Medicare Bulletin
Jurisdiction 15

Reaching Out to the Medicare Community

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# Medicare Bulletin

## Jurisdiction 15

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**Articles contained in this edition are current as of May 28, 2015**

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**Medicare Learning Network**

Official Information Health Care Professionals Can Trust

[http://go.cms.gov/MLNGenInfo](http://go.cms.gov/MLNGenInfo)
Kentucky & Ohio

SE1514: Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model

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: SE1514
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This Special Edition (SE) MLN Matters® article is intended for independently enrolled Medicare ambulance suppliers who (1) provide repetitive scheduled non-emergent ambulance transports for Medicare Fee-For-Service beneficiaries in New Jersey, Pennsylvania, and South Carolina and (2) submit claims to Medicare Administrative Contractors (MACs) for ambulance services provided to Medicare beneficiaries.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) began a 3-year prior authorization model for repetitive scheduled non-emergent ambulance transports in the states of New Jersey, Pennsylvania, and South Carolina on December 1, 2014, for transports on or after December 15, 2014, regardless of the origin or destination of the transport. CMS is issuing this Special Edition (SE) 1514 solely as an educational guide to improve compliance with documentation requirements for the repetitive scheduled non-emergent ambulance prior authorization model. SE1514 presents useful information that will help suppliers receive provisional affirmed decisions for prior authorization requests submitted for patients that meet coverage and medical necessity requirements.

See the Background and Additional Information Sections of this article for further details, and make sure that your billing staffs are aware of this information.
Background
Medicare covers ambulance services, including air ambulance (fixed wing and rotary wing) services, when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The Medicare ambulance benefit for non-emergent transports is very limited and designed only for patients who are clinically unable to be transported by other means. Non-emergent transportation by ambulance is appropriate if either:

1. The beneficiary is bed-confined and it is documented that the beneficiary’s condition is such that other methods of transportation are contraindicated; or
2. The beneficiary’s medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Therefore, bed confinement is not the sole criterion in determining the medical necessity of non-emergent ambulance transportation; rather, it is one factor that is considered in medical necessity determinations (See 42 CFR 410.40(d)(1), http://www.ecfr.gov/cgi-bin/text-idx?SID=488d7b7fd31724d34765322e4ab5fd4df&mc=true&node=pt42.2.410&rgn=div5#se42.2.410_140)

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished in 3 or more round trips (or six one way trips) within a 10-day period, or at least once per week for at least 3 weeks.

Repetitive transportation services are often needed by beneficiaries receiving dialysis, covered wound care, treatment interventions or cancer treatment. For wound care, it is anticipated that wound care is managed in the home and requires only periodic clinic appointments for:

- Debridement,
- Wound management, or
- Infection types of services.

In any case in which some means of transportation other than an ambulance could be used without endangering the individual’s health (whether or not such other transportation is actually available), no payment may be made for ambulance services. In addition, the reason for the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service, or to return from such a service.

Medicare may cover repetitive, scheduled, non-emergent transportation by ambulance if:

1. The medical necessity requirements described previously are met (that is, bed confinement or medically required); and
2. The ambulance provider/supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary’s attending physician certifying that the medical necessity requirements are met.

Note: Per 42 CFR §410.40(d)(2), the physician’s order must be dated no earlier than 60 days before the date the service is furnished (See 42 CFR 410.40(d)(2)). The written order is often referred to as a Physician Certification Statement (PCS).

In addition to the medical necessity requirements, the service must meet all other Medicare coverage and payment requirements, including requirements relating to the origin and destination of the transportation, vehicle and staff, and billing and reporting. Additional information about Medicare coverage of ambulance services can be found in 42 CFR 410.40 and 42 CFR 410.41 (http://www.ecfr.gov/cgi-bin/text-idx?SID=3e84ac918f0f1e9e34095d68e2e803dc&mc=true&node=se42.2.410_141&rgn=div8) and in the “Medicare Benefit Policy Manual”, Chapter 10 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf).

Under this model, an ambulance supplier or beneficiary is encouraged to submit to their MAC a request for prior authorization along with all relevant documentation to support Medicare coverage of a repetitive, scheduled non-emergent ambulance transport.
Note that prior authorization does not create new clinical documentation requirements. Instead, it requires the same information necessary to support Medicare payment, just earlier in the process.

Prior authorization allows ambulance suppliers to address issues with claims prior to rendering services and to avoid an appeal process. This will help ensure that all relevant coverage, coding, and clinical documentation requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment.

Submitting a prior authorization request is voluntary. However, if prior authorization has not been requested by the fourth round trip, the claims will be stopped for pre-payment review. After receipt of all relevant documentation, the MAC will make every effort to conduct a review and postmark (or fax if a fax number is provided) the notification of their decision on a prior authorization request within 10 business days for an initial submission.

**PCS and Documentation that Facilitates an Affirmative Decision**

In order to be provisionally affirmed, the request for prior authorization must meet all applicable rules and policies, and any applicable Local Coverage Determination (LCD) requirements for ambulance transport claims.

- Make sure the PCS is completed for the particular beneficiary and must not be more than 60 days prior to the requested start date. Only conditions specific for the beneficiary should be noted and all applicable comments should concern the beneficiary’s current condition.

- Make sure all signatures are legible and/or there is a signature log for the physician’s signature.

- Make sure the relevant documentation received from the ordering physician’s medical records provides a clear picture of the beneficiary’s current condition requiring ambulance transport. The documentation must not be more than 60 days prior to the requested start date. This information must be from the physician, not the ambulance supplier.

The top reasons for non-affirmations are as follows:

- A PCS was not submitted, was not signed, was missing credentials, was incomplete or was more than 60 days prior to the requested start date.

- Medical documentation was not submitted with the PCS.

- Medical documentation submitted did not support what was included on the PCS.

- Medical documentation submitted was not current (more than 60 days prior to the requested start date), did not include the patient’s name, or in some cases, was not legible.

**Key items to be addressed**

1. **PCS**
   - The PCS must be signed and dated by the patient’s attending physician.
   - The signature, credentials, and date must be readable.
   - The prefix “Dr.” is a title and not a credential.
   - Stamped signatures or file signatures are not acceptable.
   - The PCS cannot be dated more than 60 days in advance of the requested start date.
   - The PCS information must be verifiable.
   - Medical documentation must be attached that supports the PCS and that describes the beneficiary’s condition(s) that necessitate(s) the type and level of ambulance transports.
   - A signed and dated PCS does not, by itself, demonstrate that the repetitive scheduled transports are medically necessary.
2. Medical Documentation

- Medical documentation should provide sufficient information to support the prior authorization request form and the PCS.

- Documentation should:
  > Reveal the medical necessity of the type and level of transport services.
  > Reveal the exact origin address and destination address.
  > Specify the beneficiary, provider and date of service.
  > Capture the "what" and "why" of a beneficiary’s condition(s) that necessitate(s) the transports.
  > Support the diagnoses or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code(s) on the PCS with clinical assessment data and objective findings.
  > Be readable and dated no earlier than 60 days in advance of the requested start date.

- Documentation can include, but is not limited to:
  > Doctor’s progress notes,
  > Nursing notes,
  > History and Physical Exam, and
  > Physical or occupational therapy notes.

- For admission and discharge summaries for a condition itemized on the PCS, the documentation must contain statements that capture the "what" and the "why" (for example, if a patient’s condition is bed-confined, documentation must indicate why the patient is bed-confined).

- The documentation should not contradict the PCS (for example, patient is indicated as bed-confined on PCS, however, medical records document the patient uses a wheelchair).

