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Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology CPT codes. Descriptions and other data only are copyrighted 2015 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Administration

2016 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 (866.590.6703) will be closed for CSR training and staff development.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Training/Closures</th>
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<tr>
<td>Monday, February 15, 2016 (President’s Day)</td>
<td>9:00 a.m. – 5:30 p.m. Eastern Time</td>
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The Interactive Voice Response (IVR) (1.866.289.6501) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at [http://www.cgsmedicare.com/parta/cs/cgs_15_partaivr_user_guide.pdf](http://www.cgsmedicare.com/parta/cs/cgs_15_partaivr_user_guide.pdf) on the CGS website. In addition, CGS’ Internet portal, myCGS, is available to access eligibility information through the Internet. For additional information, go to [http://www.cgsmedicare.com/parta/index.html](http://www.cgsmedicare.com/parta/index.html) and click the “myCGS” button on the left side of the Web page.


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.

MLN Connects™ Provider eNews

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


MM9374: Remittance Advice Remark and Claim Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

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<tr>
<td>Related CR Release Date: November 25, 2015</td>
<td>Effective Date: April 1, 2016</td>
</tr>
<tr>
<td>Related CR Transmittal #: R3418CP</td>
<td>Implementation Date: April 4, 2016</td>
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Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs and Home Health & Hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9374 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs Medicare system maintainers to
update Medicare Remit Easy Print (MREP) and PC Print software. Make sure your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use it.

Background

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

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

CR9374 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. MACs make necessary program changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per CR9374 or as posted on the WPC website when:

- Medicare is not primary;
- The COB claim is received after the deactivation effective date; and
- The date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC website.

MACs make necessary programming changes so that deactivated reason and remark codes are allowed even after the deactivation implementation date in a Reversal and Correction situation, when a value of 22 in CLP02 identifies the claim to be a corrected claim, and in Medicare Secondary Payer (MSP) claims, when forwarded to Medicare by primary payers before the deactivation date and Medicare adjudication is done after the deactivation date.

SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the WPC website, found at http://wpc-edi.com/Reference/ on the Internet. If any new or modified code has an effective date past the implementation date specified in CR9374, MACs must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times per year and may not match the CMS systems release schedule. For this recurring CR, MACs and SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR9278, with a related MLN Matters® article available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9278.pdf on the CMS website.)

In accordance with HIPAA Legislation Published in the Federal Register (45 CFR Part 162), covered entities are required to comply with established standards and code set regulations. Furthermore, the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) further defines the requirements for the 835 transaction by specifying Phase III Operating Rules, the 835 transaction (Health Care Claim Payment/Advice) and standard paper remittance advice which require the use of CARCs and RARCs.
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

MM9410: Update to Medicare Deductible, Coinsurance and Premium Rates for 2016

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: MM9410
Related CR Release Date: November 25, 2015
Related CR Transmittal #: R96GI
Change Request (CR) #: CR 9410
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

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

Provider Action Needed
Change Request (CR) provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2016 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

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

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.
Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. In addition, some beneficiaries may pay higher Part B premiums, based on their income.

2016 PART A - HOSPITAL INSURANCE (HI)

- **Deductible:** $1,288.00
- **Coinsurance**
  - $322.00 a day for 61st-90th day
  - $644.00 a day for 91st-150th day (lifetime reserve days)
  - $161.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- **Base Premium (BP):** $411.00 a month
- **BP with 10% surcharge:** $452.10 a month
- **BP with 45% reduction:** $226.00 a month (for those who have 30-39 quarters of coverage)
- **BP with 45% reduction and 10% surcharge:** $248.60 a month

2016 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)

- **Standard Premium:** $121.80 a month
- **Deductible:** $166.00 a year
- **Pro Rata Data Amount**
  - $118.86 1st month
  - $47.14 2nd month
- **Coinsurance:** 20 percent

Additional Information


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

**Administration**

**MM9427: Claim Status Category and Claim Status Code Update**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at [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)

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<td>MM9427</td>
<td>CR 9427</td>
<td>November 20, 2015</td>
<td>April 1, 2016</td>
<td>R3413CP</td>
<td>April 4, 2016</td>
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Provider Types Affected
This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9427 informs MACs about the changes to Claim Status Category and Claim Status Codes.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee (NCMC) in the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s).

Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The NCMC meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The NCMC has decided to allow the industry 6 months for implementation of newly added or changed codes.

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

All code changes approved during the January 2016 committee meeting shall be posted on these sites on or about February 1, 2016. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes, by the implementation date of CR9427.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR9427.

CMS and the MACs must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. These contractors must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses and when sending ASC X12 277 Healthcare Claim Acknowledgments. References in this CR to “277 responses” and “claim status responses” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.866.590.6703 and choose Option 1.
Medicare Bulletin • GR 2016-02

MM9350: Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE

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: MM9350
Related CR Release Date: November 20, 2015
Related CR Transmittal #: R3411CP
Change Request (CR) #: CR 9350
Effective Date: April 1, 2016
Implementation Date: April 4, 2016

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

Provider Action Needed
Change Request (CR) 9350 instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule publication. These system updates are based on the CORE Code Combination List to be published on or about February 1, 2016.

Background
The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Patient Protection and Affordable Care Act of 2010.

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

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

CR9350 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2016. This update is based on the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2015.
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)

Revised products from the Medicare Learning Network®


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, 2016, the interest amount is 2.500%.

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

Coverage

CGS LCD Policy Updates

The following LCDs have been released from draft into their final version. Please review them on the CGS website or click on the links provided. These policies will be effective February 1, 2016.

- L36460 Bone Mass Measurement
- L36487 MolDX: Chromosome 1p/19q deletion analysis
- L36494 Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint
• L36458 MolDX: Breast Cancer Index™ Genetic Assay
• L36425 MolDX: Breast Cancer Assay: Prosigna

The following policy will be effective February 8, 2016.
• L36469 Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder

These policies will be effective February 15, 2016.
• L36485 MolDX: HLA-DQB1*06:02 Testing for Narcolepsy
• L36456 MolDX: BRCA1 and BRCA2 Genetic Testing


Kentucky:
• Part A - https://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntctr=239&ContrVer=1&ContrctrSelected=239*1&name=CGS+Administrators%2c+LLC+(15101%2c+MAC+-+Part+A)&LCntrctr=239*1&DocType=Future&bc=AgACAAA-AAAAAA%3d%3d&#ResultsAnchor
• Part B - https://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntctr=228&ContrVer=2&ContrctrSelected=228*2&name=CGS+Administrators%2c+LLC+(15102%2c+MAC+-+Part+B)&LCntrctr=228*2&DocType=Future&bc=AgACAAA-AAAAAA%3d%3d&#ResultsAnchor

Ohio:
• Part A - https://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntctr=240&ContrVer=1&ContrctrSelected=240*1&name=CGS+Administrators%2c+LLC+(15201%2c+MAC+-+Part+A)&LCntrctr=240*1&DocType=Future&bc=AgACAAA-AAAAAA%3d%3d&#ResultsAnchor
• Part B - https://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntctr=238&ContrVer=2&ContrctrSelected=238*2&name=CGS+Administrators%2c+LLC+(15202%2c+MAC+-+Part+B)&LCntrctr=238*2&DocType=Future&bc=AgACAAA-AAAAAA%3d%3d&#ResultsAnchor

Coverage

MM9252 Revised: ICD-10 Conversion/Coding Infrastructure Revisions to National Coverage Determinations (NCDs)—3rd Maintenance CR

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9252 Revised
Related CR Release Date: December 3, 2015
Related CR Transmittal #: R15800TN
Related Change Request (CR) #: CR 9252
Effective Date: October 1, 2015

Implementation Date: January 4, 2016,
Exceptions: FISS will implement the following NCDs: April 4, 2016: 260.1, 80.11, 270.6, 160.18, 110.10, 110.21, 250.5, 160.24

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters are available at no cost from our website at http://www.cgsmedicare.com. © 2015 Copyright, CGS Administrators, LLC.
Note: This article was revised on December 3, 2015, to reflect an updated CR that: 1) Removed invalid TOB 52X from NCD250.5; 2) Removed invalid TOB 25X from NCD80.11 and added TOB 85X; and 3) Included complete history in NCD160.18. In the article, the CR release date, transmittal number, and the Web address for accessing CR9252 are revised. All other information remains the same.

Provider Types Affected

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

What you Need to Know


Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

Background

CR9252 creates and updates NCD editing, both hard-coded shared system edits as well as local MAC edits that contain ICD-10 diagnosis/procedure codes, plus all associated coding infrastructure such as HCPCS/CPT codes, reason/remark codes, frequency edits, Place of Service (POS)/Type of Bill (TOB)/provider specialties, and so forth. The requirements described in CR9252 reflect the operational changes that are necessary to implement the conversion of the Medicare local and shared system diagnosis and procedure codes specific to the 26 Medicare NCD spreadsheets, which are available at https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9252.zip on the Centers for Medicare & Medicaid (CMS) website.

NCD policies may contain specific covered, non-covered and/or discretionary diagnosis and procedure coding. These 26 spreadsheets are designated as such and are based on current NCD policies and their corresponding edits.

You should be aware that nationally covered and non-covered diagnosis code lists are finite and cannot be revised without a subsequent CR. Discretionary code lists are to be regarded as CMS’ compilation of discretionary codes based on current analysis/interpretation. MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions.

Some coding details are as follows:

1. Your MAC will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages, where appropriate:
   - Remittance Advice Remark 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), along with...
Claim Adjustment Reason Code (CARC) 50 (These are noncovered services because this is not deemed a “medical necessity” by the payer),
- CARC 96 (Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)), and/or
- CARC 119 (Benefit maximum for this time period or occurrence has been reached).

2. When denying claims associated with the NCDs in the 26 spreadsheets, except where otherwise indicated, your MACs will use:
- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 (Advance Beneficiary Notice), or with occurrence code 32 and a GA modifier (The provider or supplier has provided an Advance Beneficiary Notice (ABN) to the patient), indicating a signed ABN is on file).
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier (The provider or supplier expects a medical necessity denial; however, did not provide an Advance Beneficiary Notice (ABN) to the patient), indicating no signed ABN is on file)
- For modifier GZ, your MAC will use CARC 50.

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.

Document History

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<td>Article was revised to reflect new CR that: 1) Removed invalid TOB 52X from NCD525.5, 2) Removed invalid TOB 25X from NCD50.11 and added TOB 85X and, 3) Included complete history in NCD160.18.</td>
</tr>
<tr>
<td>October 6, 2015</td>
<td>Article was revised to reflect new CR issued on October 5, 2015. In the article, the CR release date, transmittal number, and the Web address for accessing CR9252 are revised.</td>
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End-Stage Renal Disease (ESRD)

**MM9367 (Revised): Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) For Calendar Year (CY) 2016**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article on December 3, 2015. CMS then issued a revised article on December 21, 2015. 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/2015-MLN-Matters-Articles.html

**MLN Matters® Number:** MM9367 **Revised**
**Related Change Request (CR) #:** CR 9367
**Related CR Release Date:** December 15, 2015
**Effective Date:** January 1, 2016
**Related CR Transmittal #:** R214BP
**Implementation Date:** January 4, 2016
**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9367 implements the CY 2016 rate updates for the ESRD PPS. Please make sure your billing staffs are aware of these changes.

**Background**

Effective January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the ESRD PPS based on the requirements of Section 1881(b)(14) of the Social Security Act (the Act) as added by Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) and amended by Section 3401(h) of the Affordable Care Act established that beginning CY 2012, and each subsequent year, the Secretary shall annually increase payment amounts by an ESRD market basket increase factor, reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. The ESRD bundled (ESRDB) market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate. Section 217(b)(2) of the Protecting Access to Medicare Act of 2014 (PAMA) included a provision that dictated how the market basket should be reduced for CY 2016.

For CY 2016, in accordance with Section 632(c) of the American Taxpayer Relief Act of 2012 (ATRA), CMS conducted an analysis of the case-mix adjustments being used under the ESRD PPS and finalized revisions. Specifically, CMS updated the two-equation regression used to develop the payment adjustments for the CY 2011 ESRD PPS final rule using CY 2012 and 2013 Medicare cost report and claims data.

In addition to case-mix adjustments, CMS also updated the low-volume payment adjustment and is implementing a rural payment adjustment. ESRD facilities that submit an attestation to their respective MACs prior to the payment year and meet the criteria at 42 CFR 413.232(b) (https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol2/CFR-2011-title42-vol2-sec413-232) are eligible to receive the low-volume payment adjustment.

In accordance with Section 217(c) of the Protecting Access to Medicare Act of 2014 (PAMA), CMS implemented a drug designation process for:

1. Determining when a product is no longer an oral-only drug; and
2. Including new injectable and intravenous products into the ESRD PPS.

CMS is completing a two-year transition to the updated labor-related share and 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 (https://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf).

In addition, Section 204 of the Achieving a Better Life Experience Act of 2014, provided that payment for oral-only renal dialysis services cannot be made under the ESRD PPS bundled payment prior to January 1, 2025.

