**Articles contained in this edition are current as of November 28, 2016.**

**Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology CPT codes. Descriptions and other data only are copyrighted 2017 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.**
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Unsolicited/Voluntary Refunds

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

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

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


If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.866.276.9558.

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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 non-regulatory changes to Medicare including transmittals, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The purpose of the Quarterly Provider Update is to:
Inform providers about new developments in the Medicare program;
Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
Ensure that providers have time to react and prepare for new requirements;
Announce new or changing Medicare requirements on a predictable schedule; and
Communicate the specific days that CMS business will be published in the Federal Register.

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

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

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.866.276.9558 and choose Option 1.

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Stay Informed and Join the CGS ListServ Notification Service

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

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

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

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

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Each year eligible physician, practitioners and suppliers have the opportunity to make their calendar year Medicare participation decision. Thirty days after the enrollment period ends, December 31, 2016, CGS will provide a directory of Kentucky and Ohio participating physicians, practitioners, and suppliers on our website. This information will be accessible from the Provider
Kentucky & Ohio

MM9533 Revised: Comprehensive Care for Joint Replacement Model (CJR) Provider Education

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/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9533 Revised  
Related CR Release Date: February 19, 2016  
Related CR Transmittal #: R140DEMO  
Related Change Request (CR) #: CR 9533  
Effective Date: April 1, 2016  
Implementation Date: April 4, 2016

Note: This article was revised on November 9, 2016, to correct a typo in the list of G-codes in the lower half of page 6. The original article mentioned code G9499 and it should have stated G9489. 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 Comprehensive CJR services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9533 supplies information to providers about the CJR model. The intent of the CJR model is to promote quality and financial accountability for episodes of care surrounding a Lower-Extremity Joint Replacement (LEJR) or reattachment of a lower extremity procedure. CJR will test whether bundled payments to certain acute care hospitals for LEJR episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. Make sure that your billing staffs are aware of these changes.

Background

Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. Under this authority, CMS published a rule to implement a new five year payment model called the Comprehensive Care for Joint Replacement (CJR) model on April 1, 2016.

Under the CJR model, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. Episodes will begin with admission to an acute care hospital for an LEJR procedure that is paid under the Inpatient Prospective Payment System (IPPS) through Medical Severity Diagnosis-Related Group (MS-DRG) 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital.

Key Points of CR9533

LEJR procedures are currently paid under the IPPS through: MS-DRG 469 or MS-DRG 470. The episode will include the LEJR procedure, inpatient stay, and all related care covered under...
Medicare Parts A and B within the 90 days after discharge. The day of discharge is counted as the first day of the 90-day bundle.

**CJR Episodes of Care**

The model requires all hospitals paid under the IPPS in selected geographic areas to participate in the CJR model, with limited exceptions. A list of the selected geographic areas and participant hospitals is available at

**CJR Participant Hospitals**

[https://innovation.cms.gov/initiatives/cjr](https://innovation.cms.gov/initiatives/cjr) on the Internet. Participant hospitals initiate episodes when an LEJR procedure is performed within the hospital and will be at financial risk for the cost of the services included in the bundle. Eligible beneficiaries who elect to receive care at these hospitals will automatically be included in the model.

**CJR Model Beneficiary Inclusion Criteria**

Medicare beneficiaries whose care will be included in the CJR model must meet the following criteria upon admission to the anchor hospitalization:

- The beneficiary is enrolled in Medicare Part A and Part B;
- The beneficiary’s eligibility for Medicare is not on the basis of the End-Stage Renal Disease benefit;
- The beneficiary is not enrolled in any managed care plan;
- The beneficiary is not covered under a United Mine Workers of America health plan; and
- Medicare is the primary payer.

If at any time during the episode the beneficiary no longer meets all of these criteria, the episode is canceled.

**CJR Performance Years**

CMS will implement the CJR model for 5 performance years, as detailed in the table below. Performance years for the model correlate to calendar years with the exception of performance year 1, which is April 1, 2016, through December 31, 2016.

<table>
<thead>
<tr>
<th>CJR Model: 5 Performance Years</th>
<th>Date for Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Year 1 (calendar year 2016)</td>
<td>Episodes that start on or after April 1, 2016, and end on or before December 31, 2016</td>
</tr>
<tr>
<td>Performance Year 2 (calendar year 2017)</td>
<td>Episodes that end between January 1, 2017, and December 31, 2017, inclusive</td>
</tr>
<tr>
<td>Performance Year 3 (calendar year 2018)</td>
<td>Episodes that end between January 1, 2018, and December 31, 2018, inclusive</td>
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<tr>
<td>Performance Year 4 (calendar year 2019)</td>
<td>Episodes that end between January 1, 2019, and December 31, 2019, inclusive</td>
</tr>
<tr>
<td>Performance Year 5 (calendar year 2020)</td>
<td>Episodes that end between January 1, 2020, and December 31, 2020, inclusive</td>
</tr>
</tbody>
</table>

**CJR Episode Reconciliation Activities**

CMS will continue paying hospitals and other providers and suppliers according to the usual Medicare fee-for-service payment systems during all performance years. After completion of a performance year, Medicare will compare or “reconcile” actual claims paid for a beneficiary during the 90 day episode to an established target price. The target price is an expected amount for the total cost of care of the episode. Hospitals will receive separate target prices to reflect expected spending for episodes assigned to MS-DRGs 469 and 470, as well as hip fracture status. If the actual spending is lower than the target price, the difference will be paid to the hospital, subject to certain adjustments, such as for quality. This payment will be called a reconciliation payment. If actual spending is higher than the target price, hospitals will be
responsible for repayment of the difference to Medicare, subject to certain adjustments, such as for quality.

**Identifying CJR Claims**

To validate the retroactive identification of CJR episodes, CMS is associating the Demonstration Code 75 with the CJR initiative. This code will also be utilized in future CRs to operationalize a waiver of the three-day stay requirement for covered Skilled Nursing Facility (SNF) services, effective for CJR episodes beginning on or after January 1, 2017.

Medicare will automatically apply the CJR demonstration code to claims meeting the criteria for inclusion in the demonstration. **Participant hospitals need not include demonstration code 75 on their claims.** Instructions for submission of claims for SNF services rendered to beneficiaries in a CJR episode of care will be communicated once the waiver of the three-day stay requirement is operationalized.

**Waivers and Amendments of Medicare Program Rules**

The CJR model waives certain existing payment system requirements to provide additional flexibilities to hospitals participating in CJR, as well as other providers that furnish services to beneficiaries in CJR episodes. The purpose of such flexibilities would be to increase LEJR episode quality and decrease episode spending or provider and supplier internal costs, or both, and to provide better, more coordinated care for beneficiaries and improved financial efficiencies for Medicare, providers, and beneficiaries.

**Post-Discharge Home Visits**

In order for Medicare to pay for home health services, a beneficiary must be determined to be “home bound.” A beneficiary is considered to be confined to the home if the beneficiary has a condition, due to an illness or injury, that restricts his or her ability to leave home except with the assistance of another individual or the aid of a supportive device (that is, crutches, a cane, a wheelchair or a walker) or if the beneficiary has a condition such that leaving his or her home is medically contraindicated. Additional information regarding the homebound requirement is available in the “Medicare Benefit Policy Manual;” Chapter 7 ([https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf)), Home Health Services, Section 30.1.1, Patient Confined to the Home.


For those CJR beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment, CMS will waive the “incident to” direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence any time during the episode, subject to the following conditions:

- Licensed clinical staff will provide the service under the general supervision of a physician or NPP. These staff can come from a private physician office or may be either an employee or a contractor of the participant hospital.
- Services will be billed under the MPFS by the supervising physician or NPP or by the hospital or other party to which the supervising physician has reassigned his or her billing rights.
- Up to 9 post discharge home visits can be billed and paid per beneficiary during each CJR episode, defined as the 90-day period following the anchor hospitalization.
The service cannot be furnished to a CJR beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.

All other Medicare rules for coverage and payment of services incident to a physician's service continue to apply.

As described in the “Medicare Claims Processing Manual”, Chapter 12 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf), Sections 40-40.4, Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for CJR, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions. All other Medicare rules for global surgery billing during the 90 day post-operative period continue to apply.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

The service will be billed under the MPFS with a HCPCS G-code (G9490) specific to the CJR post-discharge home visit, as listed in Attachment A. The post-discharge home visit HCPCS code will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for post-discharge home visits for the CJR model will be accepted only when the claim contains the CJR specific HCPCS G-Code. Although CMS is associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code.

Additional information on billing and payment for the post-discharge home visit HCPCS G-Code will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the relative value units (RVUs) and payment for this HCPCS code will be included in the MPFS final rules and recurring updates each year.

Billing and Payment for Telehealth Services

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service. Additional information regarding Medicare telehealth services is available in the “Medicare Benefit Policy Manual,” Chapter 15 (https://www.cms.gov/Regulations-and-Guidance/Manuals/Downloads/bp102c15.pdf), Section 270 and the “Medicare Claims Processing Manual,” Chapter 12 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf), Section 190.

Under CJR, CMS will allow a beneficiary in a CJR episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in a CJR episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

- Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the CJR model.
The telehealth geographic area waiver and the allowance of home as an originating site under the CJR model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.

