>
<td>SurgiMend, fetal</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>C9360</td>
<td>SurgiMend, neonatal</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>C9363</td>
<td>Integra Meshed Bil Wound Mat</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4100</td>
<td>Skin substitute, NOS</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4101</td>
<td>Apligraf</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4102</td>
<td>Oasis wound matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4103</td>
<td>Oasis burn matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4104</td>
<td>Integra BMWD</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4105</td>
<td>Integra DRT</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4106</td>
<td>Dermagraft</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4107</td>
<td>GraftJacket</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4108</td>
<td>Integra Matrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4110</td>
<td>Primatrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4111</td>
<td>Gammagraft</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4112</td>
<td>Cymetra injectable</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4113</td>
<td>GraftJacket Xpress</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4114</td>
<td>Integra Flowable Wound Matrix</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4115</td>
<td>Alloskin</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4116</td>
<td>Alloderm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4117</td>
<td>Hyalomatrix</td>
<td>N</td>
<td>Low</td>
</tr>
</tbody>
</table>
Table 7 – Skin Substitute Product Assignment to High Cost/Low Cost Status for CY 2015

<table>
<thead>
<tr>
<th>CY 2015 HCPCS Code</th>
<th>CY 2015 Short Descriptor</th>
<th>CY 2015 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4118</td>
<td>Matristem Micromatrix</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4119</td>
<td>Matristem Wound Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4120</td>
<td>Matristem Burn Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4121</td>
<td>Theraskin</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>Q4123</td>
<td>Alloskin</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4124</td>
<td>Oasis Tri-layer Wound Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4125</td>
<td>Arthroflex</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4126</td>
<td>Memoderm/derma/tranz/integup</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4127</td>
<td>Talymed</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>Q4128</td>
<td>Flexhd/Allopatchhd/matrixhdNHighQ4129Unite Biomatrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4131</td>
<td>Epifix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4132</td>
<td>Grafix core</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4133</td>
<td>Grafix prime</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4134</td>
<td>HMatrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4135</td>
<td>Mediskin</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4136</td>
<td>EZderm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4137</td>
<td>Amnioexcel or Biodexcel, 1 cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4138</td>
<td>BioDfence DryFlex, 1 cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4139</td>
<td>Amniomatrix or Biodmatrix, 1 cc</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4140</td>
<td>Biodfence 1 cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4141</td>
<td>Alloskin ac, 1 cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4142</td>
<td>Xcm biologic tiss matrix 1 cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4143</td>
<td>Repriza, 1 cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4145</td>
<td>Epifix, 1mg</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4146</td>
<td>Tensix, 1cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect ecm px fx 1 sq cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4148</td>
<td>Neox 1k, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4149</td>
<td>Excellagen, 0.1 ccNN/AQ4150Allowrap DS or Dry 1 sq cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4151</td>
<td>AmnioBand, Guardian 1 sq cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4152</td>
<td>*Dermapure 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4153</td>
<td>Dermavest 1 square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4154</td>
<td>Biovance 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4155</td>
<td>NeoxFlo or ClarixFlo 1 mg</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4156</td>
<td>Neox 100 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4157</td>
<td>Revitalon 1 square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4158</td>
<td>MariGen 1 square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4159</td>
<td>Affinity 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4160</td>
<td>NuShield 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

* HCPCS code Q4152 was assigned to the low cost group in the CY 2015 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4152 is assigned to the high cost group for CY 2015.

Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-).
Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/01_overview.asp on the CMS website. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

Changes to OPPS Pricer Logic

a. Rural sole community hospitals and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2015. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13)(B) of the Social Security Act, as added by Section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2015. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2014 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2015. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. The fixed-dollar threshold decreases in CY 2015 relative to CY 2014. The estimated cost of a service must be greater than the APC payment amount plus $2,775 in order to qualify for outlier payments.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2015. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective October 1, 2013, and continuing for CY 2015, one device is eligible for pass-through payment in the OPPS Pricer logic. Category C1841 (Retinal prosthesis, includes all internal and external components), has an offset amount of $0, because CMS is not able to identify portions of the APC payment amounts associated with the cost of the device in APC 0672, Level III, Posterior segment eye procedures. For outlier purposes, when C1841 is billed with CPT code 0100T, assigned to APC 0672, it will be eligible for outlier calculation and payment.

g. C2624 (Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components), is effective January 1, 2015, device offset is $310.33, assigned to APC 2624. The procedure this should be billed with is C9741 (Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report), and the procedure maps to APC 0080 (which has the offset of $310.33).

h. Effective January 1, 2015, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

i. Effective January 1, 2015, there will be two diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on
a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the CY 2014 APC payments for nuclear medicine procedures and may be found on the CMS website.

j. Effective January 1, 2015, there will be four skin substitute products receiving pass-through payment in the OPPS Pricer logic. For skin substitute application procedure codes that are assigned to APC 0328 (Level III Skin Repair) or APC 0329 (Level IV Skin Repair), Pricer will reduce the payment amount for the pass-through skin substitute product by the wage-adjusted offset for the APC when the pass-through skin substitute product appears on a claim with a skin substitute application procedure that maps to APC 0328 or APC 0329. The offset amounts for skin substitute products are the "policy-packaged" portions of the CY 2014 payments for APC 0328 and APC 0329.

k. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

l. Effective January 1, 2015, CMS is adopting the FY 2015 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-Inpatient Prospective Payment System (IPPS) hospitals discussed below.

m. Effective January 1, 2015, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40%), a device offset cap will be applied based on the credit amount listed in the "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code “FD” which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

n. Effective January 1, 2015, CMS is adopting the FY 2014 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from 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.
SE1435 (Revised): FAQs – International Classification of Diseases, 10th Edition (ICD-10)
End-to-End Testing

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article on December 12, 2014, CMS then issued a revision to this article on December 24, 2014. The following reflects the revised 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: SE1435 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article was revised on December 24, 2014, to add FAQs 6-8 on page 3 and the former FAQ 6 is now FAQ 9. All other information remains the same.

Provider Types Affected
This MLN Matters® Special Edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

Provider Action Needed
Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

What to Know Prior to Testing
1. **How is ICD-10 end-to-end testing different from acknowledgement testing?**
   The goal of acknowledgement testing is for testers to submit claims with ICD-10 codes to the Medicare Fee-For-Service claims systems and receive acknowledgements to confirm that their claims were accepted or rejected.
   End-to-end testing takes that a step further, processing claims through all Medicare system edits to produce and return an accurate Electronic Remittance Advice (ERA). While acknowledgement testing is open to all electronic submitters, end-to-end testing is limited to a smaller sample of submitters who volunteer and are selected for testing.

2. **What constitutes a testing slot for this testing?**
   A testing slot is the ability to submit 50 claims to a particular Medicare Administrative Contractor (MAC) who selected you for testing.

3. **What data must I provide to the MAC before testing?**
   For each testing slot, you must provide the MAC: up to 2 submitter identifiers (IDs), up to 5 National Provider Identifiers (NPIs)/Provider Transaction Access Numbers (PTANs), and up to 10 Health Insurance Claim Numbers (HICNs). You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.
   If you were selected to test with only one submitter ID but would like to choose a second one, you must contact the MAC to add the second submitter ID. If the MAC is not aware of
your preference to use a second submitter ID, claims submitted with that ID may not be processed.

4. **What should I consider when choosing HICNs for testing?**
   The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information, claims history, and other documentation such as Certificates of Medical Necessity (CMNs). The HICNs you provide must be real beneficiaries and may not have a Date of Death on file. If you previously submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.

5. **If I was selected for the January 2015 end-to-end testing, do I need to reapply for later testing rounds?**
   No, once you are selected for testing, you are automatically registered for the later rounds of testing.

6. **Does this mean that no new submitters will be accepted for the April and July 2015 end-to-end testing periods or will a new group of 850 testers be selected for both April and July?**
   A new group will be selected for each of the April and July 2015 testing periods, and these groups will be able to test in addition to the already chosen testers. Therefore, the total number of potential testers will be 1,700 for April 2015 and 2,550 for July 2015.

7. **Do you have information on who has been selected for the January 2015 end-to-end testing?**
   We will release this information as part of the public release of our January test results.

8. **When do you expect to publically release results of the first round of end-to-end testing?**
   We expect to publically release results of the first round of end-to-end testing around the end of February 2015.

9. **Can I submit additional NPIs, PTANs, and HICNs for the later rounds of testing?**
   Yes, while you do not need to re-apply for the later rounds of testing, you may choose to submit up to 2 additional submitter IDs, up to 5 additional NPIs/PTANs, and up to 10 additional HICNs. You may also still use the information you submitted for the previous testing round. The MAC will provide the form you must use to submit this new information, and the information must be received by the due date on the form to be considered for the next round of testing.

**What to Know During Testing**

1. **Is it safe to submit test claims with Protected Health Information (PHI)?**
   The test claims you submit are accepted into the system using the same secure method used for production claims on a daily basis. They will be processed by the same MACs who process production claims, and all the same security protocols will be followed. Therefore, using real data for this test does not cause any additional risk of release of PHI.

2. **What Dates of Service can be used on test claims?**
   Professional claims with an ICD-10 code must have a date of service on or after October 1, 2015.
   
   Inpatient claims with an ICD-10 code must have a discharge date on or after October 1, 2015.
Supplier claims with an ICD-10 code must have a date of service between October 1, 2015, and October 15, 2015.

For professional and institutional claims, you may use dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

3. **Can both ICD-9 and ICD-10 codes be submitted on the same claim?**

ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later), please refer to MLN Matters® Article SE1325, “Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that span the ICD-10 Implementation Date” located at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf) on the CMS website.