The ESRD PPS includes Consolidated Billing (CB) requirements for limited Part B services included in the ESRD facility’s bundled payment. CMS periodically updates the list of items and services that are subject to Part B CB and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.
Effective January 1, 2016, Healthcare Common Procedure Coding System (HCPCS) Code J0886 (Injection, epoetin alfa, 1000 units (for esrd on dialysis)) will be terminated. All drugs and biologicals used for the treatment of ESRD are the responsibility of the ESRD facility. Practitioners treating Medicare ESRD beneficiaries with erythropoiesis stimulating agents (ESAs) for reasons other than the beneficiary’s ESRD must use the appropriate HCPCS code. Specifically, practitioners should use HCPCS code J0885 (Injection, epoetin alfa, (for non-esrd use), 1000 units).

**CY 2016 ESRD PPS Updates – ESRD PPS Base Rate:**
- A 0.15 percent update to the CY 2015 payment rate. ($239.43 x 1.0015 = $239.79)
- A wage index budget-neutrality adjustment factor of 1.000495.
- A refinement budget-neutrality adjustment factor of 0.960319. Therefore, the CY 2016 ESRD PPS base rate is $230.39 ($239.43 x 1.0015 x 0.960319 = $230.39).

**Wage Index:**
- The wage index adjustment will be updated to reflect the latest available wage data.
- The most recent OMB CBSA delineations is fully implemented; therefore, CMS is no longer transitioning the wage index and use of the special wage indicator is no longer necessary for those ESRD facilities that experienced a change in CBSA.
- The wage index floor will remain at 0.4000.

**Labor-related Share:**
The revised labor-related share of 50.673 is fully implemented.

**Update to the Patient-Level and Facility-Level Payment Adjustments:**
For the CY 2016 ESRD PPS refinement, CMS is changing the adjustment payment amounts to reflect the updated regression analysis that was completed using CY 2012 and 2013 ESRD claims and cost report data for adult and pediatric patients.

In addition, for adult beneficiaries, CMS has removed two comorbidity categories (bacterial pneumonia and monoclonal gammopathy) from being eligible for a payment adjustment and is implementing a rural payment adjustment for those ESRD facilities that are located in a rural CBSA (that is, a non-urban CBSA).

The patient-level and facility-level payment adjustments are available in Tables 1 (adult) and 2 (pediatric) below.

<table>
<thead>
<tr>
<th>Table 1: Adult ESRD Beneficiaries</th>
<th>Separately Billable Multipliers for PY 2016</th>
<th>Expanded Bundle Multipliers for PY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
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<tr>
<td>18-44</td>
<td>1.044</td>
<td>1.257</td>
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<td>45-59</td>
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<td>60-69</td>
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<td>70-79</td>
<td>1.000</td>
<td>1.000</td>
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<tr>
<td>80+</td>
<td>0.981</td>
<td>1.109</td>
</tr>
<tr>
<td>Body surface area (per 0.1 m2)</td>
<td>1.000</td>
<td>1.032</td>
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<tr>
<td>Underweight (BMI &lt; 18.5)</td>
<td>1.090</td>
<td>1.017</td>
</tr>
<tr>
<td>Time since onset of renal dialysis &lt; 4 months</td>
<td>1.409</td>
<td>1.327</td>
</tr>
<tr>
<td>Facility low volume status</td>
<td>0.955</td>
<td>1.239</td>
</tr>
<tr>
<td><strong>Comorbidities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pericarditis (acute)</td>
<td>1.209</td>
<td>1.040</td>
</tr>
<tr>
<td>Gastro-intestinal tract bleeding (acute)</td>
<td>1.426</td>
<td>1.082</td>
</tr>
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</table>
Table 1: Adult ESRD Beneficiaries

<table>
<thead>
<tr>
<th>Variable</th>
<th>Separately Billable Multipliers for PY 2016</th>
<th>Expanded Bundle Multipliers for PY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hereditary hemolytic or sickle cell anemia (chronic)</td>
<td>1.999</td>
<td>1.192</td>
</tr>
<tr>
<td>Myelodysplastic syndrome (chronic)</td>
<td>1.494</td>
<td>1.095</td>
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<tr>
<td>Rural</td>
<td>0.978</td>
<td>1.008</td>
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</table>

Table 2: Pediatric ESRD Beneficiaries

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>PY 2016 Final Rule</th>
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<tbody>
<tr>
<td>Cell</td>
<td>Age</td>
</tr>
<tr>
<td>1</td>
<td>&lt;13</td>
</tr>
<tr>
<td>2</td>
<td>&lt;13</td>
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<tr>
<td>3</td>
<td>13-17</td>
</tr>
<tr>
<td>4</td>
<td>13-17</td>
</tr>
</tbody>
</table>

Outlier Policy:
As a result of the CY 2016 ESRD PPS refinement, CMS is also changing the adjusters used for determining the Medicare Allowable Payment (MAP) amount in the outlier calculation. These values are available in Tables 1 and 2 above in the separately billable multipliers column.

CMS made the following updates to the adjusted average outlier service MAP amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $50.81.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $39.20.

CMS made 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 $86.97 for adult patients.
2. The fixed dollar loss amount is $62.19 for pediatric patients.

CMS made 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, are 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 B of CR9367 ([https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R214BP.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R214BP.pdf)).
2. The mean dispensing fee of the National Drug Codes (NDC) qualifying for outlier consideration is revised to $0.97 per NDC per month for claims with dates of service on or after January 1, 2016. See Attachment B of CR9367 ([https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R214BP.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R214BP.pdf)).

Consolidated Billing Requirements:

1. The consolidated billing requirements for drugs and biologicals included in the ESRD PPS is updated by:
   a. Removing Current Procedural Terminology code 80061 (Lipid Panel) as it has been determined that this laboratory test is routinely furnished for reasons other than for the treatment of ESRD. Therefore, for dates of service on or after January 1, 2016, the Lipid Panel is no longer subject to the ESRD PPS consolidated billing requirements.
b. Removing HCPCS J0886 injection, epoetin alfa, 1000 units (for esrd on dialysis) since the code will be terminated effective December 31, 2015.

c. Removing HCPCS Q9976 – Injection, Ferric Pyrophosphate Citrate Solution; 0.1 mg of iron since this code will be terminated effective December 31, 2015.

d. Adding HCPCS J1443 - Injection, Ferric Pyrophosphate Citrate Solution; 0.1 mg of iron since this code will be replacing Q9976 and is effective January 1, 2016.

i. J1443 is a drug that is used for anemia management. Anemia management is an ESRD PPS functional category where drugs and biologicals that fall in this category are always considered to be used for the treatment of ESRD. ESRD facilities will not receive separate payment for J1443 with or without the AY modifier and the claims shall process the line item as covered with no separate payment under the ESRD PPS.

ii. J1443 is administered via dialysate. Therefore, when billing for J1443, it should be accompanied by the JE modifier as discussed in CR 8256 issued April 26, 2013.

iii. In accordance with 42 CFR 413.237(a)(1), HCPCS J1443 is considered to be eligible outlier services and will be included in the outlier calculation when CMS provides a fee amount on the Average Sales Price fee schedule.

Attachment C of CR9367 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R214BP.pdf) reflects the items and services that are subject to the ESRD PPS consolidated billing 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.

Fee Schedule

**MM9239: Implementation of Adjusted Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule Amounts Using Information from the National Competitive Bidding Program (CBP)**

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:** MM9239  
**Change Request (CR) #:** CR 9239  
**Related CR Release Date:** September 11, 2015  
**Effective Date:** January 1, 2016  
**Related CR Transmittal #:** R3350CP  
**Implementation Date:** January 4, 2016

**Provider Types Affected**

This MLN Matters® Article is intended for DMEPOS suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.
Provider Action Needed

STOP – Impact to You
The adjusted fee schedule amounts for the applicable Healthcare Common Procedure Coding System (HCPCS) codes will be used to pay claims with dates of service on or after January 1, 2016, and will be included in the DMEPOS fee schedule files beginning January 1, 2016.

CAUTION – What You Need to Know
Section 1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the Competitive Bidding Program (CBP). Section 1842(s)(3)(B) of the Social Security Act (the Act) provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. Change Request (CR) 9239 implements the adjusted DMEPOS fees schedule from the CBP.

GO – What You Need to Do
Make sure that your billing staffs are aware of the adjusted DMEPOS fee schedule amounts from the CBP.

Background
Medicare payment for most DMEPOS is based on either fee schedules or single payment amounts (SPAs) established under the CBP in certain specified geographic areas, as mandated by 1847(a) and (b) the Act.

Competitive bidding was phased in with the Round 1 Rebid contracts beginning January 1, 2011, in 9 competitive bid areas (CBAs). Contracts for the Round 1 Rebid expired on December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is required by law to recompete contracts for the DMEPOS CBP at least once every 3 years. The same 9 CBAs were rebid under the Round 1 Recompete with the contracts and process claims with date of service beginning January 1, 2014. Competitive bidding was phased in with the Round 2 contracts beginning July 1, 2013, in 100 additional CBAs. Beginning with the Round 2 Recompete scheduled to take effect on July 1, 2016, CBAs covering more than one state will be subdivided into CBAs that do not cross state lines, resulting in an increase in the total number of CBAs.

The product categories and HCPCS codes included in each Round of the CBP are available at http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home on the Competitive Bidding Implementation Contractor (CBIC) website.

Section 1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the CBP. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. The methodologies for using information from the CBP to adjust the fee schedule amounts for DME and enteral nutrition are set forth in regulations at 42 Code of Federal Regulations (CFR) 414.210(g). There are three general methodologies:

- Adjustment of fee schedule amounts for areas within the contiguous United States, with a special rule for rural areas;
- Adjustment of fee schedule amounts for areas outside the contiguous United States; and
- Adjustment of fee schedule amounts for certain items for all areas in cases where the items have been included in competitive bidding programs in 10 or fewer CBAs.

Fee Schedule Amounts for Areas within the Contiguous United States
This methodology for adjusting the fee schedule amounts uses the average of SPAs from CBPs located in eight different regions of the contiguous United States to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are
also subject to a national ceiling (110% of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (that is, those included in more than 10 CBAs).

There is also a special rule for areas within the contiguous United States that are designated as rural areas. The fee schedule amounts for these areas will be adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural area to be a geographical area represented by a postal ZIP Code where at least 50 percent of the total geographical area of the ZIP Code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

As a result of these adjustments, the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts.

Fee Schedule Amounts for Areas outside the Contiguous United States

Areas outside the contiguous United States (noncontiguous areas such as Alaska, Guam, Hawaii) are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

Fee Schedule Amounts for Items Included in 10 or Fewer CBAs

DME items included in 10 or fewer CBAs are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs. This methodology applied to all areas (non-contiguous and contiguous).

Phasing In and Updating Fee Schedule Amounts

The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016 through June 30, 2016, so that the fee schedule amount is based on a blend of 50 percent of the current fee schedule amounts (the fee schedule amounts that would have gone into effect on January 1, 2016, if they had not been adjusted based on information from the CBP) and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the fee schedule is based on 100 percent of the adjusted fee schedule amount.

In most cases, the adjusted fee schedule amounts will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where SPAs from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment is made (for example, 2016) and for each subsequent year (for example, 2017, 2018).

The DME MAC and Part B MAC DMEPOS fee schedule file shall be adjusted to include the rural fee and rural fee indicator and these changes will be reflected in the file format and data requirements specified in Chapter 23, Section 60.1 of the “Medicare Claims Processing Manual” (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf). Similarly, the Fiscal Intermediary (FI) DMEPOS fee schedule file format, outlined in Chapter 23, Section 50.2 of the “Medicare Claims Processing Manual,” (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf) will be updated to include the rural fee and rural fee indicator. Beginning January 1, 2016, the DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodology as well as codes that are not subject to the adjustments.
The DMEPOS fee schedule file will continue to be updated and available for download on a quarterly basis as necessary.

The parenteral and enteral nutrition (PEN) fee schedule file will accommodate adjusted fees for the enteral HCPCS codes that are state specific. The PEN file layout is outlined in Chapter 23, Section 70.1 of the “Medicare Claims Processing Manual” (https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c23.pdf).

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

MM9266 (Revised): Quarterly Update in the Medicare Physician Fee Schedule Database (MPFSDB) – October CY 2015 Update

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9266 Revised Change Request (CR) #: CR 9266
Related CR Release Date: November 18, 2015 Effective Date: October 5, 2015
Related CR Transmittal #: R3407CP Implementation Date: January 1, 2015

Note: This article was revised on November 25, 2015, to reflect the revised CR9266 issued on November 18. In the article, several codes were removed from the list of codes with bilateral surgery indicator changes. The CR release date, transmittal number, and the Web address for CR9266 are also revised.

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services subject to the Medicare Physician Fee Schedule Database (MPFSDB) that are provided to Medicare beneficiaries.

What You Need to Know

Changes included in the October update to the 2015 MPFSDB are effective for dates of service on and after January 1 (unless otherwise stated). The key change is to the Malpractice Relative Value Units (RVU) of the following CPT/HCPCS codes: 33471, 33606, 33611, 33619, 33676, 33677, 33692, 33737, 33755, 33762, 33764, 33768, 33770, 33771, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33783, 33786, 33803, 33813, 33822, 33840, and 33851; and the Work RVUs for G0105 and G0121. The RVU changes for these codes are retroactive to January 1, 2015. In addition, effective January 1, 2015, codes 95866, 95866-TC, and 95866-26 have a revised bilateral surgery indicator = 3.