Example of Documentation that Identifies the “What” and the “Why”

Included in the Progress Note:

Patient is an 80 year old white male with a history of ESRD being treated with hemodialysis at ABC Dialysis Center. Wegener’s Disease, Atrial Fibrillation, severe osteoporosis, and Spinal Stenosis all treated by Dr. Smith. Recently, patient has had “bouts” of pneumonia. Patient has extremely fragile bones, to the point that any lifting of the patient even with a “Hoyer Lift” can and has resulted in dislocations and fractures. Patient has bilateral elbow flexion of 30 degrees, reduced plantar strength with a max of 1 out of 5 bilaterally and 0 degree max hip flexion bilaterally. Bilateral knee flexion is 0 degree. Patient is Alert and Oriented x4 at baseline with a GCS of 15.

Patient requires assistance in the areas of bathing, dressing, toileting and cleaning himself, transferring, unable to get up from bed, and feeding. Patient does not exercise any control over urination and defecation.

Patient is completely bed-confined. Due to contractures, weakness, and over deconditioning, patient is unable to ambulate, sit or stand. Based on the physical assessment and the physical limitations noted, the patient is on fall precautions from bed.

This patient requires stretcher for transport due to non-weight bearing, non-ambulatory, bed confined status, and patient cannot support himself for any amount of time. Monitoring is required to prevent injury or fall from stretcher.
Methods for Sending a Prior Authorization (PA) Request Package to Your MAC

Submitters have four options for submitting PA requests to their MACs:

1. Fax,
2. Mail,
3. Electronic Submission of Medical Documentation (esMD), or
4. MAC Provider Portal, if available.


Addresses and Fax Numbers of the MACs

1. For suppliers garaged in New Jersey or Pennsylvania, send requests to the MAC JL at:
   - Fax Number: 1.877.439.5479
   - Mailing Address: Novitas Solutions
     Part B Prior Authorization Request
     PO Box 3702
     Mechanicsburg, PA 17055
     or
     Novitas Solutions
     Attention: Part B Prior Authorization Request
     2020 Technology Parkway, Suite 100
     Mechanicsburg, PA 17050
     - Electronic Submission of Medical Documentation (esMD): (indicate content type “81”)

2. For suppliers garaged in South Carolina, send requests to the MAC J11 at:
   - Fax Number: 1.803.462.2702
   - Mailing Address: Palmetto GBA – Jll MAC Prior Authorization
     PO Box 100212
     Columbia, SC 29202-3212
     - Electronic Submission of Medical Documentation (esMD): (indicate content type “81”)

Additional Information

If you have questions, please contact your MAC at their toll-free number. The number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work?


Questions can also be sent to the following CMS e-mail address: AmbulancePA@cms.hhs.gov

You may want to review the following:

For more operational details about the prior authorization of repetitive scheduled non-emergent ambulance transport model please see the Ambulance Prior Authorization Operational Guide


Kentucky & Ohio

MM9125 Revised: Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print 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: MM9125 Revised
Related CR Release Date: April 27, 2015
Related CR Transmittal #: R3242CP

Note: This article was revised on April 27, 2015, to reflect an updated Change Request (CR). That CR, made changes to the Attachments I and II with regard to new and deactivated codes (pages 4-5 below) . All other information remains the same.

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

Provider Action Needed
This article is based on CR9125, which 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. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if they use that software.

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 appropriate RARCs that provide either supplemental explanation for a monetary adjustment or policy information, which generally
applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

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. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR9125, MACs will implement on the date specified on the WPC website. The WPC website is available at http://www.wpc-edi.com/Reference on the Internet.

CR9125 lists only the changes that have been approved since the last code update CR (CR9004 issued on January 9, 2015, with a related MLN Matters® article available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9004.pdf), and does not provide a complete list of codes for these two code sets. The complete list for both CARC and RARC from the WPC website is updated three times a year — around March 1, July 1, and November 1. The WPC website, which has four listings available for both CARC and RARC, is available at http://www.wpc-edi.com/Reference on the Internet.

In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version should be implemented.

Note: This recurring Code Update CR lists only the changes approved since the last recurring Code Update CR once. If any modification or deactivation becomes effective at a future date, MACs must make sure that they update on the effective date or the quarterly release date that matches the effective date as posted on the WPC website.

Changes in CARC List Since CR 9004

The following tables are changes in the CARC database since the last code update in CR 9004.

<table>
<thead>
<tr>
<th>New Codes – CARC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>269</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modified Codes – CARC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>45</td>
</tr>
<tr>
<td>55</td>
</tr>
</tbody>
</table>
### Modified Codes – CARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>133</td>
<td>The disposition of this service line is pending further review. (Use only with Group Code OA). Note: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>267</td>
<td>Claim/service spans multiple months. Rebill as separate claim/service. This change effective 9/1/2015: Claim/service spans multiple months. 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.)</td>
<td>04/01/2015</td>
</tr>
</tbody>
</table>

### Deactivated Codes – CARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7</td>
<td>Presumptive Payment Adjustment</td>
<td>07/01/2015</td>
</tr>
</tbody>
</table>

### Changes in RARC List Since CR 9004

The following tables are changes in the RARC database since the last code update in CR 9004.

#### New Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N736</td>
<td>Incomplete/invalid Sleep Study Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N737</td>
<td>Missing Sleep Study Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N738</td>
<td>Incomplete/invalid Vein Study Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N739</td>
<td>Missing Vein Study Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N740</td>
<td>The member’s Consumer Spending Account does not contain sufficient funds to cover the member’s liability for this claim/service.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N741</td>
<td>This is a site neutral payment.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N742</td>
<td>Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at <a href="http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html">http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html</a> on the CMS website.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N743</td>
<td>Adjusted because the services may be related to an employment accident.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N744</td>
<td>Adjusted because the services may be related to an auto accident.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N745</td>
<td>Missing Ambulance Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N746</td>
<td>Incomplete/invalid Ambulance Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N747</td>
<td>This is a misdirected claim/service. Submit the claim to the payer/plan where the patient resides.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N748</td>
<td>Adjusted because the related hospital charges have not been received.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N749</td>
<td>Missing Blood Gas Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N750</td>
<td>Incomplete/invalid Blood Gas Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N751</td>
<td>Adjusted because the drug is covered under a Medicare Part D plan.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N752</td>
<td>Missing/incomplete/invalid HIPPS Treatment Authorization Code (TAC).</td>
<td>03/01/2015</td>
</tr>
</tbody>
</table>

#### Modified Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N10</td>
<td>Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.</td>
<td>03/01/2015</td>
</tr>
</tbody>
</table>

#### Deactivated Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N483</td>
<td>Missing Periodontal Charts</td>
<td>05/01/2015</td>
</tr>
<tr>
<td>N484</td>
<td>Incomplete/invalid Periodontal Charts.</td>
<td>05/01/2015</td>
</tr>
<tr>
<td>N29</td>
<td>Missing documentation/orders/notes/summary/report/chart</td>
<td>05/01/2015</td>
</tr>
<tr>
<td>N225</td>
<td>Incomplete/invalid documentation/orders/notes/summary/report/chart</td>
<td>05/01/2015</td>
</tr>
</tbody>
</table>

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after January 1997 are available at no cost from our website at [http://www.cgsmedicare.com](http://www.cgsmedicare.com). © 2015 Copyright, CGS Administrators, LLC.
The full CARC and RARC lists must be downloaded from the WPC website available at http://wpc-edi.com/Reference on the Internet.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under “How Does It Work” on the CMS website.

Kentucky & Ohio

MM9150: Correction to the Multi-Carrier System (MCS) Editing on the Service Location National Provider Identifier (NPI) Reported for Anti-Markup and Reference Laboratory Claims

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: MM9150 Related Change Request (CR) #: CR 9150
Related CR Release Date: May 8, 2015 Effective Date: October 1, 2015
Related CR Transmittal #: R3255CP Implementation Date: October 5, 2015

Note: This article was revised on April 27, 2015, to reflect an updated Change Request (CR). That CR, made changes to the Attachments I and II with regard to new and deactivated codes (pages 4-5 below). All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9150 instructs the maintainer of Medicare’s Multi-Carrier System (MCS) to correct edit 043H that was incorrectly coded under CR 8806 (Transmittal 3103, issued November 13, 2014). This CR also delays implementation of CR 8806 until October 1, 2015. Make sure that your billing staffs are aware of this correction.