4. **Do Returned to Provider (RTP) claims count toward the 50 claims submitted? Can RTP’d claims be re-submitted for testing?**

Institutional claims that fail Return to Provider (RTP) editing count toward the 50 claim submission limit. Claims that are RTP’d will not appear on the electronic remittance advice, and will not be available through DDE. If claims accepted by the front end edit do not appear on the remittance advice, please contact the Medicare Administrative Contractor (MAC) for further information.

Claims that are rejected by front end editing do not count toward the 50 claim submission limit; therefore, they should be corrected and resubmitted.

5. **If a Certificate of Medical Necessity (CMN) or DME Information Form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?**

If the beneficiary has a valid CMN or DIF on file for that equipment/supply covered by the dates of service on your test claim (after 10/1/2015), you do not need to submit a new CMN/DIF.

If the beneficiary’s CMN/DIF has expired for the dates of service on your test claim (after 10/1/2015), you must submit a revised CMN/DIF to extend the end date for that CMN/DIF.

If the beneficiary does not have a CMN or DIF for that equipment/supply, you must submit a new CMN/DIF.

6. **For Home Health claims, how should I submit the Request for Anticipated Payment (RAP) and final claim for testing?**

Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the Common Working File (CWF). The RAP processing time will be short since the test beneficiaries are set up in advance.

To get your results more quickly, you may also want to consider billing Low Utilization Payment Adjustment claims with four visits or less that do not require a RAP.

7. **For Hospice claims, should I submit the Notice of Election (NOE) prior to testing?**

You will not need to provide NOEs to the MAC prior to the start of testing. The MACs will set up NOEs for any hospice claims received during testing.

8. **For an Inpatient Rehabilitation Facility (IRF) or Skilled Nursing Facility (SNF) stay, can the Case-Mix Group (CMG) or Resource Utilization Group (RUG) code be submitted on the claim even though the date of service is in the future?**
Yes, you can send the IRF claim with a valid CMG code on the claim and a SNF claim with a valid RUG code on the claim, even though the date is in the future. For testing purposes, only a claim with a valid Health Insurance Prospective Payment System (HIPPS) code will be required. You do not need to submit the supporting data sheets.

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.

ICD-10

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: SE1501
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This MLN Matters® Special Edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies who participate in Medicare ICD-10 acknowledgement testing and who are selected to participate in end-to-end testing.

Provider Action Needed
Physicians, providers, suppliers, clearinghouses, and billing agencies who participate in acknowledgement testing and who are selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 acknowledgement testing and end-to-end testing to gain an understanding of the guidelines and requirements for successful testing. When “you” is used in this publication, we are referring to ICD-10 acknowledgement testers or end-to-end testers.

<table>
<thead>
<tr>
<th>Question</th>
<th>Acknowledgement Testing</th>
<th>End-to-End Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do I need to register for testing?</td>
<td>No, you do not need to register for acknowledgement testing.</td>
<td>Yes, end-to-end testing volunteers must register on their Medicare Administrative Contractor (MAC) website during specific time periods.</td>
</tr>
</tbody>
</table>
| Who can participate in testing?  | Acknowledgement testing is open to all Medicare Fee-For-Service (FFS) electronic submitters. | End-to-end testing is open to:  
  • Medicare FFS direct submitters;  
  • Direct Data Entry (DDE) submitters who receive an Electronic Remittance Advice (ERA);  
  • Clearinghouses; and  
  • Billing agencies. |
| How many testers will be selected? | All Medicare FFS electronic submitters can acknowledge test. | 50 end-to-end testers will be selected per MAC jurisdiction for each testing round. You must be selected by the MAC for this testing. |
### Question

**What will the testing show?**

The goal of acknowledgement testing is to demonstrate that:
- Providers and submitters can submit claims with valid ICD-10 codes and ICD-10 companion qualifier codes;
- Providers submitted claims with valid National Provider Identifiers (NPIs);
- The claims are accepted by the Medicare FFS claims systems; and
- Claims receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare.

**End-to-End Testing**

The goal of end-to-end testing is to demonstrate that:
- Providers and submitters can successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- Software changes the Centers for Medicare & Medicaid Services (CMS) made to support ICD-10 result in appropriately adjudicated claims; and
- Accurate Remittance Advices are produced.

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**Will the testing test National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)?**

No, acknowledgement testing will not test NCDs and LCDs.

Yes, end-to-end test claims will be subject to all NCDs and LCDs.

**Will the testing confirm payment and return an ERA to the tester?**

No, acknowledgement testing will not confirm payment. Test claims will receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare.

Yes, end-to-end testing will provide an ERA based on current year pricing.

**How many claims can testers submit?**

There is no limit on the number of acknowledgement test claims you can submit.

You may submit 50 end-to-end test claims per test week.

**How do testers submit claims for testing?**

You submit acknowledgement test claims directly or through a clearinghouse or billing agency with test indicator “T” in the Interchange Control Structure (ISA) 15 field.

You submit end-to-end test claims directly with test indicator “T” in the ISA15 field or through DDE.

**When should testers submit test claims?**

You may submit acknowledgement test claims anytime. We encourage you to test during the highlighted testing weeks:
- March 2 – 6, 2015; and
- June 1 – 5, 2015.