Also, effective October 1, 2015, CPT/HCPCS code Q9979 is assigned a procedure status indicator of E (Excluded from the PFS by regulation. These codes are for items and services that CMS has excluded from the PFS by regulation. No payment may be made under the PFS for these codes and generally, no RVUs are shown.).
Background

The Social Security Act (Section 1848(c)(4); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians’ services.

Payment files were issued to the MACs based upon the CY 2015 Medicare Physician Fee Schedule (MPFS) Final Rule, published in the Federal Register on December 19, 2014, to be effective for services furnished between January 1, 2015, and December 31, 2015.

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.

Document History

- On September 29, 2015, additional codes (G0105 and G0121) were added in the “What You Need to Know” section listing RVU changes.
- On November 25, the “What You Need to Know” section listing RVU changes was revised to remove several codes (76641, 76641-TC, 76641-26, 76642, 76642-TC, 76642-26) that had been listed with bilateral surgery indicator changes.

Fee Schedule

**MM9431: Calendar Year (CY) 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9431
Related CR Release Date: November 23, 2015
Related CR Transmittal #: R3416CP
MLN Matters® Number: MM9431
Related CR Release Date: November 23, 2015
Related CR Transmittal #: R3416CP

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9431 provides the CY 2016 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

**Background**

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual,” Chapter 23,
Payment on a fee schedule basis is required by the Social Security Act (the Act) for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician’s office.

The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas for the items, based on information from the National Competitive Bidding Program (CBP). The Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP.

CMS issued a final rule on November 6, 2014 (79 FR 66223) on the methodologies for adjusting DMEPOS fee schedule amounts using information from competitive bidding programs. Program instructions on these changes are also available in Transmittal 3350, CR 9239 on September 11, 2015. The CBP product categories, HCPCS codes and Single Payment Amounts (SPAs) included in each Round of the CBP are available on the Competitive Bidding Implementation Contractor (CBIC) website (http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/ Home).

There are three general methodologies used in adjusting the fee schedule amounts:

1. **Adjusted Fee Schedule Amounts for Areas within the Contiguous United States**

   The average of SPAs from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are also subject to a national ceiling (110% of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (i.e., those included in more than 10 CBAs).

   Also, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural areas to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

2. **Adjusted Fee Schedule Amounts for Areas outside the Contiguous United States**

   Areas outside the contiguous United States (i.e., noncontiguous areas such as Alaska, Guam, Hawaii) receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

3. **Adjusted Fee Schedule Amounts for Items Included in 10 or Fewer Areas**

   DME items included in 10 or fewer CBAs receive adjusted fee schedule amounts so that they are equal to 110 percent of the straight average of the SPAs for the 10 or fewer CBAs. This methodology applies to all areas (i.e., non-contiguous and contiguous).
Phasing In Fee Schedule Amounts

The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the July quarterly update files will include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts.

Fee schedule amounts that are adjusted using SPAs will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where the SPAs from CBPs no longer in effect are used to adjust fee schedule amounts (§414.210(g)(4)), the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2016 for this update) and for each subsequent year (such as 2017 or 2018) claims with dates of service on or after July 1, 2016, the fee schedule amount on the DMEPOS file is based on 100 percent of the adjusted fee schedule amount.

Fee Schedule and Rural ZIP Code Files

The DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments taking effect January 1, 2016. In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file has been updated to include rural payment amounts for those HCPCS codes where the adjustment methodology is based on average regional SPAs. Also, on the PEN file the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology will remain unchanged. The DMEPOS and PEN fee schedules and the Rural ZIP code file Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties after October 29, 2015 at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched on the CMS website.

New Codes Added Effective January 1, 2016:

The HCPCS codes A4337, E1012, E0465, E0466, and L8607. are being added to the HCPCS effective January 1, 2016. Codes E1012, E0465, E0466, and L8607 will be added to the DMEPOS fee schedule file effective January 1, 2016.

Codes Deleted

The following codes will be deleted from the DMEPOS fee schedule files effective January 1, 2016: E0450, E0460, E0461, E0463, and E0464.

Shoe Modification Codes

Effective January 1, 2016, CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2016. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2016, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512...
and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during CY 2014.

**Update to CR8566—Wheelchair Accessory**

Also as part of CR9431, CMS is adding HCPCS code E1012 (wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type). Code E1012 is eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair, effective January 1, 2016.

**The 2015 Deflation Factors for Gap-Filling Purposes**

For gap-filling pricing purposes, the 2015 deflation factors by payment category are: 0.459 for Oxygen, 0.462 for Capped Rental, 0.463 for Prosthetics and Orthotics, 0.588 for Surgical Dressings, 0.639 for Parental and Enteral Nutrition, 0.978 for Splints and Casts and 0.962 for Intraocular Lenses.

**Ventilators**

Fee schedules are being added for the following ventilator HCPCS codes:

- E0465 Home ventilator, any type, used with invasive interface (e.g., tracheostomy tube); and
- Code E0466 Home ventilator, any type, used with non-invasive interface (e.g., mask, chest shell).

Code E0465 is added to the HCPCS for billing Medicare claims previously submitted under E0450 and E0463. Code E0466 is added to the HCPCS for billing Medicare claims previously submitted under E0460, E0461 and E0464. The fee schedule amounts for codes E0465 and E0466 are established using the Medicare fee schedule amounts for HCPCS code E0450, based on updated average reasonable charges for ventilators from July 1, 1986, through June 30, 1987.

**Diabetic Testing Supplies (DTS)**

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

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. The CBP for mail order diabetic supplies is effective July 1, 2013 to June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, CR 8325, dated May 17, 2013, and Transmittal 2661, CR 8204, dated February 22, 2013. (See related MLN Matters Articles MM8325 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8325.pdf) and MM8204 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8204.pdf)).

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data only for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts will be updated annually by the covered item update factor adjusted for multi-factor productivity. The mail order DTS fee schedule amounts are not used in determining the Medicare allowed payment amounts for mail order DTS. The single payment amount Public Use File (PUF) for the national mail order CBP is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.
The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with The Act, the fee schedule amounts for mail order DTS furnished in the Northern Mariana Islands are adjusted to equal 100 percent of the single payment amounts established under the national mail order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the six-month phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which are based on 50 percent of the un-adjusted mail order fee schedule amounts and 50 percent of the adjusted mail order single payment amounts, will be provided on the DMEPOS fee schedule file in the Hawaii column of the mail order (KL) DTS (A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259) codes for dates of service January 1, 2016, through June 30, 2016. Beginning July 1, 2016, the fully adjusted mail order fees (the SPAs) will apply for mail order DTS furnished in the Northern Mariana Islands. The Northern Mariana Island DTS mail order payment amounts will no longer appear in the Hawaii column and the DTS mail order (KL) fee schedules for all states and territories will be removed from the DMEPOS fee schedule file as of July 1, 2016.

2016 Fee Schedule Update Factor of -0.4 Percent

For CY 2016, an update factor of 0.1 percent is applied to certain DMEPOS fee schedule amounts. For the majority of fee schedule amounts, in accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2016 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2015, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi[AG5] -Factor Productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 0.1 percent. Thus, the 0.1 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a net decrease of -0.4 percent for the update factor.

2016 Update Labor Payment Rates for HCPCS Codes K0739, L4205 and L7520 January 1, 2016 through December 31, 2016

The 2016 labor payment amounts are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2016, through December 31, 2016. Those amounts are as follows:

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CMS is implementing the 2016 national monthly fee schedule payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2016, through June 2016. The updated national 2016 monthly payment amount of $180.10 for the stationary oxygen equipment codes will not appear on the 2016 DMEPOS fee schedule. Instead, for dates of service January 1, 2016, through June 30, 2016, the 2016 fee schedule rate of $180.10 blends with the stationary oxygen regional SPAs based on 50 percent of the un-adjusted stationary oxygen fee schedule amounts and 50 percent of the adjusted oxygen regional SPAs.

Beginning July 1, 2016, the stationary oxygen equipment fee schedule amounts on the quarterly update to the CY 2016 DMEPOS fee schedule file will reflect 100 percent of the adjusted oxygen regional SPAs.

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

### 2016 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2016 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, Change Request (CR) 6792, dated February 5, 2010, and Transmittal 717, CR6990, dated June 8, 2010. (See related MLN Matters Articles MM6792 ([https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6792.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6792.pdf)) and MM6990 ([https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6990.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6990.pdf)). To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier’s or manufacturer’s warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the “MS” modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR §414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2016 maintenance and servicing fee is adjusted by the -0.4 percent MFP-adjusted covered item update factor to yield a CY 2016 maintenance and servicing fee of $69.48 for oxygen concentrators and transfilling equipment.

### Additional Information


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

MM9465: Calendar Year (CY) 2016 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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9465
Related Change Request (CR) #: CR 9465
Related CR Release Date: December 11, 2015
Effective Date: January 1, 2016
Effective Date: January 4, 2016
Implementation Date: January 4, 2016

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

Provider Action Needed
Change Request (CR) 9465 provides instructions for the CY 2016 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), the annual update to the local clinical laboratory fees for CY 2016 is 0.10 percent. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2016 is 0.10 percent (See 42 CFR 405.509(b)(1) at http://www.ecfr.gov/cgi-bin/text-idx?SID=7e5da647e7036b4a2840fe7f30a18d9e8&mc=true&node=se42.2.405_1509&rgn=div8). 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). The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key Points of CR 9465

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. Further, payment may not exceed the actual charge. The CY 2016 national minimum payment amount is $14.39 ($14.38 times 0.10 percent update for CY 2016). 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 2016 clinical laboratory fee schedule data file is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html on the Centers for Medicare & Medicaid (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 2016 clinical laboratory fee schedule; available in multiple formats: Excel, text, and comma delimited.

Public Comments and Final Payment Determinations

On July 16, 2015, CMS hosted a public meeting to solicit input on the payment relationship between CY 2015 codes and new CY 2016 CPT codes. 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 website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html on the CMS website. Additional written comments from the public were accepted until October 26, 2015. 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/CY2016-CLFS-Codes-Final-Determinations.pdf on the CMS website.

Pricing Information

The CY 2016 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. 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 2016, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2016 clinical laboratory fee schedule also includes codes that have a “QW” modifier to both identify codes and 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

Similar to prior years, the CY 2016 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

New code G0477 is priced at the same rate as 0.75 times code G0434.

New code G0478 is priced at the same rate as code G0434.

New code G0479 is priced at the same rate as 4.00 times code G0434.

New code G0480 is priced at the same rate as 3.25 times code 82542.

New code G0481 is priced at the same rate as 5.00 times code 82542.

New code G0482 is priced at the same rate as 6.75 times code 82542.

New code G0483 is priced at the same rate as 8.75 times code 82542.

New code 87651QW is priced at the same rate as code 87651.

New code 87806QW is priced at the same rate as code 87806.

New code 87502QW is priced at the same rate as code 87502.

New code 86780QW is priced at the same rate as code 86780.
New code 87650QW is priced at the same rate as code 87650.
New code 87389QW is priced at the same rate as code 87389.
New code 86850 is priced at the same rate as code 86902.
New code 80081 is priced at the same rate as the sum of codes 85025, 87340, 87389, 86762, 86592, 86850, 86900, and 86901.
New code 80055 is priced at the same rate as the sum of codes 85025, 87340, 86762, 86592, 86850, 86900, and 86901.
New code G0472 is priced at the same rate as code 86803.
New code G0472QW is priced at the same rate as code 86803.
New code 81162 is priced at the same rate as the sum of 0.90 times code 81211, and 0.90 times code 81213.
New code 81170 is priced at the same rate as code 81235.
New code 81218 is priced at the same rate as code 81235.
New code 81219 is priced at the same rate as code 81245.
New code 81272 is priced at the same rate as code 81235.
New code 81273 is priced at the same rate as code 81270.
New code 81276 is priced at the same rate as code 81275.
New code 81311 is priced at the same rate as 1.50 times code 81275.
New code 81314 is priced at the same rate as code 81235.
New code 81528 is priced at the same rate as the sum of codes 81315, 81275, and 82274.
New code 81535 is priced at the same rate as the sum of 2.00 times code 88239 and code 87900.
New code 81536 is priced at the same rate as code 87900.
New codes to be gap filled are: 81412, 81432, 81433, 81434, 81437, 81438, 81442, 81490, 81493, 81525, 81538, 81540, 81545, 81595, 0009M, and 0010M.
The following existing codes are to be deleted: G0431, G0434, G0434QW, G0464, G6030, G6031, G6032, G6034, G6035, G6036, G6037, G6038, G6039, G6040, G6041, G6042, G6043, G6044, G6045, G6046, G6047, G6048, G6049, G6050, G6051, G6052, G6053, G6054, G6055, G6056, G6057, G6058, 82486, 82487, 82488, 82489, 82491, 82492, 82541, 82543, 82544, and 83788.

Laboratory Costs Subject to Reasonable Charge Payment in CY 2011
For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, 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 2016 is 0.1 percent.

Manual instructions for determining the reasonable charge payment are available in the "Medicare Claims Processing Manual," Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80 through 80.8 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf). If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, "Medicare Claims
Processing Manual, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 60.3 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf), instructs that the reasonable charge basis applies. However, 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


Also, payment for the following codes should be applied to the blood deductible as instructed in the "Medicare General Information, Eligibility and Entitlement Manual," Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations), Sections 20.5 through 20.5.4 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf): P9010, P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9056, P9057, and P9058.