Background

CR 8806 implemented a new policy that physicians and other suppliers would no longer be permitted to submit their own National Provider Identifier (NPI) in Item 32a of the CMS-1500 claim form for anti-markup and reference laboratory claims when the performing physician or supplier is located in another jurisdiction. CR 8806 instructed MACs to return reference laboratory and anti-markup claims as unprocessable when the billing and service location NPIs match. The MCS created edit 043H to satisfy this requirement.

It has come to the attention of the Centers for Medicare & Medicaid Services (CMS) that edit 043H is erroneously comparing the rendering physician NPI in Item 24J of the CMS-1500 to the service location NPI, rather than comparing the billing NPI to the service location NPI. CR9150 instructs the MCS to correct edit 043H to compare the billing NPI to the service location NPI.
CR9150 also delays implementation of CR 8806 until October 1, 2015. Effective for claims with a receipt date on or after October 1, 2015, MACs will return reference laboratory and anti-markup claims as unprocessable when the billing and service location NPIs match.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under “How Does It Work” on the CMS website.

Kentucky & Ohio
MM9153: Section 504: Implement National Medicare Summary Notices (MSNs) in Alternate Formats

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MLN Matters® Number: MM9153
Related Change Request (CR) #: CR 9153
Related CR Release Date: May 8, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R1499OTN
Implementation Date: October 5, 2015

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

What You Need to Know
Change Request (CR) 9153 alerts providers that the Centers for Medicare & Medicaid Services (CMS) has designated the MACs as responsible for printing requests for large print Medicare Summary Notices (MSNs) that are sent to beneficiaries in alternate formats, and to have a third party contractor responsible for requests for Braille, CD-ROM, and Audio alternate formats. MACs are required to produce large print MSNs for beneficiaries in their respective jurisdictions who prefer large print MSNs.

Background
CMS has an obligation to provide the MSN in alternate formats for beneficiaries who elect one of the formats as a preference. CMS has been working on the alternate format project for several years. Most recently, CMS has directed MACs to provide MSNs to a subset of beneficiaries through a manual process. CR9153 implements the MAC requirements to produce large print MSNs for beneficiaries with that preference in their respective jurisdictions.

Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794 forbids Executive Agencies and recipients of Federal financial assistance from excluding individuals with disabilities or denying them an equal opportunity to receive program benefits and services.
Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Kentucky & Ohio

SE1516: Chronic Care Management (CCM) Services Frequently Asked Questions (FAQs)

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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Note: This article was revised on April 27, 2015, to reflect an updated Change Request (CR). That CR, made changes to the Attachments I and II with regard to new and deactivated codes (pages 4-5 below). All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition is intended for physicians and non-physician practitioners such as Certified Nurse Midwives (CNMs), Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs) and Physician Assistants (PAs) who bill the Medicare Fee-For-Service Program (Original Medicare) for the new Chronic Care Management (CCM) services provided to Medicare beneficiaries.

Provider Action Needed

This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) revised the Medicare Learning Network® Fact Sheet on CCM services (ICN 909188, released in March 2015) to clarify Medicare’s requirement for 24/7 access by individuals furnishing CCM services to the electronic care plan rather than the entire medical record. Also, CMS released a set of Frequently Asked Questions (FAQs) and answers to address requests received from practitioners and providers for additional guidance in specific areas such as claims submission, intersection with transitional care management services, and the provision of CCM services in facility settings. Those FAQs appear later in this article.

Key Points

The revised Fact Sheet is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf on the CMS website. The CCM Services Fact Sheet is a resource that succinctly identifies the newly payable CCM service, identifies eligible providers and patients, and details the Medicare Physician Fee Schedule (PFS) billing requirements.

Background

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. Beginning January 1, 2015 Medicare pays separately under the Physician Fee Schedule (PFS) under
American Medical Association Current Procedural Terminology (CPT) code 99490, for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions.

**Frequently Asked Questions about Billing Medicare for Chronic Care Management Services**

This document answers frequently asked questions about billing CCM services to the PFS and Hospital Outpatient Prospective Payment System (OPPS) under CPT code 99490.

**Physician Fee Schedule**

1. **CPT code 99490 requires at least 20 minutes of time per calendar month by “clinical staff” in order to bill the code. Who qualifies as “clinical staff”? If the billing physician (or other appropriate practitioner) furnishes services directly, does their time count towards the required minimum 20 minutes of time?**

   In most cases, we believe clinical staff will provide CCM services incident to the services of the billing physician (or other appropriate practitioner who can be a physician assistant, nurse practitioner, clinical nurse specialist or certified nurse midwife). Practitioners should consult the CPT definition of the term “clinical staff.” In addition, time spent by clinical staff may only be counted if Medicare’s “incident to” rules are met such as supervision, applicable State law, licensure and scope of practice. If the billing physician (or other appropriate billing practitioner) provides CCM services directly, that time counts towards the 20 minute minimum time. Of course, other staff may help facilitate CCM services, but only time spent by clinical staff may be counted towards the 20 minute minimum time.

2. **Can CCM services be subcontracted out to a case management company? What if the clinical staff employed by the case management company are located outside of the United States?**

   A billing physician (or other appropriate practitioner) may arrange to have CCM services provided by clinical staff external to the practice (for example, in a case management company) if all of the “incident to” and other rules for billing CCM to the PFS are met. Because there is a regulatory prohibition against payment for non-emergency Medicare services furnished outside of the United States (42 CFR 411.9), CCM services cannot be billed if they are provided to patients or by individuals located outside of the United States.

3. **Does the billing practice have to furnish every scope of service element in a given service period, even those that may not apply to an individual patient?**

   It is our expectation that all of the scope of service elements will be routinely provided in a given service period, unless a particular service is not medically indicated or necessary (for example, the beneficiary has no hospital admissions that month so there is no management of a transition after hospital discharge).

4. **What date of service should be used on the physician claim and when should the claim be submitted?**

   The service period for CPT 99490 is one calendar month, and CMS expects the billing practitioner to continue furnishing services during a given month as applicable after the 20 minute time threshold to bill the service is met (see #3 above). However practitioners may bill the PFS at the conclusion of the service period or after completion of at least 20 minutes of qualifying services for the service period. When the 20 minute threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month.
5. **What place of service (POS) should be reported on the physician claim?**

   Practitioners must report the POS for the billing location (i.e., where the billing practitioner would furnish a face-to-face office visit with the patient). Accordingly, practitioners who furnish CCM in the hospital outpatient setting, including provider-based locations, must report the appropriate POS for the hospital outpatient setting. Payment for CCM furnished and billed by a practitioner in a facility setting will trigger PFS payment at the facility rate.

6. **CPT code 99490 is payable to hospital outpatient departments (provider-based locations) under the hospital OPPS. Can physicians practicing in these departments or in locations that are hospital-owned (but not provider-based) also bill this code to the PFS? What if the patient is a hospital or SNF inpatient or is otherwise in a Medicare “facility” or “institution?”**

   If the patient resides in a community setting and the CCM service is provided by or “incident to” services of the billing physician (or other appropriate billing practitioner) working in or employed by a hospital, CPT 99490 can be billed to the PFS and payment is made at the facility rate (if all other billing requirements are met). We discuss this further under the section below addressing billing for CCM furnished in the hospital outpatient department setting.