You must submit end-to-end test claims during the following testing weeks:
- January 26 – 30, 2015;
- April 27 – May 1, 2015; and

**What dates of service do testers use during testing?**

You must use current dates of service during acknowledgement testing.

You must use the following future dates of service during end-to-end testing:
- Professional claims – Dates of service on or after October 1, 2015;
- Inpatient claims – Discharge dates on or after October 1, 2015;
- Supplier claims – Dates of service between October 1, 2015, and October 15, 2015; and
- Professional and institutional claims – Dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

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**Important Note:** Remember that you must be selected by the MAC in order to participate in end-to-end testing.

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**RESOURCES**

The chart below provides ICD-10 resource information.

<table>
<thead>
<tr>
<th>For More Information About…</th>
<th>Resource</th>
</tr>
</thead>
</table>
For More Information About… | Resource
---|---
ICD-10 Information for Medicare Fee-For-Service Providers | [http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html](http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html)
on the CMS website
Medicare Information for Patients | [http://www.medicare.gov](http://www.medicare.gov) on the CMS website

**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.

**Preventive and Screening**

**MM8874: Preventive and Screening Services — Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy**

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/2015-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM8874  
**Related Change Request (CR) #:** CR 8874  
**Related CR Release Date:** December 11, 2014  
**Effective Date:** January 1, 2015  
**Related CR Transmittal #:** R3146CP  
**Implementation Date:** January 5, 2015

**Provider Types Affected**

This MLN Matters® Article is intended for Medicare practitioners providing preventive and screening services to Medicare beneficiaries and billing Medicare Administrative Contractors (MACs) for those services.

**Provider Action Needed**

CR 8874 is an update from CMS to ensure accurate program payment for three screening services. The coinsurance and deductible for these services are currently waived, but due to coding changes and additions, the payments for Calendar Year (CY) 2015 would not be accurate without updated CR 8874 for intensive behavioral group therapy for obesity, digital breast tomosynthesis, and anesthesia associated with screening colonoscopy. Make sure billing staffs are aware of these updates.
Background

The following outlines the CMS updates:

Intensive Behavioral Therapy for Obesity

Intensive behavioral therapy for obesity became a covered preventive service under Medicare, effective November 29, 2011. It is reported with HCPCS code G0447 (Face-to-face behavioral counseling for obesity, 15 minutes). Coverage requirements are in the "Medicare National Coverage Determinations (NCDs) Manual," Chapter 1, Section 210.

To improve payment accuracy, in CY 2015 Physician Fee Schedule (PFS) Proposed Rule, CMS created a new HCPCS code for the reporting and payment of behavioral group counseling for obesity — HCPCS codes G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes).

For coverage requirements of intensive behavioral therapy for obesity, see the NCD for Intensive Behavioral Therapy for Obesity.

The same claims editing that applies to G0447 applies to G0473. Therefore, effective for claims with dates of service on or after January 1, 2015, MACs will recognize HCPCS code G0473, but only when billed with one of the ICD-9 codes for Body Mass Index (BMI) 30.0 and over (V85.30,-V85.39, V85.41-V85.45). (Once ICD-10 is effective, the related ICD-10 codes are Z68.30-Z68.39 and Z68.41-Z68.45.) When claims for G0473 are submitted without a required diagnosis code, they will be denied using the following remittance codes:

- Claim Adjustment Reason Code (CARC) 167: This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. If you do not have Web access, you may contact the contractor to request a copy of the NCD.

Effective for claims with dates of service on or after January 1, 2015, beneficiary coinsurance and deductible do not apply to claim lines with HCPCS code G0473.

Note that Medicare pays claims with code G0473 only when submitted by the following provider specialty types as found on the provider’s Medicare enrollment record:

- 01 - General Practice
- 08 - Family Practice
- 11 - Internal Medicine
- 16 - Obstetrics/Gynecology
- 37 - Pediatric Medicine
- 38 - Geriatric Medicine
- 50 - Nurse Practitioner
- 89 - Certified Clinical Nurse Specialist
- 97 - Physician Assistant

Claim lines submitted with G0473, but without an appropriate provider specialty will be denied with the following remittance codes:

- CARC 8: The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N95: This provider type/provider specialty may not bill this service.
Further, effective for dates of service on or after January 1, 2015, claim lines with G0473 are only payable for the following Places of Service (POS) codes:

- 11 - Physician’s Office
- 22 - Outpatient Hospital
- 49 - Independent Clinic
- 71 - State or local public health clinic

Claim lines for G0473 will be denied without an appropriate POS code using the following remittance codes:

- CARC 5: The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC M77: Missing/incomplete/invalid place of service.
- Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

Remember that Medicare will deny claim lines billed for HCPCS codes G0447 and G0473 if billed more than 22 times in a 12-month period using the following codes:

- CARC 119: Benefit maximum for this time period or occurrence has been reached.
- RARC N362: The number of days or units of service exceeds our acceptable maximum.
- Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

Note: MACs will display the next eligible date for obesity counseling on all MAC provider inquiry screens.