The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the CJR episode definition.

If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).

If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the CJR model that reflect the home setting.

For CJR telehealth home visits billed with HCPCS codes G9484, G9485, G9488, and G9489, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient's home during the visit or document the reason that such a high-level visit would not require such personnel.

Physicians billing distant site telehealth services under these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.

The facility fee paid by Medicare to an originating site for a telehealth service will be waived if the service was originated in the beneficiary's home.

The telehealth home visits will be billed under the MPFS with one of nine HCPCS G-code specific to the CJR telehealth home visits. Those codes are G9481, G9482, G9483, G9484, G9485, G9586, G9487, G9488, and G9489. Attachment A of CR9533 provides the long descriptors of these codes. The telehealth home visit HCPCS codes will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for telehealth home visits for the CJR model will be accepted only when the claim contains one of nine of the CJR specific HCPCS G-Code. Although CMS is associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code. Additional information on billing and payment for the telehealth home visit HCPCS G-Codes will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

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.

Document History

<table>
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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>November 9, 2016</td>
<td>Article revised to correct typo and to show correct code of G9489 on page 6</td>
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<tr>
<td>February 22, 2016</td>
<td>Initial issuance</td>
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**MM9681: Modifications to the National Coordination of Benefits Agreement Crossover Process**

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/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM9681  
**Related Change Request (CR) #:** CR 9681  
**Related CR Release Date:** October 27, 2016  
**Effective Date:** April 1, 2017  
**Related CR Transmittal #:** R1733OTN  
**Implementation Date:** April 3, 2017

**Provider Types Affected**

This MLN Matters® Article is intended for providers, including hospices, submitting institutional claims to Medicare Administrative Contractors (MACs) requiring Coordination of Benefits (COB) for services provided to Medicare beneficiaries.

**Provider Action Needed**

Change Request (CR) 9681 modifies Medicare's Part A claims processing system to, among other things:

- Always ensure that a Remittance Advice Remark Code (RARC) accompanies claim denials tied to Claims Adjustment Reason Code (CARC) 16, as required.
- Prevent duplicate entry of hospital day counts expressed as value codes (for example, value code 80, 81, 82).
- Prevent reporting of Present on Admission (POA) indicators on outpatient Coordination of Benefits (COB) facility claims.

Make sure your billing staff is aware of these changes.

**Background**

The Council for Affordable Quality Healthcare Committee for Operating Rules for Information Exchange (CAQH CORE) dictates which CARC and RARC combinations must be used by all covered entities in the healthcare industry. Medicare routinely reports CARCs and RARCs on Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Institute (ASC) 835 Electronic Remittance Advice (ERA) transactions in accordance with HIPAA requirements. Medicare also includes CARCs and RARCs within HIPAA ASC 837-N claims transactions, including 837 Coordination of Benefits (COB) claims transactions. However, within 837 claims transactions, RARCs are referred to as "Claim Payment Reason Codes" and appear within the 2320 Medicare Inpatient Adjudication Information (MIA) and Medicare Outpatient Adjudication Information (MOA) segments.

As a result of systems issues, MACs are not always including a valid and relevant RARC in the 2320 MIA field when they deny Medicare claims. Medicare crossover claims are often being rejected by supplemental payers as a consequence. Though not the only example, this scenario seems to occur frequently when a claim service line is editing to deny with CARC code 16—"Claim lacks information or has submission/billing error(s) which is needed for adjudication......" CR9681 will ensure that at least one informational RARC is provided to comply with HIPAA and CAHQCORE requirements.
The Part A system is producing instances of duplicated hospital day counts on outbound 837 institutional COB/crossover claims. CR9681 remedies this situation. Important: Hospital billing staffs should avoid entering hospital day counts via Direct Data Entry (DDE) screens.

Lastly, at present there is no editing with the Part A system to prevent the entry of a POA indicator on incoming outpatient facility claims. CR9681 remedies this issue by returning to the provider (RTP) any outpatient claim (type of bill other than 11x, 18x, 21x, 41x, and 82x) that contains a POA indicator. Important: Billing vendors for hospitals should make it a practice to only include POA indicators on 11x, 18x, 21x, 41x, and 82x type of bill (TOB) claims submitted to Medicare.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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MM9708: Internet-Only Manual, Pub. 100-06, Chapter 3, Section 90 (Provider Liability) Revision

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/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9708 Related Change Request (CR) #: CR 9708
Related CR Release Date: November 18, 2017 Effective Date: February 21, 2017
Related CR Transmittal #: R275FM Implementation Date: February 21, 2017

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

What You Need to Know
Change Request (CR) 9708 provides additional criteria for determining when a contractor shall assume a physician, provider, or supplier should have known about a policy or rule. CR9708 updates Chapter 3, Section 90 of the “Medical Financial Management Manual.” Make sure your billing staff is aware of these updates.

Background
Contractors shall assume the provider, physician, or supplier should have known about a policy or rule, if:

• The policy or rule is in the provider, physician, or supplier manual or in Federal regulations;
• The Centers for Medicare & Medicaid Services (CMS) or a CMS contractor provided
general notice to the medical community concerning the policy or rule;
• CMS, a CMS contractor, or the Office of Inspector General (OIG) gave written notice of the policy or rule to the particular provider/physician/supplier;
• The provider, physician, or supplier was previously investigated or audited as a result of not following the policy or rule;
• The provider, physician, or supplier previously agreed to a Corporate Integrity Agreement as a result of not following the policy or rule;
• The provider, physician, or supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements which are related to the policy or rule; or
• The provider, physician, or supplier previously received documented training/outreach from CMS or one of its contractors related to the same policy or rule.

Additional Information
The official instruction, CR9708, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R275FM.pdf. The revised Chapter 3, Section 90, of the manual is attached to CR9708.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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MM9716: New Physician Specialty Code for Hospitalist

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/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9716 Related Change Request (CR) #: CR 9716
Related CR Release Date: October 28, 2016 Effective Date: April 1, 2017
Related CR Transmittal #: R3637CP and R274FM Implementation Date: April 3, 2017

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

Provider Action Needed
Change Request (CR) 9716 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for Hospitalist. The new code for Hospitalist is C6. Make sure your billing staffs are aware of this physician specialty code.

Background
When they enroll in the Medicare program, physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O), or in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). CMS uses these Medicare physician specialty codes, which describe the specific/unique types of medicine that physicians (and certain other suppliers) practice, for programmatic and claims processing purposes.

Medicare will also recognize the new code of C6 as a valid specialty for the following edits:
Ordering/certifying Part B clinical laboratory and imaging, durable medical equipment (DME), and Part A home health agency (HHA) claims

Critical Access Hospital (CAH) Method II Attending and Rendering claims

Attending, operating, or other physician or non-physician practitioner listed on CAH claims

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/monitoring-programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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MM9726: New Place of Service (POS) Code for Telehealth and Distant Site Payment Policy

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/MLN Matters Articles/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9726
Related CR Release Date: August 12, 2016
Related CR Transmittal #: R3586CP
Related Change Request (CR) #: CR 9726
Implementation Date: January 3, 2017

Effective Date: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Provider Types Affected

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

Provider Action Needed

CR 9726 updates the Place of Service (POS) code set by creating a new code (POS 02) for Telehealth services, effective January 1, 2017. You should ensure that your billing staffs are aware of this new POS code.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards, and their implementation guides, adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains. The POS code set provides setting information necessary to appropriately pay Medicare and Medicaid claims.

As a payer, Medicare must be able to recognize, as valid, any valid code from the POS code set that appears on the HIPAA standard claim transaction. Further, unless prohibited by national
policy to the contrary, Medicare not only recognizes such codes, but also adjudicates claims that contain these codes.

At times, Medicaid has had a greater need for code specificity than has Medicare; and many of the new codes, over the past few years, have been developed to meet Medicaid’s needs. While Medicare does not always need this greater specificity in order to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

Effective January 1, 2017, CMS is creating a new POS code 02 for use by the physician or practitioner furnishing telehealth services from a distant site. CR 9726 updates the current POS code set by adding this new code (POS 02: Telehealth), with a descriptor of “The location where health services and health related services are provided or received, through telecommunication technology.”

Medicare will pay for these services using the Medicare Physician Fee Schedule (MPFS), including the use of the MPFS facility rate for Method II Critical Access Hospitals billing on type of bill 85x. This Telehealth POS code would not apply to originating site facilities billing a facility fee.

Remember that under HIPAA, the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Modifiers GT (via interactive audio and video telecommunications systems) and GQ (via an asynchronous telecommunications system) are still required when billing for Medicare Telehealth services. If you bill for Telehealth services with POS code 02, but without the GT or GQ modifier, your MAC will deny the service with the following messages:

- Group Code CO
- Claim Adjustment Reason Code (CARC) 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present)
- Remittance Advice Remarks Code (RARC) MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information)

Conversely, if you bill for Telehealth services with modifiers GT or GQ, but without POS code 02, your MAC will deny the service with the following messages:

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

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/. 
### MM9727: Payment Reduction for X-Rays Taken Using Film

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/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

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<td>CR 9727</td>
<td>August 12, 2016</td>
<td>January 1, 2017</td>
<td>R3583CP</td>
<td>January 3, 2017</td>
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</tbody>
</table>

#### Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit Part B claims to Medicare Administrative Contractors (MACs) for X-ray imaging services provided to Medicare beneficiaries.