   As we discussed in the CY 2014 PFS final rule, the resources required to provide care management services to patients in facility settings significantly overlap with care management activities by facility staff that are included in the associated facility payment. Therefore, CPT 99490 cannot be billed to the PFS for patients who reside in a facility (that receives payment from Medicare for care of that beneficiary, see 78 FR 74423) regardless of the location of the billing practitioner, because the payment made to the facility under other payment systems includes care management and coordination. For example, CPT code 99490 cannot be billed to the PFS for services provided to SNF inpatients or hospital inpatients, because the facility is being paid for extensive care planning and care coordination services. However if the patient is not an inpatient the entire month, time that is spent furnishing CCM services to the patient while they are not inpatient can be counted towards the minimum 20 minutes of service time that is required to bill for that month.

   Billing practitioners in hospital-owned outpatient practices that are not provider-based departments are working in a non-facility setting, and may therefore bill CPT 99490 and be paid under the PFS at the non-facility rate. However, CPT 99490 can only be billed for CCM services furnished to a patient who is not a hospital or SNF inpatient and does not reside in a facility that receives payment from Medicare for that beneficiary.

7. **Is a new patient consent form required each calendar month or annually?**

   No, as provided in the CY 2014 PFS final rule (78 FR 74424), a new consent is only required if the patient changes billing practitioners, in which case a new consent must be obtained and documented by the new billing practitioner prior to furnishing the service.

8. **Is Medicare now paying separately under the PFS for remote patient monitoring services described by CPT code 99091 or similar CPT codes?**

   CPT 99091 continues to be bundled with other services for payment under the PFS. As per CPT guidance, CPT codes 99090, 99091 and other codes cannot be billed during the same service period as CPT 99490. However as discussed in the CY 2015 PFS final rule (79 FR 67727), analysis of patient-generated health data and other activities described by CPT 99091 or similar codes may be within the scope of CCM services, in which case these activities would count towards the minimum 20 minutes of qualifying care per month that are required to bill CPT 99490. But in order to bill CPT 99490, such activity cannot be the only work that is done—all other requirements for billing CPT 99490 must...
be met in order to bill the code, and time counted towards billing CPT 99490 cannot also be counted towards billing other codes.

9. **If a physician arranges to furnish CCM services to his/her patients “incident to” using a case management entity outside the billing practice, does the billing physician need to ever see the patient face-to-face?**

Yes, as provided in the CY 2014 final rule (78 FR 74425), CCM must be initiated by the billing practitioner during a comprehensive Evaluation & Management (E/M) visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the CCM service and can be separately billed to the PFS, but is required before CCM services can be provided directly or under other arrangements. The billing practitioner must discuss CCM with the patient at this visit. While informed patient consent does not have to be obtained during this visit, it is an opportunity to obtain the required consent. The face-to-face visit included in transitional care management (TCM) services (CPT 99495 and 99496) qualifies as a comprehensive visit for CCM initiation. CPT codes that do not involve a face-to-face visit by the billing practitioner or are not payable by Medicare (such as CPT 99211, anticoagulant management, online services, telephone and other E/M services) do not meet the requirement for the visit that must occur before CCM services are furnished. If the practitioner furnishes a comprehensive E/M, AWV, or IPPE and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.

10. **Do face-to-face activities count as billable time?**

CPT 99490 describes activities that are not typically or ordinarily furnished face-to-face, such as telephone communication, review of medical records and test results, and consultation and exchange of health information with other providers. If these activities are occasionally provided by clinical staff face-to-face with the patient but would ordinarily be furnished non-face-to-face, the time may be counted towards the 20 minute minimum to bill CPT 99490. However, see #11 below regarding care coordination services furnished on the same day as an E/M visit.

11. **Medicare and CPT allow billing of E/M visits during the same service period as CPT 99490. If an E/M visit or other E/M service is furnished the same day as CCM services, how do I allocate the total time between CPT 99490 and the other E/M code(s)?**

Under longstanding Medicare guidance, only one E/M service can be billed per day unless the conditions are met for use of modifier -25. Time cannot be counted twice, whether it is face-to-face or non-face-to-face time, and Medicare and CPT specify certain codes that cannot be billed for the same service period as CPT 99490 (see #12, 13 below). Face-to-face time that would otherwise be considered part of the E/M service that was furnished cannot be counted towards CPT 99490. Time spent by clinical staff providing non-face-to-face services within the scope of the CCM service can be counted towards CPT 99490. If both an E/M and the CCM code are billed on the same day, modifier -25 must be reported on the CCM claim.

12. **Medicare and CPT specify that CCM and TCM cannot be billed during the same month. Does this mean that if the 30-day TCM service period ends during a given calendar month and 20 minutes of qualifying CCM services are subsequently provided on the remaining days of that calendar month, CPT code 99490 cannot be billed that month to the PFS?**

CPT 99490 could be billed to the PFS during the same calendar month as TCM, if the TCM service period ends before the end of a given calendar month and at least 20 minutes of qualifying CCM services are subsequently provided during that month. However we expect that the majority of the time, CCM and TCM will not be billed during the same calendar month.
13. Are there any other services that cannot be billed under the PFS during the same calendar month as CPT 99490?

Yes, Medicare does not allow CPT 99490 to be billed during the same service period as home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182) or certain ESRD services (CPT 90951-90970) because care management is an integral part of all of these services. Also see CPT coding guidance for a list of additional codes that cannot be billed during the same month as CPT 99490. There may be additional restrictions on billing for practitioners participating in a CMS model or demonstration program; if you participate in one of these separate initiatives, please consult the CMS staff responsible for these initiatives with any questions on potentially duplicative billing.

14. Can I bill CPT 99490 if the beneficiary dies during the service period?

CPT 99490 can be billed if the beneficiary dies during the service period, as long as at least 20 minutes of qualifying services were furnished during that calendar month and all other billing requirements are met.

15. Will practitioners be able to use an acceptably certified electronic health record (EHR) technology for which certification expires mid-year in order to bill for CCM? For example, can they use technology certified to the 2011 Edition to fulfill the scope of services required to bill CPT 99490 in 2015 once this technology no longer bears a “2011 Edition certified” mark?

Yes. Under the CCM scope of services, practitioners must use technology certified to the Edition(s) of certification criteria that is acceptable for the EHR Incentive Programs as of December 31st of the year preceding each CCM payment year. In certain years, this may mean that practitioners can fulfill the scope of services requirement using multiple Editions of certification criteria. For instance, for payment in 2015, practitioners may use technology certified to either the 2011 or 2014 Edition of certification criteria to meet the EHR scope of service requirements, as both Editions could be used to meet the requirements of the EHR Incentive Programs as of December 31, 2014. This remains true for a given PFS payment year even after ONC-Authorized Certification Bodies (ONC-ACBs) have removed the certifications issued to technology certified to a given acceptable edition (e.g., the 2011 Edition for CCM payment in 2015) as a result of the relevant criteria being removed from the Code of Federal Regulations. Thus, practitioners using an acceptable EHR technology that loses its certification mid-year may still use that technology to fulfill the certified EHR criteria for billing CPT 99490 during the applicable payment year.


No, Section 103 of the MACRA codifies payment broadly for chronic care management services under the PFS, authorizing PFS payment after January 1, 2015, for CCM services furnished by physicians and the non-physician practitioners that Medicare generally recognizes to furnish and bill for E/M services (physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives). It does not impact the current billing and payment rules for CPT 99490. It provides that provision of an AWV or IPPE in advance shall not be a condition of payment for CCM services, which is consistent with our current policy. It also provides that payment shall not be duplicative of other Medicare payments, consistent with the rules we have implemented to date regarding duplicative payment for CPT 99490.