MACs will allow both a claim for the professional service and a claim for a facility fee for G0473 when that code is billed on type of bill (TOB) 13X or on TOB 85X when revenue code 096X, 097X, or 098X is on the TOB 85X. Payment on such claims is based on the following:

- TOB 13X paid based on the OPPS:
- TOB 85X in Critical Access Hospitals based on reasonable cost; except
- TOB 85X Method II hospitals based on 115 percent of the lesser of the fee schedule amount or the submitted charge.

Institutional claims submitted on other than TOB 13X or 85X will be denied using:

- CARC 171: Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428: Not covered when performed in this place of service.
- Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

Digital Breast Tomosynthesis

In the CY 2015 PFS Final Rule with comment period, CMS established a payment rate for the newly created CPT code 77063 for screening digital breast tomosynthesis mammography. The same policies that are applicable to other screening mammography codes are applicable to CPT code 77063. In addition, since this is an add-on code it should only be paid when furnished in conjunction with a 2D digital mammography.

Effective January 1, 2015, HCPCS code 77063 (Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)), must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2D imaging only. Effective January 1, 2015, beneficiary
coinsurance and deductible does not apply to claim lines with 77063 (Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)). Payment for 77063 is made only when billed with an ICD-9 code of V76.11 or V76.12 (and when ICD-10 is effective with ICD-10 code Z12.31). When denying claim lines for 77063 that are submitted without the appropriate diagnosis code, the claim lines are denied using the following messages:

- **CARC 167**: This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N386**: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx). If you do not have Web access, you may contact the contractor to request a copy of the NCD.
- Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

On institutional claims:

- MACs will pay for tomosynthesis, HCPCS code 77063, on TOBs 12X, 13X, 22X, 23X based on MPFS, and TOB 85X with revenue code other than 096x, 097x, or 098x based on reasonable cost. TOB 85X claims with revenue code 096x, 097x, or 098x are paid based on MPFS (115% of the lesser of the fee schedule amount and submitted charge).
- MACs will pay for tomosynthesis, HCPCS code 77063 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the fee schedule amount or submitted charge.
- MACs will return to the provider any claim submitted with tomosynthesis, HCPCS code 77063 when the TOB is not 12X, 13X, 22X, 23X, or 85X.
- MACs will pay for tomosynthesis, HCPCS code 77063, on institutional claims TOBs 12X, 13X, 22X, 23X, and 85X when submitted with revenue code 0403 and on professional claims TOB 85X when submitted with revenue code 096X, 097X, or 098X.
- Effective for claims with dates of service on or after January 1, 2015, MACs will RTP claims for HCPCS code 77063 that are not submitted with revenue code 0403, 096X, 097X, or 098X.

**Anesthesia Furnished in Conjunction with Colonoscopy**

Section 4104 of the Affordable Care Act defined the term “preventive services” to include “colorectal cancer screening tests” and as a result it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Act for screening colonoscopies. In addition, the Affordable Care Act amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies. These provisions are effective for services furnished on or after January 1, 2011.

In the CY 2015 PFS Proposed Rule, CMS proposed to revise the definition of “colorectal cancer screening tests” to include anesthesia separately furnished in conjunction with screening colonoscopies; and in the CY 2015 PFS Final Rule with comment period, CMS finalized this proposal. The definition of “colorectal cancer screening tests” includes anesthesia separately furnished in conjunction with screening colonoscopies in the Medicare regulations at Section 410.37(a)(1)(iii). As a result, beneficiary coinsurance and deductible does not apply to anesthesia services associated with screening colonoscopies.

As a result, effective for claims with dates of service on or after January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a screening colonoscopy (HCPCS code 00810 performed in conjunction with G0105 and G0121)
shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:

- **Modifier 33 – Preventive Services:** when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

**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.

**For Home Health Providers**

**MM9051: Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations**

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)

**MLN Matters® Number:** MM9051  
**Related CR Release Date:** December 31, 2014  
**Related CR Transmittal #:** R202BP and R3159CP  
**Related Change Request (CR) #:** CR 9051  
**Effective Date:** September 19, 2014  
**Implementation Date:** February 2, 2015

**Provider Types Affected**

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

**Provider Action Needed**

CR 9051 provides an update to the Medicare pneumococcal vaccine coverage requirements, to align with new Advisory Committee on Immunization Practices (ACIP) recommendations. Make sure your billing staffs are aware of these updates.