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 Procedure Codes

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.

Your MAC will not search their files to either retract payment or retroactively pay claims; however, 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.
MM9476: Summary of Policies in the Calendar Year (CY) 2016 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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9476
Related CR Release Date: December 18, 2015
Related CR Transmittal #: R3423CP
Change Request (CR) #: CR 9476
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

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 Change Request (CR) 9476 which provides a summary of the policies in the Calendar Year (CY) 2016 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. Make sure that your billing staff is aware of these updates for 2016.

Background
The Social Security Act (Section 1848(b)(1); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) requires the Centers for Medicare & Medicaid Services (CMS) to establish by regulation a fee schedule of payment amounts for physicians’ services for the subsequent year. CMS issued a final rule with comment period on October 30, 2015, (see http://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf), 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 2016.

The final rule also addresses public comments on Medicare payment policies proposed earlier this year. The proposed rule “Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016” was published in the Federal Register on July 15, 2015 (see http://www.gpo.gov/fdsys/pkg/FR-2015-07-15/pdf/2015-16875.pdf).

The final rule also addresses interim final values established in the CY 2015 MPFS final rule with comment period. The final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2016 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 29, 2015.

CR9476 provides a summary of the payment policies under the Medicare Physician Fee Schedule (PFS) and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2016 and they are as follows:

Sustainable Growth Rate (SGR)
The Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10, enacted on April 16, 2015) (MACRA; see http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf) repealed the Medicare SGR update formula for payments under the MPFS.

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters are available at no cost from our website at http://www.cgsmedicare.com. © 2015 Copyright, CGS Administrators, LLC.
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: Prolonged service inpatient CPT codes 99356 and 99357 and ESRD-related services 90963 through 90966. The prolonged service codes can only be billed in conjunction with subsequent hospital and subsequent nursing facility codes. Limits of one subsequent hospital visit every three days, and one subsequent nursing facility visit every 30 days, would continue to apply when the services are furnished as telehealth services.

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

Certified Registered Nurse Anesthetists (CRNAs) initially were omitted from the list of distant site practitioners for telehealth services in the regulation because CMS did not believe these practitioners would furnish any of the service on the list of Medicare telehealth services. However, CRNAs in some states are licensed to furnish certain services on the telehealth list, including evaluation and management services. Therefore, CMS revised the regulation at 42 CFR 410.78(b)(2) (Telehealth services) to include a CRNA, as described under 42 CFR 410.69 (http://www.ecfr.gov/cgi-bin/text-idx?SID=6e06827438f8f30af77b12ac2f0732b8&mc=true&node=pt42.2.410&rgn=div5%23se42.2.410_178) to the list of distant site practitioners who can furnish Medicare telehealth services.

Telehealth Origination Site Facility Fee Payment Amount Update

The Social Security Act (Section 1834(m)(2)(B); see https://www.ssa.gov/OP_Home/ssact/title18/1834.htm) establishes the payment amount for the Medicare telehealth origination 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 https://www.ssa.gov/OP_Home/ssact/title18/1842.htm).

The MEI increase for 2016 is 1.1 percent. Therefore, for CY 2016, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $25.10. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Incomplete Colonoscopies

The method for calculating the payment for incomplete colonoscopies has been revised for 2016. New payment rates will apply when modifier 53 (discontinued procedure) is appended to codes 44388, 45378, G0105, and G0121. (For more information, see the MLN Matters article (MM9317) corresponding to CR9317 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9317.pdf on the CMS website.)

Advance Care Planning, and With an Annual Wellness Visit (AWV)

Advance Care Planning (ACP) services are separately payable under the MPFS in 2016 (deductible and coinsurance apply). When voluntary ACP services are furnished as part of an Annual Wellness Visit (AWV), the deductible and coinsurance would not be applied for ACP.

Portable X-ray Transportation Fee

The “Medicare Claims Processing Manual,” Chapter13, Section 90.3 was revised to remove the word “Medicare” before “patient” in Section 90.3. Also, guidance for the billing of the...
transportation fee of portable X-ray suppliers has been clarified. When more than one patient is X-rayed at the same location, the single transportation payment under the Physician Fee Schedule is to be prorated among all patients (Medicare Parts A and B, and non-Medicare) receiving portable X-ray services during that trip, regardless of their insurance status. For more information, see the MLN Matters article (MM9354) corresponding to CR9354 for more information at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9354.pdf on the CMS website.

“Incident to” Policy

CMS finalized the changes to 42 CFR 410.26(a)(1) (http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr410_main_02.tpl) without modification, and the change to the regulation at 42 CFR 410.26(b)(5) with a clarifying modification. Specifically, CMS is amending the definition of the term, “auxiliary personnel” at § 410.26(a)(1) that are permitted to provide “incident to” services to exclude individuals who have been excluded from the Medicare program or have had their Medicare enrollment revoked. Additionally, CMS is amending § 410.26(b)(5) by revising the final sentence to make clear that the physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) that is treating the patient more broadly, and adding a sentence to specify that only the physician (or other practitioner) that supervises the auxiliary personnel that provide incident to services may bill Medicare Part B for those incident to services.

Establishing Values for New, Revised, and Misvalued Codes

The list of codes with changes for CY 2016 included under this definition of “adjustments to Relative Value Units (RVUs) for misvalued codes” is available under the “downloads” section at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html on the CMS website.

Target for Relative Value Adjustments for Misvalued Services

The Protecting Access to Medicare Act of 2014 (PAMA; Section 220(d); see http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf) added a new subparagraph to the Social Security Act (Section 1848(c)(2)(O)) to establish an annual target for reductions in MPFS expenditures resulting from adjustments to relative values of misvalued codes. Under the Social Security Act (Section 1848(c)(2)(O)(ii)), if the estimated net reduction in expenditures for a year as a result of adjustments to the relative values for misvalued codes is equal to or greater than the target for that year, reduced expenditures attributable to such adjustments will be redistributed in a budget-neutral manner within the MPFS in accordance with the existing budget neutrality requirement under the Social Security Act (Section 1848(c)(2)(B)(ii)(II)). The provision also specifies that the amount by which such reduced expenditures exceeds the target for a given year will be treated as a net reduction in expenditures for the succeeding year, for purposes of determining whether the target has been met for that subsequent year. Section 1848(c)(2)(O)(iv) defines a target recapture amount as the difference between the target for the year and the estimated net reduction in expenditures under the MPFS resulting from adjustments to RVUs for misvalued codes. Section 1848(c)(2)(O)(iii) specifies that, if the estimated net reduction in MPFS expenditures for the year is less than the target for the year, an amount equal to the target recapture amount will not be taken into account when applying the budget neutrality requirements specified in the Social Security Act (Section 1848(c)(2)(B)(ii)(II)).

The PAMA (Section 220(d)) applies to Calendar Years (CYs) 2017 through 2020 and sets the target under the Social Security Act (Section 1848(c)(2)(O)(v)) at 0.5 percent of the estimated amount of expenditures under the PFS for each of those 4 years.

The Achieving a Better Life Experience Act of 2014 (ABLE; Section 202) (Division B of Pub. L. 113-295, enacted December 19, 2014) amended the Social Security Act (Section 1848(c)(2)(O)) to accelerate the application of the MPFS expenditure reduction target to CYs 2016, 2017, and 2018, and to set a 1 percent target for CY 2016 and 0.5 percent for CYs 2017 and 2018. As a result of these provisions, if the estimated net reduction for a given year is less than the target for that year, payments under the MPFS will be reduced.
In the CY 2016 PFS proposed rule, CMS proposed a methodology to implement this statutory provision in a manner consistent with the broader statutory construct of the MPFS. CMS finalized the policy to calculate the net reduction using the simpler method as proposed. CMS estimates the CY 2016 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.23 percent. Since this does not meet the 1 percent target established by the Achieving a Better Life Experience Act of 2014 (ABLE), payments under the MPFS must be reduced by the difference between the target for the year and the estimated net reduction in expenditures (the “Target Recapture Amount”). As a result, CMS estimates that the CY 2016 Target Recapture Amount will produce a reduction to the CF of -0.77 percent.

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

MM9486: January 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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: MM9486
Related CR Release Date: December 18, 2015
Related CR Transmittal #: R3425CP

Change Request (CR) #: CR 9486
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9486, which implements changes to and billing instructions for various policies implemented in the January 2016 OPPS update. The January 2016 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR9486. CR9486 also implements several changes related to outpatient observation services, finalized in the Calendar Year (CY) 2016 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Final Rule. In addition, CR9486 also implements several changes in the manual requirements of the “Medicare Benefit Policy,” Pub. 100-02, Chapter 6, related to outpatient observation services that were finalized in the CY 2016 OPPS /ASC Final Rule (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html). Make sure that your billing personnel are aware of these changes.
Background
The key changes to and billing instructions for various payment policies implemented in the January 2016 OPPS update are as follows:

1. **New Device Pass-Through Categories**

   Section 1833(t)(6)(B) of the Social Security Act (the Act) 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 Act requires that the Centers for Medicare & Medicaid Services (CMS) create additional categories for transitional pass-through payment for new medical devices not described by existing or previously existing categories of devices.

   For the January 2016 update, HCPCS code C1822 is being added to the OPPS pass-through list as a pass-through device. This HCPCS code will be assigned to OPPS status indicator “H” (Pass-Through Device Categories), effective January 1, 2016.

   In the CY 2016 OPPS/ASC final rule, published in the Federal Register on November 13, 2015, CMS finalized a payment policy whereby the application process for device pass-through payments will add a rulemaking component to the existing quarterly process and a newness criterion. Refer to the CY 2016 OPPS/ASC final rule with comment period at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html) for complete details of these policy and process changes for device pass-through. Also, refer to [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html) for updated device pass-through application instructions.

### Device Offset from Payment for New Device Category

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. CMS has determined that a portion of the APC payment amount associated with the cost of HCPCS code C1822 is reflected in APC 5464. The HCPCS code C1822 device should always be billed with Current Procedural Terminology (CPT) Code 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling) which is assigned to APC 5464 for CY 2016. The device offset from payment represents a deduction from pass-through payments for the device in category C1822.

Table 1 below provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

<table>
<thead>
<tr>
<th>HCPCS Code</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>C1822</td>
<td>01-01-2015</td>
<td>H</td>
<td>1661</td>
<td>Gen, neuro, HF, rechg bat</td>
<td>Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system</td>
<td>$22,478.58</td>
</tr>
</tbody>
</table>

#### Revised Short and Long Descriptors for HCPCS Code C1820

With the establishment of HCPCS code C1822, CMS is modifying the short and long descriptors for existing HCPCS code C1820 to appropriately differentiate between HCPCS code C1822 and C1820. Effective January 1, 2016, the short and long descriptors for HCPCS code C1820 are listed in Table 2 below.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>CY 2016 OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1820</td>
<td>Gen, neuro, non-HF rechg bat</td>
<td>Generator, neurostimulator (implantable), non-high-frequency with rechargeable battery and charging system</td>
<td>N</td>
</tr>
</tbody>
</table>
Note that HCPCS code C1820 describes an implantable non high-frequency neurostimulator generator device with rechargeable battery and charging system, while HCPCS code C1822 describes an implantable high-frequency neurostimulator generator device with rechargeable battery and charging system.

2. **Device Edit for Procedures Assigned to Device-Intensive APCs**

For CY 2016, CMS will no longer restrict the device code reporting requirement to only those device-intensive APCs (APCs with a device offset of greater than 40 percent) which were formerly device-dependent APCs. Therefore, effective January 1, 2016, procedures requiring the implantation of a device which are assigned to device intensive APCs will require a device code to be present on the claim. CMS is updating the “Medicare Claims Processing Manual,” Chapter 4, Section 61.2 to reflect these changes to the reporting guidelines for procedures assigned to device-intensive APCs.

3. **Removal of Device Portion from Procedures that are Assigned to a Device-Intensive APC and that are Discontinued Prior to the Administration of Anesthesia**

In accordance with the regulations at 42 CFR 419.44(b) (https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol3/CFR-2011-title42-vol3-sec419-44/content-detail.html) and the “Medicare Claims Processing Manual,” Chapter 4, Section 20.6.4, when a surgical procedure, for which anesthesia is planned, is terminated after the patient is prepared and taken to the room where the procedure is to be performed, but prior to the administration of anesthesia, hospitals are instructed to append modifier “73” to the procedure line item on the claim. Medicare processes these line items by removing one-half of the full program allowance.

In the CY 2016 OPPS/ASC final rule, CMS revised its payment policy for surgical procedures for which anesthesia is planned and that are discontinued prior to the administration of anesthesia, appended with modifier 73.

Specifically, effective January 1, 2016, for such procedures that are assigned to a device-intensive APC (defined as those APCs with a device offset greater than 40 percent), CMS will remove the full device portion of the device-intensive APC procedure payment prior to applying the additional payment adjustments that apply when the procedure is discontinued.

4. **Transitional Pass-Through Payments for Designated Devices**

Certain designated new devices are assigned to APCs and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for devices used in the procedures assigned to the APC. OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device. Refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html on the CMS website for the most current OPPS APC Offset File.

5. **Services Eligible for New Technology APC Assignment and Payments**

Under OPPS, services eligible for payment through New Technology APCs are those codes that are assigned to the series of New Technology APCs published in Addendum A (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) of the latest OPPS update. OPPS considers any HCPCS code assigned to these APCs to be a “new technology procedure or service.”