17. Where can I find more guidance on CCM billing requirements?

The scope of service elements and other requirements for billing CCM to the PFS are also laid out in the CY 2014 and CY 2015 PFS final rules (CMS-1600-FC, CMS-1612-FC and CMS-1612-F2, available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html) on the CMS website). Most of the requirements were finalized in the CY 2014 PFS final rule, effective CY 2015. The CY 2015 final rule with comment period and correction notice address supervision and other “incident to” rules, electronic health record and other electronic technology requirements, valuation, and intersection with CMS’ care coordination models and demonstrations. Regarding the intersection with CMS’ care coordination models and demonstrations, please consult the CMS staff responsible for those projects. You may also direct questions to your Medicare Administrative Contractor.

**Hospital Outpatient Prospective Payment System (OPPS)**

18. **Are hospital outpatient departments (HOPDs) eligible to bill CPT code 99490 under the OPPS?**

Yes, CPT code 99490 is payable under the OPPS when certain requirements are met (see details in question #19 on billing requirements). As CPT code 99490 is defined as a physician-directed service, the OPPS provides payment to the HOPD when the hospital’s clinical staff furnishes the service at the direction of the physician (or other appropriate practitioner). Payment under the OPPS represents only payment for the facility portion of the service. Payment for the physician’s (or other appropriate practitioner’s) time directing CCM services in the HOPD setting is made under the PFS at the facility rate.

19. **What are the requirements to bill CCM under the OPPS?**

CPT code 99490 is a physician-directed service that is only payable under the OPPS when the hospital’s clinical staff furnishes the service at the direction of the physician (or other appropriate practitioner). The billing physician or practitioner directing the CCM services must meet the requirements to bill CCM services under the PFS, when the CCM service is furnished in the physician office or the hospital outpatient department. A Fact Sheet on CCM including requirements to bill CCM services to the PFS is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf) on the CMS website.

Specifically, a hospital outpatient department may bill and be paid for CCM services furnished to eligible hospital outpatients under the OPPS if the hospital’s clinical staff furnishes at least 20 minutes of care management services under the direction of the physician (or other appropriate practitioner) during the calendar month and the billing physician or practitioner directing the CCM services satisfies the billing requirements for CPT code 99490 under the PFS including the following requirements:

- **Patient Eligibility**—Patient has multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

- **Patient Agreement**—Patient consent to receive CCM services has been obtained by the practitioner and documented in the medical record.

- **CCM Scope of Service Elements** including Structured Data Reporting, Care Plan, Access to Care, and Care Management of the patient are furnished by the hospital. The full listing of required CCM Scope of Service Elements is located in the CY 2014 and CY 2015 PFS final rules (CMS-1600-FC, CMS-1612-FC and CMS-1612-F2, available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html) on the CMS website).

- **Hospital furnished the CCM services using a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year.**
year preceding each Medicare PFS payment year (referred to as “CCM certified technology”). The hospital must also meet the requirements to use electronic technology in providing CCM services, such as 24/7 access to the care plan, and electronic sharing of the care plan and clinical summaries (other than by fax), specified in the CY 2014 and CY 2015 PFS final rules.

20. How does CMS define a “hospital outpatient” for whom a hospital may bill CCM services (CPT code 99490)?

Per section 20.2 of publication 100-04 of the “Medicare Claims Processing Manual,” a hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital. Since CPT code 99490 will ordinarily be performed non face-to-face (see # 10 above), the patient will typically not be a registered outpatient when receiving the service. In order to bill for the service, the hospital’s clinical staff must provide at least 20 minutes of CCM services under the direction of the billing physician or practitioner. Because the beneficiary has a direct relationship with the billing physician or practitioner directing the CCM service, we would expect a beneficiary to be informed that the hospital would be performing care management services under their physician or other practitioner’s direction.

21. When CCM services are furnished by a physician in a hospital outpatient department, can the physician and the hospital both bill Medicare for the CCM service?

Yes, when certain conditions are met. Specifically, when CCM services are furnished by a physician in a hospital outpatient department to an eligible patient, the physician may bill Medicare for CPT code 99490 under the PFS reporting place of service (POS) 22 (outpatient hospital), which will indicate that PFS payment should be made at the facility rate, and the hospital may bill for CPT code 99490 under the OPPS.

22. Can more than one hospital bill and be paid for furnishing CCM services if the patient has been a registered hospital outpatient at more than one hospital over a 12 month span? If only one hospital can bill and receive payment for CCM services, which hospital is allowed to bill?

CPT code 99490 is only payable under the OPPS when the hospital’s clinical staff furnishes the CCM service at the direction of a qualified physician (or other appropriate practitioner). As only one physician or practitioner is allowed to bill under the PFS for CPT 99490 during a calendar month service period, accordingly, only one hospital is allowed to bill and be paid for CPT code 99490 for a particular beneficiary during a calendar month service period. We would expect the hospital billing for CPT code 99490 under physician direction to have access to the patient’s consent to receive CCM services documented in the patient’s medical record. The patient may choose a different practitioner to furnish CCM at the conclusion of the service period, at which time the practitioner assuming the provision of CCM services will be required to have the patient consent of CCM services documented in the patient’s medical record. New patient consent is only required if the patient chooses a new practitioner to furnish CCM services, in which case a new consent must be documented in the patient’s medical record prior to furnishing the service.

23. Is CPT code 99490 payable to provider-based hospital outpatient departments under the hospital OPPS? May a hospital-owned practice that is not provider-based bill the OPPS for CCM services?

A provider-based outpatient department of a hospital is part of the hospital and therefore may bill for CCM services furnished to eligible patients, provided that it meets all applicable requirements. A hospital-owned practice that is not provider-based to a hospital is not part of the hospital and, therefore, not eligible to bill for services under the
OPPS; but the physician (or other qualifying practitioner) practicing in the hospital-owned practice may bill under the PFS for CCM services furnished to eligible patients, provided all PFS billing requirements are met.

24. What is the supervision level for CCM services furnished in the hospital setting?

CPT code 99490 is assigned a general supervision level under the OPPS when furnished in the hospital setting. General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Additional Information

To review the provisions included in the Calendar Year (CY) 2015 PFS proposed rule go to: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-07-03-1.html and scroll down to read the section titled: Primary Care and Complex Chronic Care Management.

To review the Revisions to Payment Policies under the PFS, Clinical Laboratory Fee Schedule and Other Revisions to Part B for CY 2014 (CMS-1600-FC) go to page 186: CMS-1600-FC (PDF version) on the Internet.

Page 10 of the CCM Services Fact Sheet outlines a comprehensive list of resources with Web addresses for additional information on CCM services.

Kentucky & Ohio


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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Note: This article was revised on April 27, 2015, to reflect an updated Change Request (CR). That CR, made changes to the Attachments I and II with regard to new and deactivated codes (pages 4-5 below) . All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9167 and informs Medicare providers about the updating of specific drug and biological HCPCS codes that occur quarterly. It alerts providers that the July file includes new HCPCS Codes.
CR9167 also updates Chapter 17, Section 20.1.2 (Average Sales Price (ASP) Payment Methodology) in the “Claims Processing Manual” to address the use of a compounded drug not otherwise classified (NOC) code on claims for compounded drugs. Make sure that your billing staffs are aware of these changes.

Summary of New HCPCS Codes in CR9167

CR9167 adds the following HCPCS codes with the effective dates noted.