#### Provider Action Needed

Change Request (CR) 9727 reduces the technical component (TC) (including the TC portion of a global service) of X-ray imaging services provided using film. Make sure that your billing staff are aware of these changes.

#### Background

The Consolidated Appropriations Act of 2016 (Section 502(a)(1)) is titled “Medicare Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Medicare Imaging Payment Provision.”

It amends the Social Security Act by reducing the payment amounts under the Physician Fee Schedule (PFS) by 20 percent for the technical component (and the technical component of the global fee) of imaging services that are X-rays taken using film. This is effective for services provided on or January 1, 2017.

To implement this provision, the Centers for Medicare & Medicaid Services (CMS) has created modifier FX (X-ray taken using film). Beginning in 2017, claims for X-rays using film must include modifier FX that will result in the applicable payment reduction for which payment is made under the Medicare Physician Fee Schedule (MPFS).

The MPFS amount cannot be greater than the Outpatient Prospective Payment System (OPPS) amount. MACs will compare the OPPS Facility and Non-Facility Payment fields to the MPFS Facility and Non-Facility amounts and use the lower amount. The FX modifier will reduce whichever of these two amounts applies by 20 percent.

Beginning January 1, 2017, for claims in which the FX modifier reduction has been applied, MACs group code CO and the following messages:

- Claim Adjustment Reason Code 237 – Legislated/Regulatory Penalty. 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.)
- Remittance Advice Remarks Code N775 - Payment adjusted based on x-ray radiograph on film.

Note that the beneficiary is not liable for the FX modifier payment reduction.
**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

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**Kentucky & Ohio**

**MM9751: Coding Revisions to National Coverage Determination (NCDs)**

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/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM9751 **Revised**  
**Related CR Release Date:** November 17, 2016  
**Related CR Transmittal #:** R1753OTN  
**Related Change Request (CR) #:** CR 9751

**Effective Date:** January 1, 2017 - Unless otherwise noted  
**Implementation Date:** January 3, 2017

**Note:** This article was revised on November 17, 2016 to reflect the revised CR9571 issued on the same day. CR9571 was revised to change the NCD180.1 effective date in spreadsheet history to 1/1/16, in NCD160.18 remove reactivation of MCS 012L from spreadsheet history and business requirement, and in NCD220.6.20 to remove reference to ‘primary diagnosis’ regarding diagnosis code Z00.6 in spreadsheet, and reference FiSS new RC for value code D4 in spreadsheet history. In the article, the CR release date, transmittal number and the Web address for CR9571 are revised. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

Background
The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of the NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable as of October 1, 2015.

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. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed.

CR9751 makes adjustments to the following NCDs:

- NCD 20.7 Percutaneous Transluminal Angioplasty (PTA)
- NCD 20.19 Ambulatory Blood Pressure Monitoring (ABPM)
- NCD 20.33 Transcatheter Mitral Valve Repair (TMVR) Therapy
- NCD 40.1 Diabetes Self-Management Training (DSMT)
- NCD 160.18 Vagus Nerve Stimulation (VNS)
- NCD 180.1 Medical Nutrition Therapy (MNT)
- NCD 190.3 Cytogenetic Studies
- NCD 220.6.17 FDG PET for Solid Tumors
- NCD 220.6.20 PET Beta Amyloid in Dementia/Neurological/ Disorders
- NCD 230.18 Sacral Nerve Stimulation (SNS) for Urinary Incontinence
- NCD 260.1 Adult Liver Transplants


Remember that coding and payment are areas of the Medicare Program that are separate and distinct from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate:

- Remittance Advice Remark Codes (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; with
- Claim Adjustment Reason Codes (CARC)
  - 50 - These are non-covered services because this is not deemed a “medical necessity” by the payer;
  - 96 - Non-covered charge(s); or
  - 119 Benefit maximum for this time period has been reached.
Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is on file). Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

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.

Document History

<table>
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<td>August 19, 2016</td>
<td>Initial Issuance</td>
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Kentucky & Ohio

**MM9767: Implement Operating Rules - Phase III**

Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9767  Related Change Request (CR) #: CR 9767
Related CR Release Date: November 23, 2016  Effective Date: April 1, 2017
Related CR Transmittal #: R3665CP  Implementation Date: April 3, 2017

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical
Provider Action Needed

Change Request (CR) 9767 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE EFT & ERA Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

CR9767 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2017. This update is based on the Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC) updates as posted at the WPC website on or about November 1, 2016. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.


Note: Per Affordable Care Act mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
MM9769: Claim Status Category and Claim Status Codes 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/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9769
Related Change Request (CR) #: CR 9769
Related CR Release Date: November 18, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3661CP
Implementation Date: April 3, 2017

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

Provider Action Needed
Change Request (CR) 9769 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes. The codes sets are available on the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January 2017 committee meeting shall be posted on these sites on or about February 1, 2017. Your MAC will complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes, by the implementation date of CR 9769.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 9769.

Additional Information
MM9771: Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

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/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9771
Related CR Release Date: October 7, 2016
Related CR Transmittal #: R3618CP

Effective Date: January 1, 2017
Implementation Date: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

Provider Action Needed
Change Request (CR) 9771 provides the 2017 annual update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, K codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency.

The HCPCS codes in the table below are being added to the HH consolidated billing therapy code list, effective for services on or after January 1, 2017. These codes replace HCPCS codes: 97001, 97002, 97003, 97004.
G0279 and G0280 are deleted from the HH consolidated billing therapy code list. These codes were replaced with 0019T and should have been removed from the list in earlier updates. Effective January 1, 2015, these codes were redefined for another purpose. MACs will adjust claims denied due to HH consolidated billing with HCPCS codes G0279 and G0280 and line item dates of service on or after January 1, 2015, if brought to their attention.

Additional Information


Kentucky & Ohio

**MM9774: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update**

The Centers for Medicare & Medicaid Services (CMS) 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/2016-MLN-Matters-Articles.html

**MLN Matters® Number:** MM9774

**Related CR Release Date:** November 18, 2016

**Related CR Transmittal #:** R3660CP

**Effective Date:** April 1, 2017

**Implementation Date:** April 3, 2017

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9774 updates the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists and 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 and 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 RARCs, as appropriate, that provide either supplemental explanation for a monetary adjustment or policy information that generally
applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

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

CMS provides this CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in this CR, contractors must implement on the date specified on the WPC website, which is at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated three times a year and may not match the CMS release schedule. For this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR 9695).

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Kentucky & Ohio

MM9782: 2017 Annual Update to the Therapy Code List

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/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9782  Related Change Request (CR) #: CR 9782
Related CR Release Date: November 10, 2016  Effective Date: January 1, 2017
Related CR Transmittal #: R3654CP  Implementation Date: January 3, 2017

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

What You Need to Know
This article is based on Change Request (CR) 9782 which updates the therapy code list for Calendar Year (CY) 2017 by adding eight “always therapy” codes (97161 – 97168) for physical therapy (PT) and occupational therapy (OT) evaluative procedures. CR 9782 also deletes the
four codes currently used to report these services (97001 – 97004). Make sure your billing staffs are aware of these updates.

Background

Section 1834(k)(5) of the Social Security Act requires that all claims for outpatient rehabilitation therapy services and CORF services be reported using the uniform coding system. The Calendar Year (CY) 2017 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) is the coding system used for reporting these services.

For CY 2017, the Current Procedural Terminology (CPT) Editorial Panel created eight new codes (97161-97168) to replace the 4-code set (97001-97004) for Physical Therapy (PT) and Occupational Therapy (OT) evaluative procedures. The new CPT code descriptors for PT and OT evaluative procedures include specific components that are required for reporting as well as the corresponding typical face-to-face times for each service.

Evaluation Codes. The CPT Editorial Panel created three new codes to replace each existing PT and OT evaluation code, 97001 and 97003, respectively. These new evaluation codes are based on patient complexity and the level of clinical decision-making – low, moderate and high complexity: for PT, codes 97161, 97162 and 97163; and for OT, codes 97165, 97166 and 97167.

Re-evaluation Codes. One new PT code, 97164, and one new OT code, 97168, were created to replace the existing codes – 97002 and 97004, respectively. The re-evaluation codes are reported for an established patient’s when a revised plan of care is indicated.

Just as their predecessor codes were, the new codes are “always therapy” and must be reported with the appropriate therapy modifier, GP or GO, to indicate that the services are furnished under a PT or OT plan of care, respectively.