Procedures for applying for assignment of new services to New Technology APCs are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html on the CMS website.
The list of HCPCS codes indicating the APCs to which each is assigned can be found in Addendum B of the latest OPPS update regulation each year at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

6. **New Brachytherapy Source Payment**

Section 1833(t)(2)(H) of the Act mandates the creation of additional groups of covered Outpatient Department (OPD) services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) (“brachytherapy sources”) separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. CivaSheet is a new brachytherapy source. The HCPCS code assigned to this source and the payment rate under OPPS are listed in Table 3 below.

<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>C2645</td>
<td>1/1/2016</td>
<td>U</td>
<td>2648</td>
<td>Brachytx planar, p-103</td>
<td>Brachytherapy planar source, palladium - 103, per square millimeter</td>
<td>$4.69</td>
<td>$0.94</td>
</tr>
</tbody>
</table>

7. **Modifier “CA”**

Effective January 1, 2016, if an “inpatient-only” service is furnished but the patient expires before inpatient admission or transfer to another hospital and the hospital reports the “inpatient only” service with modifier “CA,” then CMS makes a single payment for all services reported on the claim, including the “inpatient only” procedure, through one unit of APC 5881, (Ancillary outpatient services when the patient dies). Hospitals should report modifier “CA” on only one procedure. CMS is updating the “Medicare Claims Processing Manual,” Chapter 4, Section 180.7 to reflect the revised payment policy.

8. **Modifier “CT”**

In accordance with Section 1834(p) of the Act, CMS has established a new modifier “CT” to identify Computed Tomography (CT) scans that are furnished on equipment that does not meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, entitled “Standard Attributes on CT Equipment Related to Dose Optimization and Management.”

Effective January 1, 2016, Medicare requires that hospitals and suppliers use this modifier on claims for CT scans described by applicable HCPCS codes that are furnished on non-NEMA Standard XR-29-2013-compliant equipment. The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes).

The use of this modifier will result in a payment reduction of 5 percent in CY 2016 for the applicable CT services when the service is paid separately. The 5 percent payment reduction will also be applied to the APC payment for the HCPCS codes listed above that are subject to the multiple imaging composite policy. This includes procedures assigned to the two APCs (8005 and 8006) in the CT and Computed Tomographic Angiography (CTA) imaging family. CR0486 updates the “Medicare Claims Processing Manual,” Chapter 4, Section 20.6.12, to include this new modifier.

9. **Comprehensive Observation Services C-APC (APC 8011)**

Effective January 1, 2016, CMS will provide payment for all qualifying extended assessment and management encounters through newly created C-APC 8011 (Comprehensive Observation Services). Any clinic visit, Type A Emergency Department (ED) visit, Type B ED visit, critical care visit, or direct referral for observation
services furnished in a non-surgical encounter by a hospital in conjunction with observation services of eight or more hours, will qualify for comprehensive payment through C-APC 8011. Effective January 1, 2016, CMS will no longer provide payment for extended assessment and management encounters through APC 8009 (Extended Assessment and Management Composite) and APC 8009 is deleted, effective January 1, 2016.

Also effective January 1, 2016, CMS has created new Status Indicator (SI) J2 to designate specific combinations of services that, when performed in combination with each other and reported on a hospital Medicare Part B outpatient claim, would allow for all other OPPS payable services and items reported on the claim (excluding all preventive services and certain Medicare Part B inpatient services) to be deemed adjunctive services representing components of a comprehensive service and resulting in a single prospective payment through C-APC 8011 for the comprehensive service based on the costs of all reported services on the claim. CMS is updating the “Medicare Claims Processing Manual,” Chapter 4, Sections 10.2.1, 10.2.3, 10.4, 290.5.1 and 290.5.2 and adding a new Section 290.5.3 to reflect the new billing guidelines for this new comprehensive APC.

10. Billing for Lung Cancer Screening Counseling and Shared Decision Making Visit, and Annual Screening for Lung Cancer with LDCT

Effective February 5, 2015, a CMS National Coverage Determination (NCD) added lung cancer screening counseling and shared decision making visit, and for certain beneficiaries, annual screening for lung cancer with Low Dose Computed Tomography (LDCT), as an additional screening service benefit under the Medicare program if all eligibility criteria described in the NCD are met.

For purposes of Medicare coverage of lung cancer screening with LDCT, beneficiaries must meet all of the following eligibility criteria:

- Age 55 – 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and
- Receives a written order for lung cancer screening with LDCT that meets the requirements described in the NCD. Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary’s medical records.

To implement this recent coverage determination, CMS created two new G-codes to report lung cancer screening counseling and shared decision making visit, and annual screening for lung cancer with LDCT. The long descriptors for both G-codes appear in Table 4 below.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>CY 2015 APC</th>
<th>CY 2016 APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0296</td>
<td>Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)</td>
<td>S</td>
<td>0432</td>
<td>5822</td>
</tr>
<tr>
<td>G0297</td>
<td>Low dose CT scan (LDCT) for lung cancer screening</td>
<td>S</td>
<td>0332</td>
<td>5570</td>
</tr>
</tbody>
</table>

For CY 2016, HCPCS codes G0296 and G0297 are assigned to APC 5822 (Level 2 Health and Behavior Services) and APC 5570 (Computed Tomography without Contrast), respectively, and both given a status indicator assignment of “S.” Further reporting guidelines on lung cancer screening counseling and shared decision making visit and annual screening for lung cancer with LDCT can be found in the “Medicare Claims Processing Manual,” Chapter 18, Section 220, as well as in MLN Matters®.
11. Billing Instructions for IMRT Planning

Payment for the services identified by CPT codes 77014, 77280 through 77295, 77305 through 77321, 77331, and 77370 is included in the APC payment for CPT code 77301 (Intensity Modulated Radiation Therapy (IMRT) planning). These codes should not be reported in addition to CPT code 77301 (on either the same or a different date of service) unless these services are being performed in support of a separate and distinct non-IMRT radiation therapy for a different tumor.

12. Billing for Stereotactic Radiosurgery (SRS) Planning and Delivery

Effective for cranial single session Stereotactic Radiosurgery (SRS) procedures (CPT code 77371 or 77372) furnished on or after January 1, 2016 until December 31, 2017, costs for certain planning and preparation CPT codes are not factored into the APC payment rate for APC 5627 (Level 7 Radiation Therapy). Rather, the ten planning and preparation codes listed in Table 5 below will be paid according to their assigned status indicator when furnished 30 days prior or 30 days post SRS treatment delivery.

<table>
<thead>
<tr>
<th>Table 5 – Excluded Planning and Preparation CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT Code</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>70551</td>
</tr>
<tr>
<td>70552</td>
</tr>
<tr>
<td>70553</td>
</tr>
<tr>
<td>77011</td>
</tr>
<tr>
<td>77014</td>
</tr>
<tr>
<td>77280</td>
</tr>
<tr>
<td>77285</td>
</tr>
<tr>
<td>77290</td>
</tr>
<tr>
<td>77295</td>
</tr>
<tr>
<td>77336</td>
</tr>
</tbody>
</table>

In addition, hospitals must report modifier “CP” (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification [C-APC] procedure) on TOB 13X claims for any other services (aside from the ten codes in Table 5) that are adjunctive or related to SRS treatment but billed on a different date of service and within 30 days prior or 30 days after the date of service for either CPT codes 77371 (Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment cranial lesion(s) consisting of 1 session; multi-source Cobalt 60-based) or 77372 (Linear accelerator based). The “CP” modifier should be reported under all circumstances in which a service adjunctive or related to SRS treatment is provided within one month of SRS treatment. This means that if multiple physicians within the same health system furnish an adjunctive SRS service, then all claims from these physicians would need to report the “CP” modifier with the HCPCS code for the related SRS adjunctive service(s).

13. Billing Instructions for Corneal Tissue

In the CY 2016 OPPS/ASC Final Rule with Comment Period (80 FR 70472), procurement/acquisition of corneal tissue will be paid separately only when it is used in corneal transplant procedures. Specifically, corneal tissue will be separately paid when used in procedures performed in the Hospital Outpatient Department (HOPD) only when the corneal tissue is used in a corneal transplant procedure described by one of the following CPT codes:
14. Revisions to Laboratory Test Packaging

For CY 2016, CMS is implementing a conditional packaging status indicator “Q4” for packaged laboratory services. Status indicator “Q4” designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” The “Q4” status indicator was created to identify 13X bill type claims where there are only laboratory HCPCS codes that appear on the Clinical Laboratory Fee Schedule (CLFS), automatically change their status indicator to “A,” and pay them separately at the CLFS payment rates. With the assignment of the “Q4” status indicator, the “L1” modifier would only be used to identify unrelated laboratory tests that are ordered for a different diagnosis and by a different practitioner than the other OPPS services on the claim.

15. New CY 2016 HCPCS Codes for Pathogen-Reduced Blood Products

For CY 2016, three new HCPCS P-codes have been created for new pathogen-reduced blood products. The term “pathogen reduction” describes various techniques (including treatment with Amotosalen and UVA light) used on blood products to eliminate certain pathogens and reduce the risk of transfusion-associated infections. Because these three HCPCS P-codes are new for CY 2016, there are currently no claims data on the charges and costs for these blood products upon which to apply our blood-specific Cost to Charge Ratio (CCR) methodology. Therefore, CMS is establishing interim payment rates for these three HCPCS P-codes based on a crosswalk to existing blood product HCPCS codes that CMS believes provides the best proxy for the costs of the three new blood products described by the new HCPCS P-codes. These new codes are listed in Table 6 below.

<table>
<thead>
<tr>
<th>HCPCS P-Code</th>
<th>Effective Date</th>
<th>Long Descriptor</th>
<th>Cross walked HCPCS P-Code</th>
<th>Cross walked HCPCS P-Code Long Descriptor</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9070</td>
<td>1/1/2016</td>
<td>Plasma, pooled multiple donor, pathogen reduced, frozen, each unit</td>
<td>P9059</td>
<td>Fresh frozen plasma between 8-24 hours of collection, each unit</td>
<td>$73.08</td>
</tr>
<tr>
<td>P9071</td>
<td>1/1/2016</td>
<td>Plasma (single donor), pathogen reduced, frozen, each unit</td>
<td>P9017</td>
<td>Fresh frozen plasma (single donor), frozen within 8 hours of collection, each unit</td>
<td>$72.56</td>
</tr>
<tr>
<td>P9072</td>
<td>1/1/2016</td>
<td>Platelets, pheresis, pathogen reduced, each unit</td>
<td>P9037</td>
<td>Platelets, pheresis, leukocytes reduced, irradiated, each unit</td>
<td>$641.85</td>
</tr>
</tbody>
</table>
16. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2016 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2016, 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 7 below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9458</td>
<td>Florbetaben F18, diagnostic, per study dose, up to 8.1 millicuries</td>
<td>G</td>
<td>9458</td>
</tr>
<tr>
<td>C9459</td>
<td>Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries</td>
<td>G</td>
<td>9459</td>
</tr>
<tr>
<td>C9460</td>
<td>Injection, cangrelor, 1 mg</td>
<td>G</td>
<td>9460</td>
</tr>
<tr>
<td>Q9980</td>
<td>Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J0714</td>
<td>Injection, ceftazidime and avibactam, 0.5g/0.125g</td>
<td>K</td>
<td>1825</td>
</tr>
<tr>
<td>J1575</td>
<td>Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin</td>
<td>K</td>
<td>1826</td>
</tr>
<tr>
<td>J1788</td>
<td>Injection, factor viii (antihemophilic factor, recombinant), (obizur), per i.u.</td>
<td>K</td>
<td>1827</td>
</tr>
<tr>
<td>J7328</td>
<td>Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J7340</td>
<td>Carbidopa 5 mg/levodopa 20 mg enteral suspension</td>
<td>K</td>
<td>1828</td>
</tr>
<tr>
<td>J7503</td>
<td>Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Q4161</td>
<td>Bio-connekt wound matrix, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4162</td>
<td>Amnioflow, bioskin flow, biornew flow, woundex flow, amniogen-a, amniogen-c, 0.5 cc</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4163</td>
<td>Amnioflow, bioskin, biornew, woundex, amniogen-45, amniogen-200, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4164</td>
<td>Helicoll, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4165</td>
<td>Keramatrix, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