<table>
<thead>
<tr>
<th>Effective for Claims with Dates of Service on or after:</th>
<th>HCPCS Code</th>
<th>Long Description</th>
<th>Short Description</th>
<th>Type of Service (TOS)</th>
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<tr>
<td>March 6, 2015</td>
<td>Q5101</td>
<td>Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram</td>
<td>Inj filgrastim g-csf biosim</td>
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<tr>
<td>July 1, 2015</td>
<td>Q9976</td>
<td>Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron</td>
<td>Inj Ferric Pyrophosphate Cit</td>
<td>1, L</td>
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<tr>
<td>July 1, 2015</td>
<td>Q9978</td>
<td>Netupitant 300 mg and Palonosetron 0.5 mg, oral</td>
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<tr>
<td>July 1, 2015</td>
<td>Q9977</td>
<td>Compounded Drug, Not Otherwise Classified</td>
<td>Compounded Drug NOC</td>
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</tr>
</tbody>
</table>

Note: The Medicare Physician Fee Schedule Status Indicator for all four codes above is E.

CR9167 also updates Section 20.1.2 Average Sales Price (ASP) Payment Methodology in Chapter 17 of the “Medicare Claims Processing Manual” to show that, beginning in July 2015, claims for compounded drugs should be submitted using a compounded drug, NOC HCPCS code.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

**Kentucky & Ohio**

**MM9152:** Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – July Calendar Year (CY) 2015 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

**MLN Matters® Number:** MM9152  
**Effective Date:** January 1, 2015 - Effective for dates of service on or after January 1, 2015, unless otherwise stated

**Related CR Release Date:** May 15, 2015  
**Related CR Transmittal #:** R3259CP  
**Related Change Request (CR) #:** CR 9152  
**Implementation Date:** July 6, 2015

Note: This article was revised on April 27, 2015, to reflect an updated Change Request (CR). That CR, made changes to the Attachments I and II with regard to new and deactivated codes (pages 4-5 below). All other information remains the same.
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.

Provider Action Needed
This article is based on Change Request (CR) 9152 which amends payment files that were previously issued to your MAC based upon the CY2015 MPFS Final Rule.

Affected providers should be aware that MACs will only adjust claims brought to their attention. Please make sure your billing staff is aware of these changes.

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

Payment files were previously issued to your MAC based on the CY2015 MPFS Final Rule, which was published in the Federal Register and effective for services furnished between January 1, 2015, and December 31, 2015 (See http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf on the Internet).

Quarterly Update to the MPFSDB July CY 2015 Update
The Medicare Access and CHIP Reauthorization Act of 2015 allowed the zero percent update that would have ended on March 31, 2015, to continue through to June 30, 2015, and allows for a 0.5 percent from July 1, 2015, to December 31, 2015. It also extends the physician work geographic practice cost index (GPCI) floor of 1.0, and the therapy cap exceptions process, through December 2017.

CR9152 provides files for MPFS changes that are effective for dates of service January 1, 2015, through June 30, 2015, at the zero percent update, and files for changes effective for dates of service on or after July 1, 2015, at the 0.5 percent rate.

The attachment in CR9152 lists new codes Q5101, Q9976, Q9977, Q9978, 0392T, 0393T, 90620, 90621, and 90697 with the applicable “HCPCS Effective Date” for each code. Tables 1-3 below also list those codes.

In accordance with Chapter 23 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf), Section 30.1 of the “Medicare Claims Processing Manual”, MACs will give providers 30-day notices before implementing the changes identified in CR 9152.

Your MAC will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, they will adjust claims brought to their attention.

New Codes: Table 1

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Q5101</th>
<th>Q9976</th>
<th>Q9977</th>
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<td>1, L</td>
<td>1, P</td>
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<tr>
<td>HCPCS Coverage Code</td>
<td>D</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Long Descriptor</td>
<td>Injection, Filgrastim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(G-CSF), Biosimilar,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 microgram</td>
<td>Injection, Ferric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pyrophosphate Citrate Solution, 0.1 mg of iron</td>
<td>Compounded Drug,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Otherwise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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### New Codes: Table 1

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<tr>
<th>HCPCS Code</th>
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<th>Q9977</th>
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<tbody>
<tr>
<td>Short Descriptor</td>
<td>Inj filgrastim g-csf</td>
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</tr>
<tr>
<td>biosim</td>
<td>Inj Ferric</td>
<td></td>
<td></td>
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<tr>
<td>Pyrophosphate Cit</td>
<td>Compounded Drug</td>
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<td></td>
</tr>
<tr>
<td>NOC</td>
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<tr>
<td>Full Non-Facility PE RVU</td>
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<td>0.00</td>
</tr>
<tr>
<td>Full Facility PE RVU</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Malpractice RVU</td>
<td>0.00</td>
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<tr>
<td>Site of Service</td>
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</tr>
<tr>
<td>PC/TC</td>
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<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Global Surgery</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>Pre</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Intra</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Post</td>
<td>0.00</td>
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<tr>
<td>Multiple Procedure</td>
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<tr>
<td>Bilateral Surgery Indicator</td>
<td>9</td>
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<td>9</td>
</tr>
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<td>Assistant Surgery Indicator</td>
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<td>9</td>
</tr>
<tr>
<td>Co-Surgery Indicator</td>
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<td>9</td>
</tr>
<tr>
<td>Team Surgery Indicator</td>
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<tr>
<td>Physician Supervision</td>
<td></td>
<td></td>
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<tr>
<td>Diagnostic Indicator</td>
<td>09</td>
<td>09</td>
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</tr>
<tr>
<td>Diagnostic Family Imaging</td>
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<tr>
<td>Indicator</td>
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<tr>
<td>Non-Facility PE used for OPPS</td>
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<tr>
<td>Payment Amount</td>
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<td>0.00</td>
</tr>
<tr>
<td>Facility PE used for OPPS</td>
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<tr>
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### New Codes: Table 2

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<th>0393T</th>
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<td>2, 8</td>
<td>2, 8</td>
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<td>C</td>
</tr>
<tr>
<td>Long Descriptor</td>
<td>Netupitant 300 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Palonosetron 0.5 mg, oral</td>
<td>Laparoscopy,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band)</td>
<td>Removal of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>esophageal sphincter augmentation device</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Short Descriptor</td>
<td>Netupitant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palonosetron oral</td>
<td>Lap es sph augment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dev place</td>
<td>Es sph augmnt device</td>
<td></td>
<td></td>
</tr>
<tr>
<td>removal</td>
<td></td>
<td></td>
<td></td>
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<td>MPFSDB Record Date</td>
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### New Codes: Table 2

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<tr>
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<tr>
<td>Full Facility PE RVU</td>
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<td>0.00</td>
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<tr>
<td>Malpractice RVU</td>
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<tr>
<td>Site of Service</td>
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<td>PC/TC</td>
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<tr>
<td>Global Surgery</td>
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<tr>
<td>Intra</td>
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<tr>
<td>Post</td>
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<tr>
<td>Multiple Procedure Indicator</td>
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</tr>
<tr>
<td>Bilateral Surgery Indicator</td>
<td>9</td>
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<tr>
<td>Assistant Surgery Indicator</td>
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<tr>
<td>Co-Surgery Indicator</td>
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<tr>
<td>Team Surgery Indicator</td>
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<tr>
<td>Physician Supervision</td>
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<tr>
<td>Diagnostic Indicator</td>
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</tr>
<tr>
<td>Diagnostic Family Imaging</td>
<td></td>
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<tr>
<td>Indicator</td>
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<td>99</td>
<td>99</td>
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<tr>
<td>Non-Facility PE used for OPPS Payment Amount</td>
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<tr>
<td>Facility PE used for OPPS Payment Amount</td>
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<tr>
<td>MP Used for OPPS Payment Amount</td>
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### New Codes: Table 3

<table>
<thead>
<tr>
<th>HCPCS Code</th>
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<th>90621</th>
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<td>C</td>
</tr>
<tr>
<td>Long Descriptor</td>
<td>Meningococcal vaccine, Serogroup B, 2 dose schedule, for intramuscular use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recombinant lipoprotein vaccine, Serogroup B, 3 dose schedule, for intramuscular use</td>
<td>Diphtheria, tetanus</td>
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<td></td>
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<tr>
<td>toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenza type b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRP-OMP conjugate vaccine, and hepatitis B vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(DTaP-IPV-Hib- HepB), for intramuscular use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short Descriptor</td>
<td>Menb rp w/omv vaccine im</td>
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### New Codes: Table 3