**Background**

Medicare Part B covers certain vaccinations including pneumococcal vaccines. Specifically, Section 1861(s)(10)(A) of the Social Security Act, which is available at [http://www.ssa.gov/OP_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm), and regulations at 42 CFR 410.57 ([http://www.ecfr.gov/cgi-bin/text-idx?SID=85dbd4cb66820b751ff8e58a6c5b988df&node=se42.2.410_157&rgn=div3](http://www.ecfr.gov/cgi-bin/text-idx?SID=85dbd4cb66820b751ff8e58a6c5b988df&node=se42.2.410_157&rgn=div3)) authorize Medicare coverage under Part B for pneumococcal vaccine and its administration. For services furnished on or after May 1, 1981, through September 18, 2014, the Medicare Part B program covered pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. Coverage included an initial vaccine administered only to persons at high risk of serious pneumococcal disease (including all people 65 and older; immunocompetent adults at increased risk of pneumococcal disease or its complications because of chronic illness; and individuals with compromised immune systems), with revaccination administered...
only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years had passed since the previous dose of pneumococcal vaccine.

However, ACIP updated its guidelines regarding pneumococcal vaccines; now recommending the administration of two different pneumococcal vaccinations.

CMS is updating the Medicare coverage requirements to align with the updated ACIP recommendations. Effective for dates of service on or after September 19, 2014, (and upon implementation of CR 9051), Medicare will cover:

- An initial pneumococcal vaccine to all Medicare beneficiaries who have never received the vaccine under Medicare Part B; and
- A different, second pneumococcal vaccine one year after the first vaccine was administered (that is, 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

Since the updated ACIP recommendations are specific to vaccine type and sequence of vaccination, prior pneumococcal vaccination history should be taken into consideration. For example, if a beneficiary who is 65 years or older received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) a year or more ago, then the 13-valent pneumococcal conjugate vaccine (PCV13) should be administered next as the second in the series of the two recommended pneumococcal vaccinations. Receiving multiple vaccinations of the same vaccine type is not generally recommended. Ideally, providers should readily have access to vaccination history, such as with electronic health records, to ensure reasonable and necessary pneumococcal vaccinations.

Medicare does not require that a doctor of medicine or osteopathy order the vaccine; therefore, the beneficiary may receive the vaccine upon request without a physician’s order and without physician supervision.

Note that MACs will not search for and adjust any claims for pneumococcal vaccines and their administration, with dates of service on and after September 19, 2014. However, they may adjust such claims that you bring to their attention.

Additional Information


The Centers for Disease Control and Prevention (CDC) recommends that providers use two pneumococcal vaccines for adults aged >65. These vaccinations are 13-Valent Pneumococcal Conjugate Vaccine (PCV13) and 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23). For more information on these recommendations, visit http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm on the CDC website.

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.
RHC/FQHC

MM8980: Calendar Year (CY) 2015 Rural Health Clinic (RHC) and Federally Qualified Health Centers (FQHC) Updates: Payment Rate Increases for RHCs and FQHCs Billing Under the All-Inclusive Rate System (AIR), and Urban and Rural Designations for FQHCs Billing Under the AIR

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: MM8980
Related CR Release Date: December 12, 2014
Related CR Transmittal #: R3147CP
Effective Date: January 1, 2015
Implementation Date: January 5, 2015

Provider Types Affected
This MLN Matters® Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed
This article is based on CR 8980 which informs MACs about instructions for the Calendar Year (CY) 2015 payment rate increases for RHCs and FQHCs billing under the all-inclusive rate (AIR) system, and updates to the urban and rural designations for FQHCs billing under the AIR. Make sure that your billing staffs are aware of these changes.

Background
CR 8980 provides instructions to MACs for the CY 2015 payment rate increases for RHCs and FQHCs billing under the AIR. As authorized by §1833(f) of the Social Security Act (the Act), the payment limits for a subsequent year are increased in accordance with the rate of increase in the Medicare Economic Index (MEI). The RHC payment limit per visit for CY 2015 is $80.44 effective January 1, 2015, through December 31, 2015. The 2015 RHC rate reflects a 0.8 percent increase above the 2014 payment limit of $79.80. The FQHC payment limit per visit for urban FQHCs for CY 2015 is $130.05 and the payment limit per visit for rural FQHCs is $112.56 effective January 1, 2015, through December 31, 2015. The 2015 FQHC rates reflect a 0.8 percent increase above the 2014 rates of $129.02 and $111.67 in accordance with the rate of increase in the MEI.

CR 8980 also provides instructions to the MACs regarding the urban and rural designations for FQHCs that are authorized to bill under the AIR system. Each FQHC site is designated as an urban or rural entity based on the urban and rural definitions in §1886(d)(2)(D) of the Act, which defines urban and rural for hospital payment purposes. If the FQHC is located within a Metropolitan Statistical Area (MSA), then the urban upper payment limit applies. If the FQHC is not in an MSA and cannot be classified as a large or other urban area, the rural payment limit applies. Rural FQHCs cannot be reclassified into an urban area for FQHC payment limit purposes.

The definition of urban and rural is based upon the most recent available data from the Bureau of Census and is issued by the Office of Management and Budget (OMB). OMB reviews its statistical area standards and delineations preceding each decennial census. On February
28, 2013, OMB issued “OMB Bulletin No. 13-01,” which established revised delineations for its statistical areas and provided guidance on the use of these delineations. OMB defines an MSA as a Core-based Statistical Area (CBSA) associated with at least one urbanized area that has a population of at least 50,000, and defines a Micropolitan Statistical Area as a CBSA associated with at least one urban cluster that has a population of at least 10,000 but less than 50,000 (75 FR 37252).