b. Other Changes to CY 2016 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2016. In addition, several temporary HCPCS C-codes have been deleted, effective December 31, 2015, and replaced with permanent HCPCS codes in CY 2016. 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 8 below notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product’s CY 2015 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2016 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9025</td>
<td>Injection, ramucirumab, 5 mg</td>
<td>J9308</td>
<td>Injection, ramucirumab, 5 mg</td>
</tr>
<tr>
<td>C9026</td>
<td>Injection, vedolizumab, 1 mg</td>
<td>J3380</td>
<td>Injection, vedolizumab, 1 mg</td>
</tr>
<tr>
<td>C9027</td>
<td>Injection, pembrolizumab, 1 mg</td>
<td>J9271</td>
<td>Injection, pembrolizumab, 1 mg</td>
</tr>
<tr>
<td>Q9975</td>
<td>Injection, Factor VIII, FC Fusion Protein (Recombinant), per i.u</td>
<td>J7205</td>
<td>Injection, factor vii fc fusion protein (recombinant), per i.u</td>
</tr>
<tr>
<td>C9442</td>
<td>Injection, belinostat, 10 mg</td>
<td>J9032</td>
<td>Injection, belinostat, 10 mg</td>
</tr>
<tr>
<td>C9443</td>
<td>Injection, dalbavancin, 10 mg</td>
<td>J0875</td>
<td>Injection, dalbavancin, 5 mg</td>
</tr>
</tbody>
</table>
## Table 8 – Other CY 2016 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>C9444</td>
<td>Injection, oritavancin, 10 mg</td>
<td>J2407</td>
<td>Injection, oritavancin, 10 mg</td>
</tr>
<tr>
<td>C9445</td>
<td>Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units</td>
<td>J0596</td>
<td>Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units</td>
</tr>
<tr>
<td>C9446</td>
<td>Injection, tedizolid phosphate, 1 mg</td>
<td>J3090</td>
<td>Injection, tedizolid phosphate, 1 mg</td>
</tr>
<tr>
<td>Q9978</td>
<td>Netupitant 300 mg and Palonosetron 0.5 mg, oral</td>
<td>J8655</td>
<td>Netupitant 300 mg and palonosetron 0.5 mg</td>
</tr>
<tr>
<td>C9449</td>
<td>Injection, blinatumomab, 1 mcg</td>
<td>J9039</td>
<td>Injection, blinatumomab, 1 microgram</td>
</tr>
<tr>
<td>C9450</td>
<td>Injection, fluocinolone acetonide intravitreal implant, 0.01 mg</td>
<td>J7313</td>
<td>Injection, fluocinolone acetonide, intravitreal implant, 0.01 mg</td>
</tr>
<tr>
<td>C9451</td>
<td>Injection, peramivir, 1 mg</td>
<td>J2547</td>
<td>Injection, peramivir, 1 mg</td>
</tr>
<tr>
<td>C9452</td>
<td>Injection, ceftolozane 50 mg and tazobactam 25 mg</td>
<td>J0695</td>
<td>Injection, ceftolozane 50 mg and tazobactam 25 mg</td>
</tr>
<tr>
<td>C9453</td>
<td>Injection, nivolumab, 1 mg</td>
<td>J9299</td>
<td>Injection, nivolumab, 1 mg</td>
</tr>
<tr>
<td>C9454</td>
<td>Injection, pasireotide long acting, 1 mg</td>
<td>J2502</td>
<td>Injection, pasireotide long acting, 1 mg</td>
</tr>
<tr>
<td>C9455</td>
<td>Injection, siltuximab, 10 mg</td>
<td>J2860</td>
<td>Injection, siltuximab, 10 mg</td>
</tr>
<tr>
<td>C9456</td>
<td>Injection, isavuconazonium sulfate, 1 mg</td>
<td>J1833</td>
<td>Injection, isavuconazonium, 1 mg</td>
</tr>
<tr>
<td>C9457</td>
<td>Injection, sulfur hexafluoride lipid microsphere, per ml</td>
<td>Q9950</td>
<td>Injection, sulfur hexafluoride lipid microspheres, per ml</td>
</tr>
<tr>
<td>J0571</td>
<td>Buprenorphine, oral, 1 mg</td>
<td>J0571</td>
<td>Buprenorphine, oral, 1 mg</td>
</tr>
<tr>
<td>J0572</td>
<td>Buprenorphine/naloxone, oral, less than or equal to 3 mg</td>
<td>J0572</td>
<td>Buprenorphine/naloxone, oral, less than or equal to 3 mg</td>
</tr>
<tr>
<td>J0573</td>
<td>Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg</td>
<td>J0573</td>
<td>Buprenorphine/naloxone, greater than 3 mg, but less than or equal to 6 mg</td>
</tr>
<tr>
<td>J0574</td>
<td>Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg</td>
<td>J0574</td>
<td>Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg</td>
</tr>
<tr>
<td>J0575</td>
<td>Buprenorphine/naloxone, oral, greater than 10 mg</td>
<td>J0575</td>
<td>Buprenorphine/naloxone, oral, greater than 10 mg</td>
</tr>
<tr>
<td>J1446</td>
<td>Injection, tbo-filgrastim, 5 micrograms</td>
<td>J1447</td>
<td>Injection, tbo-filgrastim, 1 microgram</td>
</tr>
<tr>
<td>J7302</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg</td>
<td>J7297</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration</td>
</tr>
<tr>
<td>J7302</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg</td>
<td>J7298</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration</td>
</tr>
<tr>
<td>J7506</td>
<td>Prednisone, oral, per 5mg</td>
<td>J7512</td>
<td>Prednisone, immediate release or delayed release, oral, 1 mg</td>
</tr>
<tr>
<td>J7508</td>
<td>Tacrolimus, extended release, oral, 0.1 mg</td>
<td>J7508</td>
<td>Tacrolimus, extended release, (astagraf xl), oral, 0.1 mg</td>
</tr>
<tr>
<td>Q9979</td>
<td>Injection, alemtuzumab, 1 mg</td>
<td>J0202</td>
<td>Injection, alemtuzumab, 1 mg</td>
</tr>
<tr>
<td>Q4153</td>
<td>Dermavest, per square centimeter</td>
<td>Q4153</td>
<td>Dermavest and plurivest, per square centimeter</td>
</tr>
<tr>
<td>Q9976</td>
<td>Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron</td>
<td>J1443</td>
<td>Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron</td>
</tr>
<tr>
<td>Q9977</td>
<td>Compounded Drug, Not Otherwise Classified</td>
<td>J7999</td>
<td>Compounded Drug, Not Otherwise Classified</td>
</tr>
<tr>
<td>S5011</td>
<td>5% dextrose in lactated ringer’s, 1000 ml</td>
<td>J7121</td>
<td>5% dextrose in lactated ringers infusion, up to 1000 cc</td>
</tr>
</tbody>
</table>

**c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)**
Effective January 1, 2016

For CY 2016, payment for non-pass-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 2016, 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, 2016, payment rates for many drugs and biologicals have changed from the values published in the CY 2016 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 2015. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2016 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this CR implementing the January 2016 update of the OPPS. However, the updated payment rates, effective January 1, 2016, can be found in the January 2016 update of the OPPS Addendum A and Addendum B, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

d. Correction to Effective Dates for Certain Vaccines

CR9486 revises the effective dates for vaccine CPT codes 90620 and 90621 as shown in Table 9 below.

<table>
<thead>
<tr>
<th>CPT</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Corrected Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90620</td>
<td>K</td>
<td>1807</td>
<td>Menb rp w/omv vaccine im</td>
<td>Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use</td>
<td>1/23/2015</td>
</tr>
<tr>
<td>90621</td>
<td>K</td>
<td>1808</td>
<td>Menb rp vaccine im</td>
<td>Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use</td>
<td>10/29/2014</td>
</tr>
</tbody>
</table>

e. 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 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html on the CMS website. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

f. Payment Correction for Diagnostic Radiopharmaceutical C9458

The payment rate listed in Addendum B of the CY 2016 OPPS/ASC final rule with comment period for HCPCS code C9458 (Florbetaben F18) is incorrect. The corrected payment rate of $2,968 per study dose for HCPCS code C9458 is listed in Addendum B of this January update and has been installed in the January 2016 OPPS Pricer, effective for services furnished on or after January 1, 2016.

g. Biosimilar Payment Policy

Effective January 1, 2016, the payment rate for biosimilars in the OPPS will be the same as the payment rate in the physician office setting, calculated as the ASP of the biosimilar(s) described by the HCPCS code + 6% of the ASP of the reference
product. Biosimilars will also be eligible for transitional pass-through payment; however, pass-through payment will be made to the first eligible biosimilar biological product to a reference product. Subsequent biosimilar biological products to a reference product will not meet the newness criterion, and, therefore, will be ineligible for pass-through payment.

h. Updated Guidance: Billing and Payment for New Drugs, Biologicals, or Radiopharmaceuticals Approved by the Food and Drug Administration (FDA) but Before Assignment of a Product-Specific HCPCS Code

Hospital outpatient departments are allowed to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals that are approved by the FDA on or after January 1, 2004, for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the "unclassified" drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs, biologicals, and therapeutic radiopharmaceuticals that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under the OPPS unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, should be billed with the appropriate “A” NOC code as follows:

1. Diagnostic Radiopharmaceuticals – All new diagnostic radiopharmaceuticals are assigned to either HCPCS code A4641 (Radiopharmaceutical, diagnostic, not otherwise classified), HCPCS code A9599 (Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (PET) imaging, per study dose), or HCPCS code J3490 (Unclassified drugs) (applicable to all new diagnostic radiopharmaceuticals used in non-beta-amyloid PET imaging). HCPCS code A4641, A9599, or J3490, whichever is applicable, should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS codes A4641, A9599, and J3490 are assigned status indicator “N” and, therefore, the payment for a diagnostic radiopharmaceutical assigned to any of these HCPCS codes is packaged into the payment for the associated service.

2. Contrast Agents – All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator “N” and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.

i. 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 10 below 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 code C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT code 15271-15278.

<table>
<thead>
<tr>
<th>CY 2016 HCPSC Code</th>
<th>CY 2016 Short Descriptor</th>
<th>CY 2016 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9349</td>
<td>PuraPly, PuraPly antimic</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>C9363</td>
<td>Integra Meshed Bil Wound Mat</td>
<td>N</td>
<td>High</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>High</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>Gammangraft</td>
<td>N</td>
<td>Low</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>
<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>High</td>
</tr>
<tr>
<td>Q4121</td>
<td>Theraskin</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell</td>
<td>N</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>Q4126</td>
<td>Memodermd/derma/tranz/integup</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4127</td>
<td>Talymed</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4128</td>
<td>Flexhd/Allopatchhd/Matrixhd</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4129</td>
<td>Unite Biomatrix</td>
<td>N</td>
<td>Low</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>Low</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, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4138</td>
<td>Biofence DryFlex, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4140</td>
<td>Biofence 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4141</td>
<td>AlloSkin ac, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4143</td>
<td>Repriza, 1cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4146</td>
<td>Tensix, 1CM</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect ecm, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4148</td>
<td>Neox 1k, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4150</td>
<td>Allowrap DS or Dry 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4151*</td>
<td>AmnioBand, Guardian 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4152*</td>
<td>Dermapure 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>
**Table 10 – Skin Substitute Product Assignment to High Cost/Low Cost Status for CY 2016**

<table>
<thead>
<tr>
<th>CY 2016 HCPCS Code</th>
<th>CY 2016 Short Descriptor</th>
<th>CY 2016 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4153</td>
<td>Dermavest 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4154*</td>
<td>Biovance 1 square cm</td>
<td>N</td>
<td>High</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>Revitlon 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>
<tr>
<td>Q4161</td>
<td>Bio-Connekt per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4162</td>
<td>Amnio bio and woundex flow</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4163</td>
<td>Amnion bio and woundex sq cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4164</td>
<td>Helicoll, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4165</td>
<td>Keramatrix, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
</tbody>
</table>

* HCPCS codes Q4151, Q4152, Q4154, and Q4156 were assigned to the low cost group in the CY 2016 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4151, Q4152, Q4154, and Q4156 are assigned to the high cost group for CY 2016.

17. **Changes to OPPS Pricer Logic**

   a. Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2016. 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 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, 2016. 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 2016 inpatient deductible.

   c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2016. 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 \((\text{cost} - (\text{APC payment} \times 1.75))/2\).

   d. The fixed-dollar threshold increases in CY 2016 relative to CY 2015. The estimated cost of a service must be greater than the APC payment amount plus $3,250 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 2016. 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 \((\text{cost for nuclear medicine procedures} - [\text{APC 0173 payment} \times 3.4])/2\).

   f. Effective October 1, 2013, and expiring December 31, 2015, one device (C1841 - Retinal prosthesis, includes all internal and external components) was eligible for pass-through payment in the OPPS Pricer logic. After pass-through status expires for a medical device, the payment for the device is packaged into the payment for the...
Effective January 1, 2016, CMS is packaging C1841 and assigning CPT code 0100T (which includes the retinal prosthesis device) to New Technology APC 1599, which has a final payment of $95,000 for CY 2016.

Effective January 1, 2015, and continuing for CY 2016, 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.

Effective January 1, 2016, there will be three diagnostic radiopharmaceuticals and one contrast agent 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 or contrast agent payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical or contrast agent with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical or contrast agent expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the CY 2016 APC payments for nuclear medicine procedures and may be found on the CMS website.

Effective January 1, 2016, there will be two skin substitute products receiving pass-through payment in the OPPS Pricer logic. For skin substitute application procedure codes that are assigned to APC 5054 (Level 4 Skin Procedures) or APC 5055 (Level 5 Skin Procedures), 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 5054 or APC 5055. The offset amounts for skin substitute products are the “policy-packaged” portions of the CY 2016 payments for APC 5054 and APC 5055.

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.

Effective January 1, 2016, CMS is adopting the FY 2016 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals.

Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), 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 at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html) on the CMS website.