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<tr>
<th>HCPCS Code</th>
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<th>90621</th>
<th>90697</th>
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<tr>
<td>Full Facility PE RVU</td>
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<td>0.00</td>
</tr>
<tr>
<td>Malpractice RVU</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Site of Service</td>
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<td>0</td>
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</tr>
<tr>
<td>PC/TC</td>
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<tr>
<td>Global Surgery</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>Pre</td>
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<td>0.00</td>
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<tr>
<td>Intra</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>Post</td>
<td>0.00</td>
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<tr>
<td>Multiple Procedure Indicator</td>
<td>9</td>
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<tr>
<td>Bilateral Surgery Indicator</td>
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<td>Assistant Surgery Indicator</td>
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<tr>
<td>Co-Surgery Indicator</td>
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<tr>
<td>Team Surgery Indicator</td>
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</tr>
<tr>
<td>Physician Supervision Indicator</td>
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<tr>
<td>Diagnostic Family Imaging Indicator</td>
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</tr>
<tr>
<td>Non-Facility PE used for OPPS Payment Amount</td>
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</tr>
<tr>
<td>Facility PE used for OPPS Payment Amount</td>
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<td>MP Used for OPPS Payment Amount</td>
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The following changes are effective for dates of service on and after January 1, 2015.

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<tr>
<th>CPT/HCPCS</th>
<th>Modifier</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>34839</td>
<td>PC/TC Indicator = 0</td>
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</tr>
<tr>
<td>88366</td>
<td>Non-Facility PE RVU = 5.27; Facility PE RVU = 5.27</td>
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<tr>
<td>88366</td>
<td>TC</td>
<td>Non-Facility PE RVU = 4.76; Facility PE RVU = 4.76</td>
</tr>
<tr>
<td>93355</td>
<td>Multiple Surgery Indicator = 6</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Information

You may want to review the following articles:


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.
**MM9159: July 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files**

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:** MM9159  
**Related Change Request (CR) #:** CR 9159  
**Related CR Release Date:** May 15, 2015  
**Effective Date:** July 1, 2015  
**Related CR Transmittal #:** R3258CP  
**Implementation Date:** July 6, 2015

**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) 9159 which instructs MACs to download and implement the July 2015 Average Sales Price (ASP) drug pricing files and, if released by CMS, the April 2015, January 2015, October 2014, and July 2014 ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 6, 2015, with dates of service July 1, 2015, through September 30, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

**Background**

The Medicare Modernization Act of 2003 (MMA; Section 303(c) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the “Medicare Claims Processing Manual” (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER, [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf)).

The following table shows how the quarterly payment files will be applied:

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<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
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<tbody>
<tr>
<td>July 2015 ASP and ASP NOC</td>
<td>July 1, 2015, through September 30, 2015</td>
</tr>
<tr>
<td>April 2015 ASP and ASP NOC</td>
<td>April 1, 2015, through June 30, 2015</td>
</tr>
<tr>
<td>January 2015 ASP and ASP NOC</td>
<td>January 1, 2015, through March 31, 2015</td>
</tr>
<tr>
<td>October 2014 ASP and ASP NOC</td>
<td>October 1, 2014, through December 31, 2014</td>
</tr>
<tr>
<td>July 2014 ASP and ASP NOC</td>
<td>July 1, 2014, through September 30, 2014</td>
</tr>
</tbody>
</table>
NOTE: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Kentucky & Ohio

MM9177: July Quarterly Update for 2015 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: MM9177
Related CR Release Date: May 15, 2015
Related CR Transmittal #: R3257CP
Related Change Request (CR) #: CR 9177
Effective Date: January 1, 2015 - for implementation of fee schedule amounts for codes in effect on January 1, 2015; July 1, 2015 for all other changes
Implementation Date: July 6, 2015

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

This article is based on Change Request (CR) 9177 which advises providers of the July 2015 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 staff is aware of these updates.

Background

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

Section 1834 (a), (h), and (i) of the Social Security Act requires payment on a fee schedule basis for 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 and casts, and intraocular lenses (IOLs) inserted in a physician’s office.
Key Points

Specific Coding and Pricing Issues

1. As part of this update, fees are established for Healthcare Common Procedure Coding System (HCPCS) code A4602, which was added to the HCPCS file effective January 1, 2015. This item has been paid on a local fee schedule basis prior to this update. Claims for code A4602 that have already been processed and have dates of service on or after January 1, 2015, may not be adjusted to reflect newly established fees.


3. As of July 1, 2015, HCPCS codes describing vacuum erection systems are statutorily excluded from Medicare coverage and are not payable when billed to Medicare. The fee schedules for the following vacuum erection system HCPCS codes will be removed from the DMEPOS fee schedule file effective July 1, 2015:
   a. L7900 Male vacuum erection system; and
   b. L7902 Tension ring, for vacuum erection device, any type, replacement only, each

   Effective for claims with dates of service on or after July 1, 2015, claims submitted with HCPCS codes L7900 and L7902 will be denied using the following codes:
   - Claim Adjustment Reason Codes (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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
   - Remittance Advice Remark Code (RARC) N425 – “Statutorily excluded service(s)”.

   Also, note that MACs will follow existing procedures for denying statutorily non-covered items, when these codes are billed with the “GY” modifier.

4. As part of the January 2015 update, fee schedules for HCPCS code A7048 (Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each) were added to the DMEPOS fee schedule file. In response to questions received on these fee schedule amounts, CMS is providing the following clarification:
   a. HCPCS code A7048 describes all supplies, including the appropriately sized collection container, that are needed for a collection unit change when draining an implanted catheter.
   b. A7048 is used for each single, complete collection and represents a supply allowance rather than a specifically defined kit.
   c. Items included in this code are not limited to pre-packaged kits that are bundled by manufacturers or distributors.
   d. The A7048 supplies include, but are not limited to, drainage tubing, gauze, dressings and any number of collection units of various sizes needed to capture the drainage for each complete drainage collection.
   e. Since included in A7048, supplies that are used in a collection change should not be separately billed using miscellaneous codes.
Additional Information


Kentucky & Ohio

MM9087 Revised: ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to National Coverage Determinations (NCDs)—2nd Maintenance CR

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: MM9087 Revised
Related CR Release Date: May 20, 2015
Effective Date: April 6, 2015 - For designated ICD-9 updates and all local system edits (ICD-9 and ICD-10); July 1, 2015 - For all ICD-9 shared system edits; October 1, 2015 - For all ICD-10 shared system edits (or whenever ICD-10 is implemented)

Note: This article was revised on May 22, 2015, to reflect a revised Change Request. That revision changed C8681 to L8681 in spreadsheet NCD160.18 and added a requirement to change the provider query eligibility screens for bone density to support CWF updates to NCD150.3. The transmittal number, CR release date and link to the CR also changed. 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.

Provider Action Needed

This article is based on CR9087 which is the second maintenance update of ICD-10 conversions and coding updates specific to National Coverage Determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR7818, CR8109, CR8197, and CR 8691. Links to related MLN Matters® Articles MM7818, MM8109, MM8197, and MM8691 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates. 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. Make sure that your billing staffs are aware of these spreadsheets attached to CR9087 for the following 13 NCDs:
Background

CR9087’s purpose is to create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, plus all associated coding infrastructure such as HCPCS/CPT codes, reason/remark codes, frequency edits, POS/TOB/provider specialties, and so forth. The requirements described in CR9087 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the attached Medicare NCD spreadsheets.