The new PT Evaluative procedure codes are listed in the chart below with their short descriptors* and the required corresponding therapy modifier:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor*</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>97161</td>
<td>PT EVAL LOW COMPLEX 20 MIN</td>
<td>GP</td>
</tr>
<tr>
<td>97162</td>
<td>PT EVAL MOD COMPLEX 30 MIN</td>
<td>GP</td>
</tr>
<tr>
<td>97163</td>
<td>PT EVAL HIGH COMPLEX 45 MIN</td>
<td>GP</td>
</tr>
<tr>
<td>97164</td>
<td>PT RE-EVAL EST PLAN CARE</td>
<td>GP</td>
</tr>
</tbody>
</table>

The new OT Evaluative procedure codes are listed in the chart below with their short descriptors* and the required OT therapy modifier:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor*</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>97165</td>
<td>OT EVAL LOW COMPLEX 30 MIN</td>
<td>GO</td>
</tr>
<tr>
<td>97166</td>
<td>OT EVAL MOD COMPLEX 45 MIN</td>
<td>GO</td>
</tr>
<tr>
<td>97167</td>
<td>OT EVAL HIGH COMPLEX 60 MIN</td>
<td>GO</td>
</tr>
<tr>
<td>97168</td>
<td>OT RE-EVAL EST PLAN CARE</td>
<td>GO</td>
</tr>
</tbody>
</table>

*NOTE: Please note that the short descriptors cannot be used in place of the CPT long descriptions which officially define each new PT and OT service. Refer to the two tables with these new CPT codes and their long descriptions that appear at the end of this article.

Additional Information

The therapy code list of “always” and “sometimes” therapy services is available at http://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/监测-项目-医疗保险-FFS-核查-项目-互动-地图/.

Table 1. For CY 2017 - New CPT Codes and Long Descriptors for PT Evaluative Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97161</td>
<td>Physical therapy evaluation: low complexity, requiring these components:</td>
</tr>
<tr>
<td></td>
<td>• A history with no personal factors and/or comorbidities that impact the plan of care;</td>
</tr>
<tr>
<td></td>
<td>• An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;</td>
</tr>
<tr>
<td></td>
<td>• A clinical presentation with stable and/or uncomplicated characteristics; and</td>
</tr>
<tr>
<td></td>
<td>• Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.</td>
</tr>
<tr>
<td></td>
<td>Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>97162</td>
<td>Physical therapy evaluation: moderate complexity, requiring these components:</td>
</tr>
<tr>
<td></td>
<td>• A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care;</td>
</tr>
<tr>
<td></td>
<td>• An examination of body system(s) using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;</td>
</tr>
<tr>
<td></td>
<td>• An evolving clinical presentation with changing characteristics; and</td>
</tr>
<tr>
<td></td>
<td>• Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.</td>
</tr>
<tr>
<td></td>
<td>Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>97163</td>
<td>Physical therapy evaluation: high complexity, requiring these components:</td>
</tr>
<tr>
<td></td>
<td>• A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care;</td>
</tr>
<tr>
<td></td>
<td>• An examination of body system(s) using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;</td>
</tr>
<tr>
<td></td>
<td>• A clinical presentation with unstable and unpredictable characteristics; and</td>
</tr>
<tr>
<td></td>
<td>• Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.</td>
</tr>
<tr>
<td></td>
<td>Typically, 45 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>97164</td>
<td>Re-evaluation of physical therapy established plan of care, requiring these components:</td>
</tr>
<tr>
<td></td>
<td>• An examination including a review of history and use of standardized tests and measures is required; and</td>
</tr>
<tr>
<td></td>
<td>• Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome.</td>
</tr>
<tr>
<td></td>
<td>Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>

Table 2. For CY 2017: New CPT Codes and Long Descriptors for OT Evaluative Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97165</td>
<td>Occupational therapy evaluation, low complexity, requiring these components:</td>
</tr>
<tr>
<td></td>
<td>• An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem;</td>
</tr>
<tr>
<td></td>
<td>• An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and</td>
</tr>
<tr>
<td></td>
<td>• Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options.</td>
</tr>
<tr>
<td></td>
<td>Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component.</td>
</tr>
<tr>
<td></td>
<td>Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>
Table 2. For CY 2017: New CPT Codes and Long Descriptors for OT Evaluative Procedures

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97166</td>
<td>Occupational therapy evaluation, moderate complexity, requiring these components:</td>
</tr>
<tr>
<td>• An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance;</td>
<td></td>
</tr>
<tr>
<td>• An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and</td>
<td></td>
</tr>
<tr>
<td>• Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component.</td>
<td></td>
</tr>
<tr>
<td>Typically, 45 minutes are spent face-to-face with the patient and/or family.</td>
<td></td>
</tr>
<tr>
<td>97167</td>
<td>Occupational therapy evaluation, high complexity, requiring these components:</td>
</tr>
<tr>
<td>• An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance;</td>
<td></td>
</tr>
<tr>
<td>• An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and</td>
<td></td>
</tr>
<tr>
<td>• Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component.</td>
<td></td>
</tr>
<tr>
<td>Typically, 60 minutes are spent face-to-face with the patient and/or family.</td>
<td></td>
</tr>
<tr>
<td>97168</td>
<td>Re-evaluation of occupational therapy established plan of care, requiring these components:</td>
</tr>
<tr>
<td>• An assessment of changes in patient functional or medical status with revised plan of care;</td>
<td></td>
</tr>
<tr>
<td>• An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and</td>
<td></td>
</tr>
<tr>
<td>• A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required.</td>
<td></td>
</tr>
<tr>
<td>Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
<td></td>
</tr>
</tbody>
</table>

Kentucky & Ohio

**MM9797: New Waived Tests**

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/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM9797  
**Related Change Request (CR) #:** CR 9797  
**Related CR Release Date:** November 23, 2016  
**Effective Date:** January 1, 2017  
**Related CR Transmittal #:** R3666CP  
**Implementation Date:** January 3, 2017

**Provider Types Affected**

This MLN Matters® Article is intended for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

Change Request (CR) 9797 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify the MACs of the new tests so that they can accurately process claims. Make sure that your billing staffs are aware of these CLIA-related changes.

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.cmsmedicare.com](http://www.cmsmedicare.com). © 2017 Copyright, CGS Administrators, LLC.
Background
The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR9797 (that is, CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0477QW</td>
<td>February 12, 2016</td>
<td>Greenbrier International, Inc. Assured THC One Step Marijuana Test Cassette</td>
</tr>
<tr>
<td>G0477QW</td>
<td>February 12, 2016</td>
<td>Greenbrier International, Inc. Assured THC One Step Marijuana Test Strip</td>
</tr>
<tr>
<td>G0477QW</td>
<td>March 18, 2016</td>
<td>Safecare Biotech Urine Test Amphetamine Cassette</td>
</tr>
<tr>
<td>G0477QW</td>
<td>March 18, 2016</td>
<td>Safecare Biotech Urine Test Amphetamine Cup</td>
</tr>
<tr>
<td>G0477QW</td>
<td>March 18, 2016</td>
<td>Safecare Biotech Urine Test Amphetamine DipCard</td>
</tr>
<tr>
<td>G0477QW</td>
<td>March 18, 2016</td>
<td>Safecare Biotech Urine Test Cocaine Cassette</td>
</tr>
<tr>
<td>G0477QW</td>
<td>March 18, 2016</td>
<td>Safecare Biotech Urine Test Cocaine DipCard</td>
</tr>
<tr>
<td>G0477QW</td>
<td>March 18, 2016</td>
<td>Safecare Biotech Urine Test Marijuana Cassette</td>
</tr>
<tr>
<td>G0477QW</td>
<td>March 18, 2016</td>
<td>Safecare Biotech Urine Test Marijuana Cup</td>
</tr>
<tr>
<td>G0477QW</td>
<td>March 18, 2016</td>
<td>Safecare Biotech Urine Test Marijuana DipCard</td>
</tr>
<tr>
<td>G0477QW</td>
<td>March 18, 2016</td>
<td>Safecare Biotech Urine Test Marijuana DipCard with OPI 2000 Tests</td>
</tr>
<tr>
<td>G0477QW</td>
<td>June 9, 2016</td>
<td>Native Diagnostics International DrugSmart Multi-Panel Drug Screen Cup Tests</td>
</tr>
<tr>
<td>G0477QW</td>
<td>June 9, 2016</td>
<td>Native Diagnostics International DrugSmart Multi-Panel Drug Screen Cup with OPI 2000 Tests</td>
</tr>
<tr>
<td>G0477QW</td>
<td>June 9, 2016</td>
<td>Native Diagnostics International DrugSmart Dip Multi-Panel Drug Screen Dip Card Tests</td>
</tr>
<tr>
<td>G0477QW</td>
<td>June 9, 2016</td>
<td>On-Site Testing Specialists, Inc. On-Site Testing Specialists Multi-Panel Drug Screen Cup Tests</td>
</tr>
<tr>
<td>G0447QW</td>
<td>June 9, 2016</td>
<td>Alfa Scientific Designs, Inc. Instant-View Multi-Drug Urine Test Cup</td>
</tr>
<tr>
<td>G0477QW</td>
<td>July 18, 2016</td>
<td>Assure Tech. Co., Ltd. AssureTech Marijuana Dip Card Test</td>
</tr>
<tr>
<td>G0477QW</td>
<td>July 18, 2016</td>
<td>Assure Tech. Co., Ltd. AssureTech Marijuana Quick Cup Test</td>
</tr>
<tr>
<td>G0477QW</td>
<td>July 18, 2016</td>
<td>Assure Tech. Co., Ltd. AssureTech Methamphetamine Dip Card Test</td>
</tr>
<tr>
<td>G0477QW</td>
<td>July 18, 2016</td>
<td>Assure Tech. Co., Ltd. AssureTech Methamphetamine Quick Cup Test</td>
</tr>
<tr>
<td>G0477QW</td>
<td>July 18, 2016</td>
<td>Assure Tech. Co., Ltd. AssureTech Methamphetamine Strip Test</td>
</tr>
<tr>
<td>G0477QW</td>
<td>July 18, 2016</td>
<td>Assure Tech. Co., Ltd. AssureTech Methamphetamine Turn-Key Split Cup Test</td>
</tr>
</tbody>
</table>
### Medicare Bulletin • GR 2017-01

**Kentucky & Ohio**

**MM9806 Revised: Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2017**

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/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM9806 Revised  
**Related CR Release Date:** November 16, 2016  
**Related CR Transmittal #:** R3656CP  
**Related Change Request (CR) #:** CR 9806  
**Effective Date:** October 1, 2016  
**Implementation Date:** December 5, 2016

**Note:** This article was revised on November 17, 2016, to reflect the revised CR issued on November 16. In the article, the implementation date is now December 5, 2016. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9806 announces changes that will be included in the January 2017 quarterly release of the edit module for clinical diagnosis laboratory services. Make sure your billing staffs are aware of these changes to ensure proper billing to Medicare.