**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...
**Medicare Secondary Payer (MSP)**

**MM8486: Instructions on Utilizing 837 Institutional Claim Adjustment Segment (CAS) for Medicare Secondary Payer (MSP) Part A Claims in Direct Data Entry (DDE) and 837I 5010 Claims Transactions**

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:** MM8486  
**Change Request (CR) #:** CR 8486  
**Related CR Release Date:** November 24, 2015  
**Effective Date:** January 1, 2016  
**Related CR Transmittal #:** R116MSP  
**Implementation Date:** January 4, 2016  

**Provider Types Affected**

This MLN Matters® Article is intended for providers submitting Medicare MSP claims to Medicare Administrative Contractors (A/MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

**STOP – Impact to You**

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8486 to inform you about the changes necessary for MSP payment calculations from incoming DDE and the paper claim transactions.

**CAUTION – What You Need to Know**

CR 8486 is limited to providers billing Part A claims.

**GO – What You Need to Do**

Include your CAS segment adjustments from the primary payer(s) remittance advice report (835 electronic remittance advice (ERA) or paper remittance) on your 837I transaction, DDE, or your paper claim when you send your claim to Medicare for secondary payment. These adjustments are needed to process your MSP Part A claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which explains why the claim’s billed amount was not fully paid.

**Background**

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards...
of compliance for claim transactions, and the implementation guides for each transaction are available at [http://www.wpc-edi.com](http://www.wpc-edi.com) on the Internet.

The instructions in CR 8486 ensure Medicare’s compliance with HIPAA transaction and code set requirements and ensure that MSP claims are properly calculated, using payment information derived from the paper, DDE, or incoming 837I, Institutional claim. This updates instructions from CR 6426 which did not allow the acceptance of DDE claims. Additionally, paper, DDE, and 837I claims can be adjusted or corrected utilizing the DDE.

The instructions detailed by CR8486 ensure that Medicare’s secondary payment for Part A MSP claim is based on:

1. Provider charges, or the amount the provider is obligated to accept as payment in full (OTAF), whichever is lower. In the case where there are multiple primary payers to Medicare the lowest OTAF is used, unless the Medicare covered charges are lower;
2. What Medicare would have paid as the primary payer; and
3. The primary payer(s) payment.

MSP policy also defines what must be considered when processing MSP claims. This includes adjustments made by the primary payer(s), which, for example, explains why the claim’s billed amount was not fully paid. Adjustments made by the payer are reported in the CAS segments on the 835 ERA or paper remittance. The provider must take the CAS segment adjustments, as found on the 835 standard format or crosswalk them if they were not received in the standard format, and report these adjustments with the paper, DDE, or 837I, unchanged, when sending the claim to Medicare for secondary payment. To review specific examples of 837I claims transactions see the MSP manual revisions in the attachment in CR 8468.

**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.


**MolDX**

**CGS Announces MolDX Expansion to J15**

CGS Administrators, LLC (CGS) is happy to announce that we are working with the MolDX contractor, Palmetto GBA concerning Molecular Diagnostic Testing (MDT). All laboratory service providers in the Jurisdiction 15 providing Molecular Diagnostic Testing (MDT) must register those MDT procedures/services with the MolDX contractor and submit coverage requests prior to being considered for reimbursement. Providers will have until December 28, 2015, to complete this process for current and any new tests billed before the claim is returned unable to process if the unique identifier is not present on the claim. At this time, Part A providers are not required but are encouraged to obtain an identifier and use the TA process, if needed, as this will expedite claims processing. Part A providers when billing MolDX tests, since the notepad is for the entire claim please, please enter L, line number, and the short description /identifier, (L2- APC, fgs). This will allow us to distinguish which test is for which line.

As a CMS contractor, the MolDX contractor must determine reasonable and necessary services and apply fair reimbursement to services that are provided to Medicare beneficiaries.
In the AMA’s instructions for use of the CPT codebook, providers are instructed to select the name of the procedure/service that accurately identifies the service provided. Providers are not to select a CPT code that merely approximates the service provided. When no such specific code exists, providers are required to report the service using the appropriate unlisted procedure/service code.

For a wide range of laboratory and molecular diagnostic services, correct coding is complicated because the available code descriptions do not identify the specific test/service performed.

The vast numbers of new diagnostic and molecular assays entering the market magnify these issues. To address these vulnerabilities, the MolDx contractor has expanded to a laboratory and molecular diagnostic services program to meet the following objectives:

- Identify the specific services performed and billed to Medicare
- Collect and analyze claim submission data
- Develop correct coding/billing guidelines to report services
- Determine coverage for services
- Determine a fair reimbursement for services within current CMS guidelines

This program will affect diagnostic services reported with the following AMA® CPT codes:

### Effective for services performed on or after January 1, 2013

<table>
<thead>
<tr>
<th>Code Category/Description</th>
<th>2013 MolDx Code Range</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>81161-81383; 81500-81599</td>
<td>New codes 1/1/13</td>
</tr>
<tr>
<td>Tier 2</td>
<td>81400-81479</td>
<td>New codes 1/1/13</td>
</tr>
<tr>
<td>HCPCS: Molecular pathology procedure; physician interpretation and report</td>
<td>G0452</td>
<td>New codes 1/1/13</td>
</tr>
<tr>
<td>Microdissection</td>
<td>88380-88381</td>
<td>No change from 2012-2013</td>
</tr>
<tr>
<td>NOC</td>
<td>81479</td>
<td>New codes 1/1/13</td>
</tr>
<tr>
<td>**NOC</td>
<td>84999, 85999, 86849, 87999, 88199, 88299, 88399, 89398</td>
<td>No change from 2012-2013</td>
</tr>
</tbody>
</table>

For services performed prior to 01/01/13:

<table>
<thead>
<tr>
<th>Code Category</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodology-based stacking codes</td>
<td>83890-83914</td>
</tr>
<tr>
<td>Micro-array codes</td>
<td>88384-88386</td>
</tr>
</tbody>
</table>

MolDx defines a clear, evidence-based process to ensure clinical quality and manage molecular diagnostic services and the associated impact that they have on cost.

Four major challenges are addressed in this project:

- No standardized process to evaluate the safety and efficacy of each test/assay
- No standardized process to correlate clinical information with patient outcomes
- No standardized process to describe and assign a value for the assay service
- No unique identifier to track assay utilization

The project will require a registration process to address these challenges in the following manner:

- **Create/maintain a master catalog/test registry**
  
  Identification and cataloging of all known molecular diagnostic tests, assessment status, and the final CMS coverage determination and code assignments will be maintained in an electronic, readily accessible, Internet-based registry with secure information access levels for CMS, administrators, and the provider community. Click [http://www.palmettogba.com/palmetto/MolDX.nsf/DocsCat/MolDx%20Website~MolDx~Browse%20By%20Topic~Gene](http://www.palmettogba.com/palmetto/MolDX.nsf/DocsCat/MolDx%20Website~MolDx~Browse%20By%20Topic~Gene)
Provide objective, evidence-based assessments for each test

In addition to evaluating analytical and clinical validity data, this project will provide a comprehensive assessment of clinical utility. Subject-matter experts will evaluate tests and develop coverage recommendations to CMS. For more information, please refer to the Test Assessment Process (http://www.palmettogba.com/palmetto/MolDX.nsf/docsCat/MolDx%20Website~MolDx~Browse%20By%20Topic~Technical%20Assessment?open&expand=1&navmenu=Browse%5eBy%5eTopic) section at the MolDx contractor website.

Provide test specific description recommendation

Subject-matter experts will review new test literature and design unique descriptions or designate current appropriate descriptions to facilitate the CMS development of unique codes for appropriate utilization tracking and potential payment.

Provide reimbursement recommendation

The MolDx contractor will review the overall test elements and make a value based determination for each test.

MolDx will be supported by the LCD Laboratory and Molecular Diagnostics Testing LCD Program, establishes a clear, evidence-based process to ensure clinical quality and to manage molecular diagnostic services and the associated healthcare cost impact. The MolDx contractor has contracted with McKesson Health Solutions to configure and maintain a Master Test Code Registry that will increase the efficiency and transparency of the evaluation and valuation of the affected procedures/assays.

A/B MAC affected by this Project: Jurisdiction 15

Diagnostic services affected: Molecular Diagnostic Testing (MDT) refers to any laboratory assay that quantifies a measurable characteristic of the patient care process at the molecular level. This includes gene tests (e.g. DNA or RNA, reported with codes listed in the above tables), infectious disease probes, tumor markers (any type), pharmacogenomic assays, selected predictive and/or risk assessment interpretative scores, and any other molecular test, with or without an existing CPT or HCPCS code that does not specify ONE test per ONE code. Multi-variant Molecular testing (MVMT) is considered a subset of Molecular Diagnostic Testing (MDT).

Provider Requirements: Register MDT procedures/services with MolDx contractor and submit coverage requests.

Timelines: Claims for MDT will NOT be considered for adjudication unless the test in question has been submitted to the test registry for review and a McKesson Z-Code Identifier has been assigned to the test. Please refer to Palmetto GBA MolDx J11 Program Timelines section for more information

For more information, please refer to the MolDx contractor website (http://www.palmettogba.com/palmetto/MolDX.nsf/docsCat/MolDx%20Website~MolDx~Browse%20By%20Topic~General?open&expand=1&navmenu=Browse%5eBy%5eTopic).

Preventive Services

Each Office Visit is an Opportunity to Recommend Influenza Vaccination

Protect your patients, your staff, and yourself. Medicare Part B covers one influenza vaccination...
and its administration each influenza season for Medicare beneficiaries. If medically necessary, Medicare may cover additional seasonal influenza vaccinations.

- Preventive Services Educational Tool - [https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf](https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf)
- CDC Influenza website - [http://www.cdc.gov/FLU/](http://www.cdc.gov/FLU/)

**Preventive Services**

**MM9357: New Influenza Virus Vaccine Code**

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:** MM9357  
**Change Request (CR) #:** CR 9357  
**Related CR Release Date:** November 9, 2016  
**Effective Date:** August 1, 2015  
**Related CR Transmittal #:** R3403CP  
**Implementation Date:** April 4, 2016  

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9357 provides instructions for Medicare systems to be updated to include influenza virus vaccine code 90630 (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use) for claims with dates of service on or after August 1, 2015. Make sure your billing staffs are aware of this code change.

**Background**

CR9357 provides that (effective for claims with dates of service on or after August 1, 2015, processed on or after April 4, 2016) Medicare will pay for vaccine Current Procedural Terminology (CPT) code 90630 (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use).

Your MAC will add influenza virus vaccine CPT code 90630 to existing influenza virus vaccine edits and accept it for claims with dates of service on or after August 1, 2015.

Effective for dates of service on and after August 1, 2015, MACs will:

- Pay for vaccine code 90630 on institutional claims as follows:
  - Hospitals – Types of Bill (TOB) 12X and 13X, Skilled Nursing Facilities (SNFs) – TOB 22X and 23X, Home Health Agencies (HHAs) – TOB 34X, hospital-based Renal Dialysis Facilities (RDFs) – TOB 72X, and Critical Access Hospitals (CAHs) – TOB 85X, based on reasonable cost;
  - Indian Health Service (IHS) Hospitals – TOB 12X, and 13X and IHS CAHs – TOB 85X, based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP); and
Comprehensive Outpatient Rehabilitation Facility (CORF) – TOB 75X, and independent RDFs – TOB 72X, based on the lower of actual charge or 95 percent of the AWP.

- Pay for code 90630 on professional claims using the CMS Seasonal Influenza Vaccines Pricing Web page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html to determine the payment rate for influenza virus vaccine code 90630.

Note: In all of the above instances, annual Part B deductible and coinsurance do not apply.

In addition, until Medicare systems changes are implemented, MACs will hold institutional claims containing influenza virus vaccine CPT codes 90630 (with dates of service on or after August 1, 2015) that they receive before April 4, 2016. Once the system changes described in CR9357 are implemented, these institutional claims will be processed and paid.

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.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

MM9234 (Revised): Chronic Care Management (CCM) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

The Centers for Medicare & Medicaid Services (CMS) has revised the following Medicare Learning Network® (MLN) Matters article on December 3, 2015. CMS then issued a revised MM9234 article on December 9, 2015. 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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9234
Change Request (CR) #: CR 9234
Related CR Release Date: November 18, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R1576OTN
Implementation Date: January 4, 2016

Note: This article was revised on December 8, 2015, to clarify language and to emphasize some sections. All other information remains unchanged.

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 Chronic Care Management (CCM) services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 9234, which provides instructions to MACs regarding payment for CCM services for dates of service on or after January 1, 2016, to RHCs billing under the RHC All-Inclusive Rate (AIR) and FQHCs billing under the FQHC Prospective Payment System (PPS).

Background

The Centers for Medicare & Medicaid Services (CMS) recognizes care management as one of
the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending. On January 1, 2015, CMS began making separate payment under the Medicare Physician Fee Schedule (PFS) for CCM services under American Medical Association (AMA) Current Procedural Terminology (CPT) Code 99490.

CMS finalized aspects of the payment methodology, scope of services, and requirements for billing and supervision for practitioners permitted to bill Medicare under the PFS in the Calendar Year (CY) 2014 PFS final rule (78 74414 through 74427) and made further refinements in the CY 2015 final rule (79 67715 through 67730).

As authorized by the Social Security Act (Section 1861(aa)), RHCs and FQHCs are paid for physician services and services and supplies incident to physician services. In the CY 2016 PFS proposed rule (80 FR 41793), CMS proposed requirements and a payment methodology for CCM services furnished by RHCs and FQHCs. In the CY 2016 PFS final (80 FR 71080), CMS finalized the requirements and payment methodology for CCM services furnished by RHCs and FQHCs.