Please note that there are 10 spreadsheets attached to CR9087. These spreadsheets relate to 13 NCDs, and provide pertinent policy/coding information necessary to implement ICD-10. Further, you should be aware that NCD policies may contain specific covered, non-covered and/or discretionary diagnosis coding. These spreadsheets are designated as such and are based on current NCD policies and their corresponding edits. Nationally covered and non-covered diagnosis code editing is finite and cannot be revised without subsequent discussions with CMS. Discretionary code lists are to be regarded as CMS’ compilation of discretionary codes based on current analysis/interpretation. Local MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions. Nothing contained in CR9087 should be construed as new policy.

Some coding details are as follows:

1. The ICD-10 diagnosis/procedure codes associated with the NCDs attached to CR9087 are not to be implemented until October 1, 2015, or until ICD-10 is implemented.

2. 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).

3. When denying claims associated with the attached NCDs, 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

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<thead>
<tr>
<th>NCD</th>
<th>NCD Title</th>
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<tbody>
<tr>
<td>20.29</td>
<td>Hyperbaric Oxygen Therapy</td>
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<tr>
<td>20.9.1</td>
<td>Ventricular Assist Devices</td>
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<tr>
<td>50.3</td>
<td>Cochlear Implantation</td>
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<tr>
<td>80.2</td>
<td>Photodynamic Therapy</td>
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<tr>
<td>80.2.1</td>
<td>Ocular Photodynamic Therapy (OPT)</td>
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<tr>
<td>80.3</td>
<td>Photosensitive Drugs</td>
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<td>80.3.1</td>
<td>Verteporfin</td>
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<td>110.10</td>
<td>Intravenous Iron Therapy</td>
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<tr>
<td>150.3</td>
<td>Bone (Mineral) Density Studies</td>
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<tr>
<td>160.18</td>
<td>Vagus Nerve Stimulation</td>
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<tr>
<td>180.1</td>
<td>Medical Nutrition Therapy</td>
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<tr>
<td>210.2</td>
<td>Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer</td>
</tr>
<tr>
<td>250.3</td>
<td>Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases</td>
</tr>
</tbody>
</table>
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).

**NOTE:** For modifier GZ, use CARC 50 and MSN 8.81 (If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/supplier).

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

**Kentucky & Ohio**

**Web-Based Training Course:**

**Power Mobility Pearls for the Practicing Physician**

The Centers for Medicare & Medicaid Services (CMS) has announced that Medicare Minute MD℠: Power Mobility Pearls for the Practicing Physician Web-Based Training Course (WBT) is available. This WBT is designed to provide education on the fundamentals of a Power Mobility Devices compliance program. Continuing education credits are available to learners who successfully complete this course. See course description for more information.

In this course, Dr. Robert Hoover, CGS’ chief medical officer - Jurisdiction C DME MAC, offers a no-nonsense look at documentation requirements for Power Mobility Devices from a practicing physician’s perspective. The video is a collaboration of all DME MAC jurisdictions for the benefit of physicians who prescribe Power Mobility Devices (PMDs).

To access the WBT, go to MLN Products ([http://www.cms.gov/MLNProducts](http://www.cms.gov/MLNProducts)), scroll to the bottom of the Web page and under “Related Links” click on “Web-Based Training Courses.”

The video was produced by CGS and is one in a series of other videos for practicing physicians who prescribe durable medical equipment items/services.
“CGS is constantly looking for ways to incentivize physicians to learn more about Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) because of the symbiotic relationship between practicing physicians and suppliers.” Dr. Hoover said. “Both are focused on the Medicare beneficiary but each is dependent upon the other to deliver the care that is required. Our Medicare Minute MD\textsuperscript{SM} video program helps strengthen those ‘provider/supplier’ relationships through effective education. To reach a broad audience of physician and other healthcare providers, CGS partnered with CMS and the MLN WBT program and we’re proud to offer Continuing Medical Education (CME) credit for the Medicare Minute MD\textsuperscript{SM}: Power Mobility Pearls for the Practicing Physician video program.”

To date, only the “Power Mobility Pearls for the Practicing Physician” WBT is available to earn CME credits.

Kentucky & Ohio

Stay Informed and Join the CGS ListServ Notification Service

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

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

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

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

HHA and Hospice Providers

Quarterly Provider Update

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

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.
To receive notification when regulations and program instructions are added throughout the quarter, go to https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/CMS-Quarterly-Provider-Updates-E-mail-Updates.html to sign up for the Quarterly Provider Update (electronic mailing list).

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

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

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**News Flash Items**

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

- **Coding for ICD-10-CM: More of the Basics MLN Connects® Video** - In this MLN Connects® video on Coding for ICD-10-CM: More of the Basics (https://www.youtube.com/watch?v=s86pXhhOG7c&list=UUhHTRPxz8awulGat3SAk), Sue Bowman from the American Health Information Management Association (AHIMA) and Nelly Leon-Chisen from the American Hospital Association (AHA) provide a basic introduction to ICD-10-CM coding. The objective of this video is to enhance viewers' understanding of the characteristics and unique features of ICD-10-CM, as well as similarities and differences between ICD-9-CM and ICD-10-CM. Run time: 36 minutes.

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

- **National Nutrition Month** - The Centers for Medicare & Medicaid Services reminds health care professionals that March is National Nutrition Month®- a time to “Bite into a Healthy Lifestyle” with informed food choices now and throughout the year. Medicare provides coverage for a variety of nutrition-related health services that can help eligible beneficiaries reach their nutrition and dietary goals. Read more (http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Health-Observance-Messages-New-Items/2015-03-05-National-Nutrition-Month.html?DLPage=1&DLSort=0&DLSortDir=descending) to learn about nutrition-related health services covered by Medicare.

- **New Product “The Medicare Home Health Benefit” Web-Based Training Course – Released**
  - “The Medicare Home Health Benefit” Web-Based Training Course (WBT) was released and is now available. This WBT is designed to provide education on Medicare home health services. It includes information on qualifying for home health services, consolidated billing, therapy services, and billing and payment. Continuing education
credits are available to learners who successfully complete this course. See course
description for more information.

To access the WBT, go to MLN Products (http://www.cms.gov/Outreach-and-Education/
Medicare-Learning-Network-MLN/MLNProducts/index.html?redirect=/MLNProducts),
scroll to the bottom of the Web page and under “Related Links” click on “Web-Based
Training Courses.”

• REVISED product from the Medicare Learning Network®
  ▪ “Guidelines for Teaching Physicians, Interns, and Residents” (http://www.cms.gov/
Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/
Teaching-Physicians-Fact-Sheet-ICN006437.pdf) Fact Sheet (ICN 006347),
downloadable.

• NEW products from the Medicare Learning Network®
  ▪ “The DMEPOS Competitive Bidding Program Repairs and Replacements Fact Sheet,”
Fact Sheet, ICN 905283, downloadable

The MAC Satisfaction
Indicator (MSI) is used by
the Centers for Medicare & Medicaid
Services (CMS) to measure provider satisfaction
with CGS. Please help by participating in the
10 minute survey. To access the survey,
please refer to the attachment on
the next page.
Your feedback matters!

Your opinion is important to us. Please help us by participating in the 2015 MAC Satisfaction Indicator (MSI) survey. Complete the quick 10 minute survey to share your experience with the services we provide.

You can access the survey at

https://cfigroup.qualtrics.com/SE/?SID=SV_3UBxriB8PrHZ0ZEN&MAC_BRNC=16

The CFI Group is conducting this survey on behalf of the Centers for Medicare & Medicaid Services (CMS). We appreciate your willingness to participate and assure you your responses will be kept completely confidential.

If you experience technical difficulties accessing or submitting the survey, please contact CFI Support at nripberger@cfigroup.com.