**Background**

The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was...
CR9806 communicates requirements to Medicare system maintainers and the MACs regarding changes to the NCD code lists used for laboratory claims edit software for January 2017. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-10-CM codes. Please see Section II (Business Requirements Table) of CR9806 for the lengthy list of codes added or deleted. Note that where codes are deleted, the effective date of deletion is September 30, 2016 and the effective date for codes added is October 1, 2016.

**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).

### Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 16, 2016</td>
<td>Article revised to show a revised implementation date of December 5, 2016.</td>
</tr>
<tr>
<td>September 23, 2016</td>
<td>Initial Issuance</td>
</tr>
</tbody>
</table>

### Kentucky & Ohio

**MM9817 Revised: Issuing Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of Qualified Medicare Beneficiaries (QMBs) for Medicare Cost-Sharing**

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/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM9817 Revised

**Related CR Release Date:** November 18, 2016

**Related CR Transmittal #:** R1757OTN

**Related Change Request (CR) #:** CR 9817

**Effective Date:** December 16, 2016

**Implementation Date:** March 8, 2017

**Note:** This article was revised on November 18, 2016, to reflect the revised CR9817 issued that same day. In the article, the effective date, CR release date, transmittal number, and the Web address for CR9817 are revised. The sample letters at the end of the article have slight wording changes to show that the Medicaid program also helps low-income beneficiaries pay their Medicare premiums. All other information remains the same.

### Provider Types Affected

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

Federal law bars Medicare providers from charging individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) for Medicare Part A and B deductibles, coinsurances, or copays. QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. Change Request (CR) 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing. Please make sure your billing staffs are aware of this aspect of your Medicare provider agreement.

**Background**

In 2013, approximately seven million Medicare beneficiaries were enrolled in QMB, a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost sharing.

State Medicaid programs are liable to pay Medicare providers who serve QMB individuals for the Medicare cost sharing. However, federal law permits states to limit provider payment for Medicare cost sharing to the lesser of the Medicare cost sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service provided. Regardless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to a QMB individual.

Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions, as described in Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); and 1848(g)(3) of the Social Security Act (the Act).

In July 2015, the Centers for Medicare & Medicaid Services issued a study finding that:

- Erroneous billing of QMB individuals persists
- Confusion about billing rules exists amongst providers and beneficiaries

**Note:** The study, titled “Access to Care Issues Among Qualified Medicare Beneficiaries (QMB),” is available at [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf).

In September 2016, all Medicare beneficiaries received “Medicare & You 2017,” which contains new language to advise QMB individuals about their billing protections. Also, a toll-free number ([1.800.MEDICARE](tel:1.800.MEDICARE)) is available to QMB individuals if they cannot resolve billing problems with their providers. In addition, effective September 17, 2016, Beneficiary Contact Center (BCC) Customer Service Representatives (CSRs) can identify a caller’s QMB status and advise them about their billing rights.

BCC CSRs will begin escalating beneficiary inquiries involving QMB billing problems that the beneficiary has been unable to resolve with the provider to the appropriate MAC. MACs will issue a compliance letter for all inquiries referred. This compliance letter will instruct named providers and suppliers to refund any erroneous charges and recall any past or existing QMB billing (including referrals to collection agencies).

MACs will also send a copy of the compliance letter to the named beneficiary, with a cover letter advising the beneficiary to show the mailing to the named provider and verify that the provider corrected the billing problem. Examples of these letters are included following the “Document History” section of this article.

**Additional Information**

If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

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<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>November 18, 2016</td>
<td>The effective date, CR release date, transmittal number, and the Web address for CR9817 are revised in the article due to a revised CR9817. The sample letters at the end of the article have slight wording changes to show that the Medicaid program also helps low-income beneficiaries pay their Medicare premiums.</td>
</tr>
<tr>
<td>November 4, 2016</td>
<td>Initial Issuance</td>
</tr>
</tbody>
</table>

### Example of Cover Letter for affected QMB Individuals sent by MAC

```
[month] [day], [year]
[address]
[City] ST [Zip]
Reference ID: (NPI, etc.)
Dear [Beneficiary Name]:

You contacted Medicare about a bill you got from [Provider/Supplier Name]. Then we sent [Provider/Supplier Name] the letter on the next page.

You are in the Qualified Medicare Beneficiary (QMB) program. It helps pay your Medicare premiums and costs. Medicare providers cannot bill you for Medicare deductibles, coinsurance, or copays for covered items and services.

The letter tells the provider to stop billing you and to refund you any amounts you already paid. Here's what you can do:

1. Show this letter to your provider to make sure they fixed your bill.
2. Tell all of your providers and suppliers you are in the QMB program.
3. Show your Medicare and your Medicaid or QMB cards each time you get items or services.

If you have questions about this letter, call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. Call 1.877.486.2048 if you use TTY.

Sincerely,

[Name]
[Title]
[MAC name]
```
Example of Compliance Letter Sent to Provider by the MAC

[month] [day], [year]
[address]
[City] ST [Zip]
Reference ID: (NPI, etc.)

Dear [Provider/Supplier Name]:

The Centers for Medicare & Medicaid Services (CMS) received information that [Provider/Supplier Name] is improperly billing [Medicare beneficiary name/HICN number] for Medicare cost-sharing. This beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program, a state Medicaid program that helps low-income beneficiaries pay their Medicare premiums and cost-sharing. Federal law says Medicare providers can’t charge individuals enrolled in the QMB program for Medicare Part A and B deductibles, coinsurance, or copays for items and services Medicare covers.

- Promptly review your records for efforts to collect Medicare cost-sharing from [Medicare beneficiary name/HICN number], refund any amounts already paid, and recall any past or existing billing (including referrals to collection agencies) for Medicare-covered items and services
- Ensure that your administrative staff and billing software exempt individuals enrolled in the QMB program from all Medicare cost-sharing billing and related collection efforts

Medicare providers must accept Medicare payment and Medicaid payment (if any) as payment in full for services given to individuals enrolled in the QMB program. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); 1848(g)(3) of the Social Security Act.)

Finally, please refer to this Medicare Learning Network (MLN) Matters® article for more information on the prohibited billing of QMBs: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf. If you have questions, please contact [MAC information].

Sincerely,
[Name]
[Title]
[MAC name]

Kentucky & Ohio

MM9841: Updates to Pub. 100-04, Chapters 8, 13 and 14 to Correct Remittance Advice Messages

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/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9841 Related Change Request (CR) #: CR 9841
Related CR Release Date: November 10, 2016  Effective Date: February 10, 2017
Related CR Transmittal #: R3650CP  Implementation Date: February 10, 2017

Provider Types Affected

This MLN Matters® Article is intended for physicians and providers, especially clinical diagnostic laboratories, ambulatory surgical centers, and end stage renal disease facilities submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9841 revises Chapters 8, 13, and 14 of the "Medicare Claims Processing Manual" to ensure that all remittance advice coding is consistent with nationally standard
operating rules. CR9841 also provides a format for consistently showing remittance advice coding throughout the "Medicare Claims Processing Manual."

Background

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry’s use of Electronic Data Interchange (EDI) transactions. Operating Rule 360: Uniform Use of Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs), regulates the way in which group codes, CARCs, and RARCs may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. The Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) authored this rule.

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. CR9841 updates Chapters 8, 13, and 14 of the manual to reflect the standard format and to correct any non-compliant code combinations. Certain sections of Chapter 8 that contained remittance advice codes are deleted since the instructions are now obsolete. Additional CRs will follow to provide similar revisions to the remaining chapters of the “Medicare Claims Processing Manual.”