Beginning on January 1, 2016, RHCs and FQHCs may receive an additional payment for the costs of CCM services that are not already captured in the RHC AIR or the FQHC PPS for CCM services to Medicare beneficiaries having multiple (two or more) chronic conditions that are expected to last at least 12 months (or until the death of the patient), and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

RHCs and FQHCs can bill for CCM services when a RHC or FQHC practitioner furnishes a comprehensive evaluation and management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) to the patient prior to billing the CCM service, and initiates the CCM service as part of this visit.

CCM payment will be based on the Medicare PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. The rate will be updated annually and has no geographic adjustment. The RHC and FQHC face-to-face requirements are waived when CCM services are furnished to a RHC or FQHC patient.

Coinsurance would be applied as applicable to FQHC claims, and coinsurance and deductibles would apply as applicable to RHC claims. RHCs and FQHCs would continue to be required to meet the RHC and FQHC Conditions of Participation and any additional RHC or FQHC payment requirements.

RHCs and FQHCs cannot bill for CCM services for a beneficiary during the same service period as billing for transitional care management or any other program that provides additional payment for care management services (outside of the RHC AIR or FQHC PPS payment) for the same beneficiary.

Patient Agreement Requirements - Overview

The RHC or FQHC must inform eligible patients of the availability of CCM services and obtain consent for the CCM service before furnishing or billing the service. Some of the patient agreement provisions require the use of certified Electronic Health Record (EHR) technology. See Table 1 below for more detailed information.

Patient consent requirements include:

- Informing the patient of the availability of the CCM service and obtaining written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers.

- Explaining and offering the CCM service to the patient and documenting this discussion in the patient’s medical record, noting the patient’s decision to accept or decline the service.

- Explaining how to revoke the service.

- Informing the patient that only one practitioner can furnish and be paid for the service.
This agreement process should include a discussion with the patient, and caregiver when applicable, about:

- What the CCM service is;
- How to access the elements of the service;
- How the patient’s information will be shared among practitioners and providers;
- How cost-sharing (co-insurance and deductibles) applies to these services; and
- How to revoke the service.

Informed patient consent should only be obtained once prior to furnishing the CCM service, or if the patient chooses to change the practitioner who will furnish and bill the service.

**CCM Scope of Service Elements - Overview**

The CCM service includes the structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. Some of the CCM Scope of Service elements require the use of a certified EHR or other electronic technology. For a complete listing of the CCM Scope of Service elements and electronic technology requirements that must be met in order to bill the service, see Table 1 below.

**Structured Data Recording**

- Record the patient’s demographics, problems, medications, and medication allergies and create structured clinical summary records using certified EHR technology.

**Care Plan**

- Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues).
- Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record.
- Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service.
- Share the care plan electronically outside the practice as appropriate.

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list;
- Expected outcome and prognosis;
- Measurable treatment goals;
- Symptom management;
- Planned interventions and identification of the individuals responsible for each intervention;
- Medication management;
- Community/social services ordered;
- A description of how services of agencies and specialists outside the practice will be directed/coordinated; and
- Schedule for periodic review and, when applicable, revision of the care plan.

**Access to Care**

during a calendar month.
• Ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services, providing the patient with a means to make timely contact with health care practitioners in the practice who have access to the patient’s electronic care plan to address his or her urgent chronic care needs.

• Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.

• Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient’s care. Do this through telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Care Management

Care management services such as:

• Systematic assessment of the patient’s medical, functional, and psychosocial needs;

• System-based approaches to ensure timely receipt of all recommended preventive care services;

• Medication reconciliation with review of adherence and potential interactions; and

• Oversight of patient self-management of medications.

Manage care transitions between and among health care providers and settings, including referrals to other providers, including:

• Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.

Coordinate care with home and community based clinical service providers.

EHR and Other Electronic Technology Requirements

CMS requires the use of certified EHR technology to satisfy some of the CCM scope of service elements. In furnishing these aspects of the CCM service, CMS requires the use of a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year (referred to as “CCM certified technology”). For more information, visit [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms) on the CMS website.

For CCM payment in calendar year (CY) 2016, practitioners may use EHR technology certified to the 2014 edition(s) of certification criteria.

At this time, CMS does not require the use of certified EHR technology for some of the services involving the care plan and clinical summaries, allowing for broader electronic capabilities. These are described in Table 1, CCM Scope of Service and Billing Requirements.

<table>
<thead>
<tr>
<th>CCM Scope of Service Element/Billing Requirement</th>
<th>Certified EHR or Other Electronic Technology Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation during an AWV, IPPE, or comprehensive E/M visit (billed separately).</td>
<td>None.</td>
</tr>
<tr>
<td>Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.</td>
<td>Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology.</td>
</tr>
<tr>
<td>Access to care management services 24/7 that provides the beneficiary with a means to make timely contact with health care practitioners in the practice who have access to the patient's electronic care plan to address his or her urgent chronic care needs regardless of the time of day or day of the week.</td>
<td>None.</td>
</tr>
<tr>
<td>CCM Scope of Service Element/Billing Requirement</td>
<td>Certified EHR or Other Electronic Technology Requirement</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.</td>
<td>None.</td>
</tr>
<tr>
<td>Care management for chronic conditions including systematic assessment of the beneficiary’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.</td>
<td>None.</td>
</tr>
<tr>
<td>Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. Share the care plan as appropriate with other practitioners and providers.</td>
<td>Must at least electronically capture care plan information; make this information available on a 24/7 basis to all practitioners within the practice whose time counts towards the time requirement for the practice to bill the CCM code; and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers.</td>
</tr>
<tr>
<td>Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.</td>
<td>Document provision of the care plan as required to the beneficiary in the EHR using CCM certified technology.</td>
</tr>
<tr>
<td>Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.</td>
<td>Format clinical summaries according to CCM certified technology. Not required to use a specific tool or service to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by fax).</td>
</tr>
<tr>
<td>Coordination with home and community based clinical service providers.</td>
<td>Communication to and from home and community based providers regarding the patient’s psychosocial needs and functional deficits must be documented in the patient’s medical record using CCM certified technology.</td>
</tr>
<tr>
<td>Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary’s care through not only telephone access, but also through the use of secure messaging, Internet or other asynchronous non-face-to-face consultation methods.</td>
<td>None.</td>
</tr>
<tr>
<td>Beneficiary consent—Inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers.</td>
<td>Document the beneficiary’s written consent and authorization in the EHR using CCM certified technology.</td>
</tr>
<tr>
<td>Document in the beneficiary’s medical record that all of the CCM services were explained and offered, and note the beneficiary’s decision to accept or decline these services.</td>
<td>None.</td>
</tr>
<tr>
<td>Beneficiary consent—Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of the calendar month) and the effect of a revocation of the agreement on CCM services.</td>
<td>None.</td>
</tr>
<tr>
<td>Beneficiary consent—Inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.</td>
<td>None.</td>
</tr>
</tbody>
</table>

Table 2: Billing Examples for CCM Services

The following examples are provided to assist RHCs and FQHCs in billing for CCM services: CCM Furnished as a Stand-alone Service

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/ Deductible Applied (when applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>52x¹</td>
<td>99490</td>
<td>01/01/2016²</td>
<td>1</td>
<td>$XX.XX³</td>
<td>Based on the PFS national average non-facility payment rate</td>
<td>Yes</td>
</tr>
</tbody>
</table>

¹ Based on the PFS national average non-facility payment rate.
² May not be used to bill for the same care on the same date.
³ Specific revenue codes may require additional coding guidance.
Table 2: Billing Examples for CCM Services

The following examples are provided to assist RHCs and FQHCs in billing for CCM services:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
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<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/ Deductible Applied (when applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>52x¹</td>
<td>A FQHC payment code and a qualifying visit HCPCS for FQHCs or A valid HCPCS for a billable service for RHCs</td>
<td>01/01/2016²</td>
<td>1</td>
<td>$XX.XX³</td>
<td>FQHC Prospective Payment System (PPS) Methodology for FQHCs or All-inclusive rate (AIR) for RHCs</td>
<td>Yes⁴</td>
</tr>
<tr>
<td>52x¹</td>
<td>99490</td>
<td>01/01/2016²</td>
<td>1</td>
<td>$XX.XX³</td>
<td>Based on the PFS national average non-facility payment rate</td>
<td>Yes</td>
</tr>
</tbody>
</table>

¹ Use the revenue code most appropriate for the service
² Any date of service on or after 1/1/2016
³ Enter charge amount
⁴ Coinsurance and/or deductible is waived when an approved preventive service is billed

Additional Information


The following documents and websites provide additional information about CCM:

- PFS and OPPS Frequently Asked Questions on CCM: See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf.
- Chronic Conditions Data Warehouse: See https://www.ccwdata.org/web/guest.
- Final Rules in the Federal Register (policies governing CCM services):

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

MM9267: Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) that were Provider-Based Clinics on or Before April 7, 2000
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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9267
Change Request (CR) #: CR 9267
Related CR Release Date: November 23, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3415CP
Implementation Date: January 4, 2016

Provider Types Affected
This MLN Matters® Article is intended for grandfathered tribal federally qualified health centers (FQHCs) that were provider-based clinics on or before April 7, 2000 submitting institutional claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9267 updates instructions to the Medicare Administrative Contractors (MACs) for payment to grandfathered tribal FQHCs that were provider-based clinics on or before April 7, 2000.

Background
Effective for dates of service on or after January 1, 2016, Indian Health Services (IHS) and tribal facilities and organizations that met the conditions of 42 CFR 413.65(m) (https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec413-65.pdf) on or before April 7, 2000, and have a change in their status on or after April 7, 2000, from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the Conditions of Participation (CoPs), may seek to become certified as grandfathered tribal FQHCs. These grandfathered tribal FQHCs would be required to meet all FQHC certification and payment requirements.

The FQHC Prospective Payment System (PPS) adjustment for grandfathered tribal clinics would not apply to a currently certified tribal FQHC, a tribal clinic that was not provider-based as of April 7, 2000, or an IHS-operated clinic that is no longer provider-based to a tribally-operated hospital. This provision would also not apply in those instances where both the hospital and its provider-based clinic(s) are operated by the tribe or tribal organization.

Grandfathered tribal FQHCs will be paid the lesser of their charges or a grandfathered tribal FQHC PPS rate for all FQHC services furnished to a beneficiary during a medically-necessary, face-to-face FQHC visit. The grandfathered PPS rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS.

From January 1, 2015, through December 31, 2015, the grandfathered tribal FQHC PPS rate is $307. The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC PPS Geographic Adjustment Factor (GAF) or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an IPPE or an AWV. The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the Medicare Economic Index (MEI) or a FQHC market basket adjustment that is applied annually to the FQHC PPS base rate, will not apply to the grandfathered tribal FQHC PPS rate.

Grandfathered tribal FQHCs will be paid for services included in the FQHC benefit, even if those services are not included in the IHS Medicare outpatient all-inclusive rate. Services that are included in the IHS outpatient all-inclusive rate but not in the FQHC benefit will not be paid.

Grandfathered tribal FQHCs are subject to the payment requirements under the FQHC PPS. The five FQHC payment G-codes shall be used by grandfathered tribal FQHCs when submitting claims under the PPS based on the services furnished. Grandfathered tribal FQHCs shall use
the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment. Each grandfathered tribal FQHC shall report a charge for the visit code that would reflect the sum of regular rates charged to both beneficiaries and other patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary. Additional information on the coverage and payment requirements for FQHC visits is available in the “Medicare Benefit Policy Manual,” Chapter 13 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf). Additional information regarding the services that are qualifying visits is available on the FQHC PPS center page at http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html on the Centers for Medicare & Medicaid Services (CMS) website.

MACs shall generally pay 80 percent of the lesser of the grandfathered tribal FQHC’s charge for the FQHC payment code or the grandfathered tribal FQHC PPS rate. Coinsurance will generally be 20 percent of the lesser of the actual charge or the grandfathered tribal FQHC PPS rate. For claims that consist solely of preventive services that are exempt from beneficiary coinsurance, contractors shall pay 100 percent of the lesser of the actual charge or the grandfathered tribal FQHC PPS rate, and no beneficiary coinsurance would be assessed.

For claims that include a mix of preventive and non-preventive services, MACs shall use the current methodology established under the FQHC PPS to calculate coinsurance.

Additional Information

The official instruction, CR9267, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3415CP.pdf

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.

Therapy

MM9448: Therapy Cap Values for Calendar Year (CY) 2016

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: MM9448
Related CR Release Date: November 25, 2015
Related CR Transmittal #: R3417CP
Change Request (CR) #: CR 9448
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9448, from which this article was developed, describes the amounts and the policy for outpatient therapy caps for CY 2016. For physical therapy and speech-language pathology combined, the 2016 therapy cap will be $1,960. For occupational therapy, the cap for 2016 will be $1,960. Please make sure your billing staffs are aware of these updates.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual
financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as “therapy caps.” The therapy caps are updated each year based on the Medicare Economic Index. An exceptions process to the therapy caps for reasonable and medically necessary services was required by section 5107 of the Deficit Reduction Act of 2005. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy cap exceptions process through December 31, 2017.

Additional Information


For more information on the therapy caps and other issues related to outpatient therapy services, please see the Therapy Services Web page at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html on the CMS 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.