On August 22, 2014, CMS published the FY 2015 Hospital Inpatient Prospective Payment System (IPPS) Final Rule (79 FR 49952). This final rule states the CMS policy for using OMB’s revised CBSA delineations based on the 2010 Census data for updating the definitions of labor market or geographic areas for purposes of payment under the IPPS, effective October 1, 2014. For the IPPS, MSAs are defined as urban, and Micropolitan Statistical Areas and other non-urban areas are defined as rural. In addition, the IPPS definition of rural and urban is used to determine the rural or urban status of FQHC sites.

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.

RHC/FQHC

MM8981: 2015 Update of the Medicare Benefit Policy Manual, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

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: MM8981
Related CR Release Date: December 12, 2014
Related CR Transmittal #: R201BP
Effective Date: January 1, 2015
Implementation Date: January 5, 2015

Provider Types Affected

This MLN Matters® Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

CR 8981 advises MACs of updates to Chapter 13 of the “Medicare Benefit Policy Manual.” These updates include new and clarifying information on the FQHC Prospective Payment System (PPS) rate, adjustments, payment codes, and qualifying visits; RHC employment requirements; RHC and FQHC preventive health services; and other issues related to RHC and FQHC billing and services.
Background

CMS has released an update to the “Medicare Benefit Policy Manual,” Chapter 13, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services.” Some of the key section updates as a result of CR 8981 are as follows:

- **Section 10.1 - RHC General Information**
  
  **Clarification** - A provider-based CMS Certification Number is not an indication that the RHC has a provider-based determination for purposes of an exception to the payment limit.

- **Section 10.2 - FQHC General Information**
  
  **New** - On or after October 1, 2014, FQHCs began to transition to the FQHC PPS as required by Section 10501(i)(3)(B) of the Affordable Care Act.

- **Section 30.1.1 – RHC Requirements**
  
  **Clarification** - An Advanced Practice Registered Nurse who is not a Nurse Practitioner (NP), or Physician Assistant (PA), or a NP or PA who is working as a substitute in an arrangement similar to a locum tenens physician, would not satisfy the RHC employment requirements.

  **New** - As of July 1, 2014, RHCs may contract with NPs, PAs, certified nurse midwives, clinical psychologists, or clinical social workers as long as at least one NP or PA is employed by the RHC (subject to the waiver provision for existing RHCs set forth at Section 1861(aa)(7) of the Social Security Act).

- **Section 40 - RHC and FQHC Visits**
  
  **New** - A list of qualifying visits for FQHCs paid under the PPS is located on the FQHC PPS Web page at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html) on the CMS website.

- **Section 40.3 - Multiple Visits on Same Day and Exceptions**
  
  **Clarification** - Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where a RHC or FQHC patient has a medically-necessary face-to-face visit with a RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner (including a specialist) for evaluation of a different condition on the same day.

  **New** - Exceptions for FQHCs that are authorized to bill under the PPS

  - The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC or FQHC) (2 visits can be billed), or
  - The patient has a medical visit and a mental health visit on the same day (2 visits can be billed).

- **50.1 - RHC Services**
  
  **New** – RHC services includes Hepatitis C screenings.

  **Clarification** - Except for influenza and pneumococcal vaccines and their administration, which are paid through the cost report, RHCs are paid for the professional component of these services based on their AIR.
50.2 – FQHC Services

New – FQHC services includes Hepatitis C screenings.

Clarification/New - Except for influenza and pneumococcal vaccines and their administration which are paid through the cost report, FQHCs are paid for the professional component of these services based on their AIR, or, for FQHCs that are authorized to bill under the PPS, based on the lesser of the FQHC’s charge or the PPS rate for the specific payment code.

Section 70.1.2 – FQHC Per-Visit Payment Limit

New – FQHCs that bill under the AIR and are located within a Metropolitan Statistical Area are considered urban FQHCs. MSAs are Core-Based Statistical Areas that are associated with at least one urbanized area that has a population of at least 50,000 people.

Section 70.2 – FQHCs Billing Under the PPS Payment Rate and Adjustments

New – For FQHCs that are authorized to bill under the PPS, Medicare pays 80 percent of the lesser of the FQHC’s charge or the PPS payment rate for the specific payment code, unless otherwise noted. The PPS payment rate reflects a base rate that is the same for all FQHCs, a geographic adjustment, and other applicable adjustments as described below. The PPS base rate will be updated annually by the Medicare Economic Index (MEI) or by a FQHC market basket.

Geographic Adjustment: The PPS base rate will be adjusted for each FQHC based on its location by the FQHC Geographic Adjustment Factor (FQHC GAF). The PPS payment rate is the PPS base rate multiplied by the FQHC GAF for the location where the service is furnished. Since the FQHC GAF is based on where the services are furnished, the FQHC payment rate may differ among FQHC sites within the same organization. FQHC GAFs are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html on the CMS website.