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Kentucky & Ohio

MM9843: January 2017 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/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9843
Related CR Release Date: October 28, 2016
Related CR Transmittal #: R3640CP
Related Change Request (CR) #: CR 9843
Effective Date: January 1, 2017
Implementation Date: January 3, 2017

Provider Types Affected

This MLN Matters® Article is 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) 9843 provides the January 2017 quarterly update and instructs MACs to download and implement the January 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised October 2016, July 2016, April 2016, and the January 2016 Average Sales Price (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 January 3, 2017 with dates of service January 1, 2017, through March 31, 2017. MACs will not search and adjust claims previously processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs 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 Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the “Medicare Claims Processing Manual” at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

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

<table>
<thead>
<tr>
<th>Files</th>
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</tr>
</thead>
<tbody>
<tr>
<td>January 2017 ASP and ASP NOC</td>
<td>January 1, 2017, through March 31, 2017</td>
</tr>
<tr>
<td>October 2016 ASP and ASP NOC</td>
<td>October 1, 2016, through December 31, 2016</td>
</tr>
<tr>
<td>July 2016 ASP and ASP NOC</td>
<td>July 1, 2016, through September 30, 2016</td>
</tr>
<tr>
<td>April 2016 ASP and ASP NOC</td>
<td>April 1, 2016, through June 30, 2016</td>
</tr>
<tr>
<td>January 2016 ASP and ASP NOC</td>
<td>January 1, 2016, through March 31, 2016</td>
</tr>
</tbody>
</table>

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Kentucky & Ohio

**MM9847: Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 23.0, Effective January 1, 2017**

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/2016-MLN-Matters-Articles.html

**MLN Matters® Number:** MM9847  
**Related CR Release Date:** November 4, 2016  
**Related CR Transmittal #:** R3646CP  
**Effective Date:** January 1, 2017  
**Implementation Date:** January 3, 2017

**Provider Types Affected**

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
Provider Action Needed
Change Request (CR) 9847 instructs MACs of the normal update to the Correct Coding Initiative (CCI) Procedure to Procedure (PTP) edits, effective January 1, 2017. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) developed the National CCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The latest package of CCI PTP edits, Version 23.0, effective January 1, 2017, will be available via the CMS Data Center (CDC). A test file will be available on or about November 2, 2016, and a final file will be available on or about November 17, 2016.

Version 23.0 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. In order to simplify the use of CCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits.

CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file. Refer to the CMS NCCI webpage for additional information at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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MM9865: Therapy Cap Values for Calendar Year (CY) 2017

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/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9865
Related CR Release Date: November 4, 2016
Related CR Transmittal #: R3644CP
Effective Date: January 1, 2017
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) 9865, from which this article was developed, describes the amounts and policies for outpatient therapy caps for CY 2017. For physical therapy and speech-language pathology combined, the 2017 therapy cap will be $1,980. For occupational therapy, the cap for 2017 will be $1,980. Make sure that your billing staffs are aware of these therapy cap value updates.

Background
The Balanced Budget Act of 1997 (P.L. 105-33), Section 4541(c) applies annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B per beneficiary, commonly referred to as “therapy caps.” Therapy caps are updated each year based on the Medicare Economic Index.

An exception for the therapy caps for reasonable and medically necessary services has been in place since CY 2006. Originally required by Section 5107 of the Deficit Reduction Act of 2005, the exceptions process for the therapy caps has been continuously extended multiple times through subsequent legislation.

The current therapy caps exceptions process, as required by Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015, expires on December 31, 2017.

CR 9865 establishes that therapy caps for CY 2017 will be $1,980. MACs will update to this amount for physical therapy and speech-language pathology combined, and for occupational therapy.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
SE1434 Revised: Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs

The Centers for Medicare & Medicaid Services (CMS) has revised the following Special Edition 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/2016-MLN-Matters-Articles.html

MLN Matters® Number: SE1434 Revised Related Change Request (CR) #: N/A
Related CR Release Date: November 16, 2016 Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Note: The article was revised on November 16, 2016, to show a phased approach to enforcement that will begin in the second calendar quarter of 2017 and end with full implementation and enforcement of the Part D prescriber enforcement requirement on January 1, 2019.

Provider Types Affected

This MLN Matters® Special Edition is intended for physicians, dentists, and other eligible professionals who write prescriptions for Medicare beneficiaries for Medicare Part D drugs. The article is also directed to Medicare Part D plan sponsors.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F, “Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs” on May 23, 2014. CMS later published CMS-6107-IFC, “Medicare Program; Changes to the Requirements for Part D Prescribers,” an interim final rule with comment (“IFC”), that made changes to the Final Rule (CMS-4159-F), on May 6, 2015. Together, these rules require virtually all physicians and other eligible professionals, including dentists, who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be coverable under Part D, except in very limited circumstances. To allow sufficient time for the prescribers to enroll in Medicare and the Part D sponsors and the Pharmacy Benefit Managers (PBMs) to make the complex system enhancements needed to comply with the prescriber enrollment requirements, CMS announced a delay in enforcement of this rule until February 1, 2017.

While the full implementation date is January 2019, CMS encourages all providers who prescribe Part D drugs, but are not yet enrolled or validly opted out of Medicare, to enroll in the Medicare Program. Enrollment information is available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Part-D-Prescriber-Enrollment-About.html.

While CMS is committed to the implementation of the prescriber enrollment requirements, CMS also recognizes the need to minimize the impact on the beneficiary population and ensure beneficiaries have access to the care they need. To strike this balance, CMS will implement a multifaceted, phased approach which will align full enforcement of the Part D prescriber enrollment requirements with other ongoing CMS initiatives. Full enforcement of the Part D prescriber enrollment requirement is January 1, 2019.

In the lead-up to the January 1, 2019 full implementation date, CMS will undertake the following incremental strategic actions designed to increase on-going prescriber enrollment, while protecting beneficiaries and the Medicare program.
• **Precluded Providers** - Prescriptions will be denied at the point of sale from sanctioned providers including, but not limited to, providers that are currently excluded by the OIG, revoked by the Medicare program and non-enrolled providers with a felony conviction within the last 10 years. (Implementation in Second Quarter 2017)

• **Easy Enroll Application Process** - CMS will make an easy enrollment application process to enable providers to quickly enroll in Medicare. This process will allow providers to review, update, electronically sign and submit a pre-populated enrollment application online. (Implementation in Second Quarter 2017)

• **Targeted Risk-Based Prescriber Outreach** - CMS will begin targeted, prioritized risk-based outreach and education. This prioritized approach will include direct mailings and coordination with the Part D plans to enroll these prescribers. (Implementation in Second Quarter 2017)

• **Direct Mailing to all Non-Enrolled Providers** - CMS will target and send direct mailings via email and/or paper to all prescribers that are not enrolled in the program. In addition, direct mailing notifications will be triggered for unenrolled providers based on PDE events. (Implementation in Third Quarter 2017)

• **Current Education and Outreach** - CMS will continue with the current education and outreach efforts including such activities as stakeholder meetings and conferences, assembly meetings, and presentations. (Continuously on-going)

The purpose of these rules are to ensure that Part D drugs are prescribed only by physicians and eligible professionals who are qualified to do so under state law and under the requirements of the Medicare program and who do not pose a risk to patient safety. By implementing these rules, CMS is improving the integrity of the Part D prescription drug program by using additional tools to reduce fraud, waste, and abuse in the Medicare program. Prescribers who are determined to have a pattern or practice of prescribing Part D drugs that are abusive and represents a threat to the health and safety of Medicare enrollees or fails to meet Medicare requirements will have their billing privileges revoked under 42 USC 424.535 (a)(14).

**Background**

If you write prescriptions for covered Part D drugs and you are not already enrolled in Medicare in an approved status or have a valid record of opting out, you should submit an enrollment application or an opt-out affidavit to your Medicare Administrative Contractor (MAC) as soon as possible, so that the prescriptions you write for Part D beneficiaries are coverable as Medicare begins to enforce this requirement on February 1, 2017 with full implementation and enforcement slated for January 1, 2019.

**To enroll in Medicare for the limited purpose of prescribing:**


The CMS-855O is a shorter, abbreviated form and takes minimal time to complete. While the CMS-855O form states it is for physicians and non-physician practitioners who want to order and certify, it is also appropriate for use by prescribers, who want to enroll to also prescribe Part D drugs. (CMS is in the process of updating the CMS-855O form). If you do not see your specialty listed on the application, please select the Undefined Physician/Non-Physician Type option and identify your specialty in the space provided.
The average processing time for CMS-855O applications submitted online is 45 days versus paper submissions which is 60 days. However, your application could be processed sooner depending on the MAC's current workload.

To enroll to bill for services (and prescribe Part D drugs):

To enroll in Medicare to bill for your services, you may complete the CMS-855I application. The CMS-855R should also be completed if you wish to reassign your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries. All actions can be completed via PECOS or the paper enrollment application. For more information on enrolling in Medicare to bill for services refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.

If you are a physician or non-physician practitioner who wants to opt-out of Medicare, you must submit an opt-out affidavit to the MAC that services your geographic area. Physicians and non-physician practitioners should be aware that if they choose to opt-out of Medicare, they are not permitted to participate in a Medicare Advantage Plan. In addition, once a physician or non-physician practitioner has opted out they are not permitted to terminate their opt-out affidavit early. Section 1802(b)(3)(B)(ii) of the Act establishes the term of the opt-out affidavit. The Act does not provide for early termination of the opt-out term. Under CMS regulations, physicians and practitioners who have not previously submitted an opt-out affidavit under Section 1802(b)(3) of the Act, may choose to terminate their opt-out status within 90 days after the effective date of the opt-out affidavit, if the physician or practitioner satisfies the requirements of 42 CFR § 405.445(b). No other method of terminating opt-out status before the end of the two year opt-out term is available.

Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for 2 years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015, will automatically renew every 2 years. If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all MACs with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period. Valid opt-out affidavits signed before June 16, 2015 will expire 2 years after the effective date of the opt out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all MACs with which they would have filed claims absent the opt-out. For more information on the opt-out process, refer to MLN Matters® article SE1311, titled “Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries,” which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf and https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-06-25-eNews.html?DLPPage=1&DLEntries=10&DLSort=0&DLSortDir=descending&imagelink=y#.Toc422891549.

CMS would like to highlight the following limitations that apply to billing and non-billing providers:

- A resident is defined in 42 CFR § 413.75 as an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board. Interns, residents, and fellows may enroll in Medicare to prescribe if the state licenses them. Licensure can include a provisional license or similarly-regulated credential. Unlicensed interns, residents, and fellows must specify the teaching physician who is enrolled in Medicare as the authorized prescriber on a prescription for a Part D drug (assuming this
is consistent with state law). Licensed residents have the option to either enroll themselves or use the teaching physician’s name on prescriptions for Part D drugs, unless state law specifies which name is to be used. CMS strongly encourages teaching physicians and facilities to ensure that the NPI of the lawful prescriber under state law is included on prescriptions to assist pharmacies in identifying the correct prescriber and avoid follow up from the pharmacies, which experience rejected claims from Medicare Part D plans due to missing or wrong prescriber NPIs on the claims.

- The prescriber enrollment requirements also apply to physicians and non-physician practitioners who write prescriptions for Part D drugs and are employed by a Part A institutional provider (e.g., hospital, Federally Qualified Health Center (FQHC), Rural Health Center (RHC)). Since Part A institutional providers may bill for services provided by an employed physician or non-physician practitioner, the physician or non-physician practitioner may not have separately enrolled, unless he or she is also billing for Part B services. Therefore, if the physician or non-physician practitioner prescribes Part D drugs as an employee of the institutional provider, he or she must be enrolled in an approved status for their prescriptions to be coverable under Part D beginning June 1, 2016.

- “Other authorized prescribers” are exempt from the Medicare Part D prescriber enrollment requirement. In other words, prescriptions written by “other authorized prescribers are still coverable under Part D, even if the prescriber is not enrolled in or opted out of Medicare. For purposes of the Part D prescriber enrollment requirement only, “other authorized prescribers” are defined as individuals other than physicians and eligible professionals who are authorized under state or other applicable law to write prescriptions but are not in a provider category that is permitted to enroll in or opt-out of Medicare under the applicable statutory language. CMS believes “other authorized prescribers” are largely pharmacists who are permitted to prescribe certain drugs in certain states, but based on the applicable statute, pharmacists are not able to enroll in or opt-out of Medicare.

- If you believe you are an “other authorized prescriber” and are not a pharmacist, please contact providerenrollment@cms.hhs.gov. In addition, CMS strongly recommends that pharmacists in particular make sure that their primary taxonomy associated with their NPI in the National Plan & Provider Enumeration System (NPPES) reflects that they are a pharmacist. To review and update your NPPES information, please go to the National Plan & Provider Enumeration System webpage at https://nppes.cms.hhs.gov/NPPES/Welcome.do. Upon enforcement of the regulation, Part D plans will need to be able to determine if the prescriber is a pharmacist in order to properly adjudicate the pharmacy claim at point-of-sale.

In an effort to prepare the prescribers and Part D sponsors for the first phase February 1, 2017 enforcement date, CMS has made available an enrollment file that identifies physician and eligible professional who are enrolled in Medicare in an approved or opt-out status. However, the file does not specify if a particular prescriber is eligible to prescribe, as prescribing authority is largely determined by state law. The enrollment file is available at https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx. The file contains production data but is considered a test file since the Part D prescriber enrollment requirement is not yet applicable. An updated enrollment file will be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement.

The file displays physician and eligible professional eligibility on and after November 1, 2014, (that is, currently enrolled, new approvals, or changes from opt-out to enrolled as of November 1, 2014). Any periods, prior to November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will not be displayed on the enrollment file. However, any gaps in enrollment after November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will be reflected on the file with its respective effective and end dates for that given provider. For opted out providers, the opt-out flag will display a Y/N (Yes/No) value to indicate the periods the provider was opted out of Medicare. The file will include the provider’s:
Example 1 - Dr. John Smith's effective date of enrollment is January 1, 2014. Since he was enrolled prior to the generation of the test file, his effective date will display as November 1, 2014. Dr. Smith submits an enrollment application to voluntarily withdraw from Medicare effective December 15, 2014. Dr. Smith will appear on the applicable file as:

<table>
<thead>
<tr>
<th>NPI</th>
<th>First Name</th>
<th>Last Name</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Opt-Out Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>John</td>
<td>Smith</td>
<td>11/01/2014</td>
<td>12/15/2014</td>
<td>N</td>
</tr>
</tbody>
</table>

Example 2 - Dr. Mary Jones submits an affidavit to opt-out of Medicare, effective December 1, 2014. Since she has opted out after the generation of the test file, her effective date will display as December 1, 2014. After the 2 year opt-out period expires, Dr. Jones decides she wants to enroll in Medicare to bill, order, and certify, or to write prescriptions. The enrollment application is received on January 31, 2017, and the effective date issued is January 1, 2017. Dr. Jones will display on the applicable file as:

<table>
<thead>
<tr>
<th>NPI</th>
<th>First Name</th>
<th>Last Name</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Opt-Out Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>987654321</td>
<td>Mary</td>
<td>Jones</td>
<td>12/01/2014</td>
<td>12/01/2016</td>
<td>Y</td>
</tr>
<tr>
<td>987654321</td>
<td>Mary</td>
<td>Jones</td>
<td>01/01/2017</td>
<td></td>
<td>N</td>
</tr>
</tbody>
</table>

After the enforcement date of February 1, 2017, the applicable effective dates on the file will be adjusted to February 1, 2017, and it will no longer be considered a test file. All inactive periods prior to February 1, 2017, will be removed from the file and it will only contain active and inactive enrollment or opt-out periods as of February 1, 2017, and after. The file will continue to be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement. Part D sponsors may utilize the file to determine a prescriber’s Medicare enrollment or opt-out status when processing Part D pharmacy claims. The file will not validate the provider’s ability to prescribe under applicable laws. Please submit questions or issues encountered in accessing the file to providerenrollment@cms.hhs.gov.

Additional Information

For more information on the enrollment requirements, visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

For a list of Frequency Asked Questions (FAQs) refer to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMS-4159_FAQs.pdf.

Document History

<table>
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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>November 16, 2016</td>
<td>The article was revised to show a phased approach to enforcement that will begin in the second calendar quarter of 2017 and end with full implementation and enforcement of the Part D prescriber enforcement requirement on January 1, 2019.</td>
</tr>
<tr>
<td>April 18, 2016</td>
<td>The article was revised to amend additional dates in the article to reflect the delayed enforcement date of February 1, 2017.</td>
</tr>
<tr>
<td>April 7, 2016</td>
<td>The article was revised to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until February 1, 2017, and to provide clarifying information regarding the enrollment process.</td>
</tr>
</tbody>
</table>
Date of Change | Description
--- | ---
December 5, 2014 | The article was revised to add language to emphasize that form CMS-855O is appropriate for use by prescribers.
October 20, 2015 | The article was revised to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until June 1, 2016, and to provide clarifying information regarding the enrollment process.

**Kentucky & Ohio**


The Centers for Medicare & Medicaid Services (CMS) has issued the following Special Edition 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/2016-MLN-Matters-Articles.html

**MLN Matters® Number:** SE1624  
**Related CR Release Date:** November 22, 2016  
**Related CR Transmittal #:** N/A  
**Related Change Request (CR) #:** N/A  
**Effective Date:** N/A  
**Implementation Date:** N/A

**Provider Types Affected**
This article is intended for providers billing Medicare Administrative Contractors (MACs) for services related to stem cell transplantation.

**Provider Action Needed**
The Office of the Inspector General (OIG) recently completed a review of Medicare claims related to stem cell transplants. This article is intended to address issues of incorrect billing as a result of the February 2016 OIG report (https://oig.hhs.gov/oas/reports/region9/91402037.pdf) and to clarify coverage of stem cell transplantation. This article does not introduce any new policies. It is intended to clarify the billing for stem cell services.

**Background**
The Centers for Medicare & Medicaid Services (CMS) has a coverage policy for stem cell transplantation, and the "Medicare National Coverage Determination (NCD) Manual" (Publication 100-03, Section 110.8, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf) states that stem cell transplantation is a process in which stem cells are harvested from either a patient’s or donor’s bone marrow or peripheral blood for intravenous infusion.

**Types of Stem Cell Transplants that are covered:**
Medicare covers allogeneic and autologous transplants. Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses.

1. **Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)**
   
   Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor’s stem cells is obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect.

   Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.
2. **Autologous Stem Cell Transplantation (AuSCT)**

Autologous stem cell transplantation is a technique for restoring stem cells using the patient’s own previously stored cells. Autologous stem cell transplants (AuSCT) must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (High Dose Chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

Medicare policy as stated in Transmittal 1805 ([https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1805A3.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1805A3.pdf)) states that stem cell transplants are typically performed in the outpatient setting. Should complications occur, then the procedure would be performed on an inpatient basis. However, the OIG report suggests that an inpatient stay of just 1 or 2 days is more likely a miscoded claim as opposed to submitting an outpatient claim to cover stem cell transplantation.

In their February 2016 OIG ([https://oig.hhs.gov/oas/reports/region9/91402037.pdf](https://oig.hhs.gov/oas/reports/region9/91402037.pdf)) report, the OIG determined that Medicare paid for many stem cell transplant procedures incorrectly. The main finding was that providers billed these procedures as inpatient when they should have been submitted as outpatient or outpatient with observation services. The key points in the report are as follows:

- **Stem cell transplants are typically performed in the outpatient setting.**
  - Hospitals may have incorrectly thought that stem cell transplantation was on CMS’s list of inpatient-only procedures.
  - Hospitals often billed these services using incorrect Medicare Severity Diagnosis Related Groups (MS-DRGs). Of critical importance, the OIG found that many claims contained an MS-DRG suggesting a Geometric Mean Length of Stay (GMLOS) in the hospital that should have been much longer than the claim actually showed. For example, the following table shows the length of stay one might expect for the given MS-DRGs. Yet, the submitted claims reflected a length of stay of just 1 or 2 days. This suggests the claims should have been billed as outpatient, which is what Medicare policy considers to be the norm for stem cell transplants.

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>MS-DRG Title</th>
<th>GMLOS</th>
<th>Arithmetic Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>014</td>
<td>ALLOGENEIC BONE MARROW TRANSPLANT</td>
<td>20.0</td>
<td>25.1</td>
</tr>
<tr>
<td>016</td>
<td>AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC</td>
<td>17.5</td>
<td>19.1</td>
</tr>
<tr>
<td>017</td>
<td>AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC</td>
<td>8.9</td>
<td>12.4</td>
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</table>


**The Two-Midnight Rule**

To assist providers in determining whether inpatient admission is reasonable and payable under Medicare Part A, CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria that should be used when determining whether an inpatient admission is reasonable and payable under Medicare Part A.

In general, the Two-Midnight rule states that:

- Inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.
The Two-Midnight rule also specified that all treatment decisions for beneficiaries were based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule does not prevent the physician from providing any service at any hospital, regardless of the expected duration of the service.

For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.

Additional Information

The OIG report is available at https://oig.hhs.gov/oas/reports/region9/91402037.pdf.


Table 5 of the Acute Inpatient FY2015 Final Rule is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html


You may want to review the following MLN Matters articles for further information:


Additional information is in a transcript of an MLN Connects® conference call discussing the Two-Midnight rule, which is available at https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2-27-14MidnightRuleTranscript.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map.
**KENTUCKY & OHIO PART B**

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). © 2017 Copyright, CGS Administrators, LLC.

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**SE1629: Guidance to Physician/Practitioner and Supplier Billing Offices that Submit Hard Copy Claims to Medicare to Help Reduce Incidence of Claims Not Crossing Over Due to Duplicate Diagnosis Codes and Diagnosis Code Pointers**

The Centers for Medicare & Medicaid Services (CMS) has issued the following *Special Edition 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/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

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**Provider Types Affected**

This MLN Matters Special Edition (SE) Article is intended for physician/practitioner and supplier billing offices mailing CMS-1500 claim forms to Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

This article instructs physician/practitioner and supplier billing offices to correctly submit CMS-1500 claim forms to reduce the number of claims that are not “crossed over,” or transferred electronically to the destination supplemental payer. Make sure your billing staff is aware of this guidance.

**Background**

Currently, when physician/practitioner and supplier billing offices mail CMS-1500 claim forms to their MAC or DME MAC, the MAC or DME MAC’s shared system uses the resulting adjudication data in the creation of outbound Medicare crossover claims. More specifically, Medicare uses the results from the processing of the incoming hard copy claims to create outbound Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12-N 837 professional Coordination of Benefits (COB) claims.

After the incoming hard-copy claims have met their Medicare payment floor requirements, MACs and DME MACs then transfer these claims to the Centers for Medicare & Medicaid Services (CMS) Benefits Coordination & Recovery Center (BCRC). The BCRC administers CMS’ Medicare claims crossover process.

Upon receipt at the BCRC, the claims are edited for HIPAA ASC X12-N 837 claims compliance. Claims that pass compliance are “crossed over,” or transferred electronically, to the destination supplemental payer. Claims that fail HIPAA compliance are not crossed over. Instead, the BCRC submits an electronic report to the associated MAC or DME MAC advising why the claims were not crossed over. MACs and DME MACs then create a notification letter that is mailed to the physician/practitioner or supplier’s correspondence address of record, which is on file with the MAC or DME MAC. It is within the context of this process that CMS is creating SE1629.

Beginning in October 2015, billing vendors for physicians and medical practitioners and suppliers in the healthcare industry have been including International Classification of Diseases, Clinical Modifications, Version 10 (ICD-CM-10), on healthcare claims submitted to Medicare in association with specified Service-From Date requirements.
Diagnosis Coding on Claims and Processing and Editing of Those Claims

- Example: If a claim’s Service-From Date is October 15, 2015, physicians/practitioners and suppliers are to bill the claim to Medicare using an ICD-10, rather than ICD-9, diagnosis code.

CMS MACs and DME MACs have either a front-end Contractor Common Edits Module (CCEM) or Common Electronic Data Interchange (CEDI) module that activates when ICD diagnosis code versions are incorrectly used for claim service dates. Additionally, the MAC and DME MAC CCEM and CEDI have logic that activates when incoming electronically-submitted claims contain duplicate ICD-10 diagnosis codes, as well as duplicate diagnosis code pointers.

MACs and DME MACs currently do not have established Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that may be used through Medicare’s unprocessable claims procedure to advise physician/practitioners or suppliers that they have either incorrectly:

1. Included a duplicate ICD-10 diagnosis code on an incoming CMS-1500 Claim; or
2. Included a diagnosis code pointer reference more than once (for example, “1, 1”) on such claims.

CMS is providing the informational guidance to physicians/practitioners and medical suppliers in the hopes that they will have fewer issues with Medicare crossing their claims over to supplemental payers.

BCRC Editing and Claims Failing to Cross Over

Prior to and after the implementation of ICD-10 diagnosis reporting in October 2015, representatives from the Medicare supplemental payer community informed CMS and its BCRC that the ICD-10-CM, Version 5010 Manual provides direction to users regarding the inappropriateness of reporting ICD-10-CM diagnosis codes more than once. The guidance is as follows:

Within Section B, “General Coding Guidelines, number 12, page 19,” the Manual states, “12. Reporting Same Diagnosis Code More Than Once: Each unique ICD-10-CM diagnosis code may be reported only once per encounter. This also applies to bilateral conditions when there are no distinct codes identifying laterally or two different conditions classified to the same ICD-10-CM diagnosis code.”

CMS has determined that the above guidance has influenced many healthcare plans, payers, and clearinghouses to create edits that will activate if the same ICD-10 diagnosis code is duplicated on claims. The BCRC, at the discretion of CMS, has also done so, to ensure that supplemental payers will not reject Medicare crossover claims with this characteristic upon receipt. Therefore, any claims that MACs and DME MACs transmit to the BCRC that contain duplicate ICD-10 diagnosis codes are encountering the following error:

- H54271 – “ICD-10 codes cannot be duplicated.”

Since MACs and DME MACs have duplicate diagnosis code editing included in their CCEM or CEDI front-end editing routines, incoming electronic HIPAA ASC X12-N 837 claims with these characteristics are being rejected through Medicare’s 277-CA process. This means it is primarily incoming hard copy (CMS-1500) claims that are now encountering the H54271 edit rejection.

Additionally, guidance in the HIPAA Technical Report Version 3 (TR-3) Guide governing 837 professional claims transactions makes reference to use of distinct diagnosis pointers to differentiate among multiple diagnosis codes when included on healthcare claims. It appears Medicare’s CCEM or CEDI routines catch situations where diagnosis code pointer references are used more than once. However, there is no available CARC or RARC that can be used to identify this situation as part of Medicare’s unprocessable claims procedure. Because of this,
claims where a diagnosis pointer reference is duplicated, such as “1, 1,” are encountering the following error at the BCRC:

- H25670 – “Diagnosis code pointers should not be duplicated.”

Next Steps to RemEDIATE This Issue

CMS recognizes it is possible for a physician/practitioner or supplier to reference a given reported diagnosis code, through a diagnosis code pointer, more than once when billing Medicare for multiple services on the same claim. However, vendors or physician/practitioner and supplier offices that create CMS-1500 claims can obtain better Medicare claims crossover results if they:

- Cease reporting the same ICD-9 or ICD-10 diagnosis more than once and
- Cease reporting a diagnosis code pointer reference more than once (for example, 1, 1, or 2, 2)

Additional Information

If you have any questions, please contact your MAC at its toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Document History

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