New Patient Adjustment: The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes care to a patient who is new to the FQHC. A new patient is someone who has not received any professional health services (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.

IPPE and AWV Adjustment: The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes an IPPE or an Annual Wellness Visit (AWV) to a Medicare beneficiary.

Section 70.2.1 – Payment Codes for FQHCs Billing Under the PPS

New – FQHCs that are authorized to bill under the PPS must include a FQHC payment code on their claim for payment. FQHCs set their own charges for services they provide and determine which services are included in the bundle of services associated with each FQHC G-code. The five specific payment codes to be used by FQHCs submitting claims under the PPS are:

G0466 – FQHC visit, new patient
G0467 – FQHC visit, established patient
G0468 – FQHC visit, Initial Preventative Physical Exam (IPPE) or AWV
G0469 – FQHC visit, mental health, new patient
G0470 – FQHC visit, mental health, established patient
• Section 70.3 - Cost Reports
  
  **New** - FQHCs that are authorized to bill under the FQHC PPS are required to file a cost report annually and are paid for the costs of GME, bad debt, and influenza and pneumococcal vaccines and their administration through the cost report.

• Section 70.4 - Productivity Standards
  
  **New** - FQHCs that are authorized to bill under the FQHC PPS are not subject to the productivity standards.

• Section 80 - RHC and FQHC Patient Charges, Coinsurance, Deductible, and Waivers
  
  **New** - For FQHCs billing under the PPS, the coinsurance is 20 percent of the lesser of the FQHC’s charge for the specific payment code or the PPS rate.

• Section 100.4 – Transitional Care Management (TCM) Services
  
  **Clarification** - TCM services can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.

• Section 110.3 - Payment for Incident to Services and Supplies
  
  **Clarification** - If a Medicare-covered Part B drug is furnished by a RHC or FQHC practitioner to a Medicare patient as part of a billable visit, the cost of the drug and its administration is included in the RHC or FQHC’s AIR or the FQHC’s PPS payment. RHCs and FQHCs cannot bill separately for Part B drugs or other incident to services or supplies.

• Section 170 - Physical and Occupational Therapy
  
  **New** - PT and OT therapists who provide services incident to a physician, NP, or PA visit may be an employee of the RHC or FQHC or contracted to the RHC or FQHC.

• Section 190 - Telehealth Services
  
  **Clarification** - RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by a RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract.

• Section 210 - Preventive Health Services
  
  **Clarification** - RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met. The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Healthcare Common Procedure Coding System (HCPCS) coding is required on all claims to allow for the coinsurance and deductible to be waived.

• Section 210.1 - Preventive Health Services in RHCs
  
  **Clarification** – HCPCS codes, payment and billing, and coinsurance and deductible information is provided for Influenza (G0008) and Pneumococcal Vaccines (G0009), Hepatitis B Vaccine (G0010), Initial Preventive Physical Exam (G0402), Annual Wellness Visit (G0438 and G0439), Screening Pelvic and Clinical Breast Examination (G0101), Screening Pap test for cancer (Q0091), Prostate Cancer Screening (G0102), and Glaucoma Screening (G0117 and G0118).

  **New** – Hepatitis C Screening (GO472)
  
  Hepatitis C screening is included in a RHC visit and is not separately billable. The cost of the professional component of the screening can be included in the line item for the
otherwise qualifying visit. A visit cannot be billed if this is the only service the RHC provides. Effective for claims with dates of service on or after June 2, 2014, the beneficiary coinsurance and deductible are waived.

- **210.3 - Preventive Health Services in FQHCs**

  **Clarification** - HCPCS codes, payment and billing, and coinsurance information is provided for Influenza and Pneumococcal Vaccines (G0009), Hepatitis B Vaccine (G0010), Initial Preventive Physical Exam (G0402), Annual Wellness Visit (G0438 and G0439), Diabetes Counseling and Medical Nutrition Services, Screening Pelvic and Clinical Breast Examination (G0101), Screening Papanicolaou Smear (Q0091), Prostate Cancer Screening (G0102), Glaucoma Screening (G0117 and G0118).

  **New** - Hepatitis C Screening (G0472)

  Hepatitis C screening is included in a FQHC visit and is not separately billable. The cost of the professional component of the screening can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if this is the only service the FQHC provides. Effective for claims with dates of service on or after June 2, 2014, the beneficiary coinsurance is waived.

- **Section 210.4 - Copayment for FQHC Preventive Health Services**

  **Clarification** - When one or more qualified preventive service is provided as part of a FQHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayment. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary copayment is based on $100 of the total charge, and Medicare would pay 80 percent of the $100, and 100 percent of the $50. If no other FQHC service took place along with the preventive service, there would be no copayment applied, and Medicare would pay 100 percent of the payment amount.

  **New** - FQHCs that are authorized to bill under the FQHC PPS would follow the same process, but would deduct the total charges for the preventive services from the lesser of the FQHC’s charge or the PPS rate.

**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.