The JM HHH Medicare Advisory contains coverage, billing and other information for Jurisdiction M HHH. This information is not intended to constitute legal advice. It is our official notice to those we serve concerning their responsibilities and obligations as mandated by Medicare regulations and guidelines. This information is readily available at no cost on the Palmetto GBA website. It is the responsibility of each facility to obtain this information and to follow the guidelines. The JM HHH Medicare Advisory includes information provided by the Centers for Medicare & Medicaid Services (CMS) and is current at the time of publication. The information is subject to change at any time. This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no-cost from our website at http://www.PalmettoGBA.com/Medicare.

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Learning and Education Information (continued)


The Golden Years – Medicare at 50! .......................................................... 37

Medicare Affairs Information ........................................................................ 39

Update to Pub. 100-03, National Coverage Determination Manual, Chapter 1, Part 1, Section 50.1 Speech Generating Device ........................................ 39

Tools That You Can Use ............................................................................. 42

Interactive Part A Remittance Advice .......................................................... 42

Welcome to Online Provider Services ......................................................... 43

Helpful Information .................................................................................... 45

Contact Information for Palmetto GBA Home Health and Hospice .............. 45

Don’t Forget to Register for These Upcoming Education Activities

2015 Home Health and Hospice Workshop Series

December 10, 2015, Quarterly Updates, Changes and Reminders Webcast

For more information and registration instructions about these sessions, please go to the Learning and Education section beginning on Page 35 of this issue.

CMS E-NEWS

CMS e-News will contain a week’s worth of Medicare-related messages from the Centers of Medicare & Medicaid Services (CMS). These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. Please share with appropriate staff. To view the most recently issues, please copy and paste the following links into your Web browser:

September 17, 2015

September 10, 2015

September 3, 2015

August 27, 2015
CMS Conducts Final Successful Medicare FFS ICD-10 End-to-End Testing Week in July

From July 20 through 24, 2015, Medicare Fee-For-Service (FFS) health care providers, clearinghouses, and billing agencies participated in a third successful ICD-10 end-to-end testing week with all Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common Electronic Data Interchange (CEDI) contractor. CMS was able to accommodate most volunteers, representing a broad cross-section of provider, claim, and submitter types.

This final end-to-end testing week demonstrated that CMS systems are ready to accept and process ICD-10 claims. Approximately 1,200 providers and billing companies participated, and testers submitted over 29,000 test claims. View the results.

Overall, participants in the July end-to-end testing week were able to successfully submit ICD-10 test claims and have them processed through Medicare billing systems. The acceptance rate for July was similar to the rates in January and April, but with an increase in the number of testers and test claims submitted. Most of the claim rejections that occurred were due to errors unrelated to ICD-9 or ICD-10.

Through its robust system release testing, CMS has ensured that the Medicare FFS claims processing systems changes for ICD-10 implementation have been thoroughly tested and validated. CMS also has conducted an unprecedented additional level of testing to help providers prepare for ICD-10. This was the final end-to-end testing week, but providers are encouraged to participate in acknowledgement testing, which can be completed at any time prior to the implementation date.

Be Prepared
Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015; or accept claims that contain both ICD-9 and ICD-10 codes.

CMS has created a number of ICD-10 tools and resources for providers. One tool is the “Road to 10,” aimed specifically at smaller physician practices with primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help with implementation.

For more information, visit the Medicare FFS Provider Resources web page.
HOME HEALTH AND HOSPICE INFORMATION

January 2016 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files Manual Update to Clarify Claims Processing Multiple Suppliers

MLN Matters® Number: MM9351
Related Change Request (CR) #: CR 9351
Related CR Release Date: September 18, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3354CP
Implementation Date: January 4, 2016

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

Provider Action Needed
Medicare will use the January 2016 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2016, with dates of services from January 1, 2016, through March 31, 2016.

Change Request (CR) 9351, from which this article is taken, instructs MACs to implement the January 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised October 2015, July 2015, and April 2015, and January 2015 files. Make sure your billing personnel 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 Medicare Claims Processing Manual, Chapter 4, Section 50, Outpatient Code Editor (OCE).

The following table shows how the files will be applied.

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective for Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2016 ASP and ASP NOC</td>
<td>January 1, 2016, through March 31, 2016</td>
</tr>
<tr>
<td>October 2015 ASP and ASP NOC</td>
<td>October 1, 2015, through December 31, 2015</td>
</tr>
<tr>
<td>July 2015 ASP and ASP NOC</td>
<td>July 1, 2015, through September 30, 2015</td>
</tr>
</tbody>
</table>
Increase Tax Withholding to 100 Percent for Internal Revenue Service (IRS) Federal Payment Levy Program (FPLP)

MLN Matters® Number: MM9285
Related CR Release Date: August 21, 2015
Related Transmittal #: R1536OTN
Change Request (CR) #: CR 9285
Implementation Date: October 16, 2015
Effective Date: October 16, 2015

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) and who may owe back taxes to the Internal Revenue Service (IRS).

What You Need to Know
Change Request (CR) 9154 instructs the Healthcare Integrated General Ledger Accounting System (HIGLAS) system maintainer to make necessary programming changes to increase the tax withhold percentage from 30 percent to 100 percent. If you owe back taxes to the IRS and those taxes are eligible to be withheld from payments due you from Medicare, the withhold rate will increase from the current 30 percent to 100 percent on October 16, 2015.

Background
In July 2000, the IRS, in conjunction with the Department of the Treasury, started the Federal Payment Levy Program (FPLP) which is authorized by Internal Revenue Code Section 6331 (h) (see http://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleF-chap64-subchapD-part1Isec6331.pdf), as prescribed by the Taxpayer Relief Act of 1997 Section 1024 (see http://www.gpo.gov/fdsys/pkg/PLAW-105publ34/html/PLAW-105publ34.htm).

Through the FPLP, authority is provided to the Centers for Medicare & Medicaid Services (CMS) to collect overdue taxes through a levy on certain federal payments. This includes federal payments made to providers, contractors and vendors doing business with the government.

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Consistent with this authority, CMS introduced CR6125 in October of 2008, which reduced federal payments subjected to the levy by the required 15 percent, or the exact amount of the tax owed if it is less than 15 percent of the payment. You can review the MLN Matters® Article MM6125, corresponding to CR6125, at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6125.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6125.pdf) on the CMS website.

In December 2014, the Internal Revenue Code Section 6331(h) was amended by the Tax Increase Prevention Act of 2014 Section 209(a) (see [http://www.gpo.gov/fdsys/pkg/BILLS-113hr5771enr/html/BILLS-113hr5771enr.htm](http://www.gpo.gov/fdsys/pkg/BILLS-113hr5771enr/html/BILLS-113hr5771enr.htm)), which mandated an increase to the tax levy to 30 percent. In order to do this, CMS introduced CR9154. You can review the MLN Matters® Article MM9154 corresponding to CR9154, at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9154.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9154.pdf) on the CMS website.

In April 2015, the Internal Revenue Code Section 6331(h) was amended by the Medicare Access and CHIP Reauthorization Act of 2015, Section 413(a), which increases the tax levy withholding to 100 percent.

**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-LearningNetworkMLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-LearningNetworkMLN/MLNMattersArticles/index.html) under - How Does It Work.

### 2016 Annual Update of Healthcare Common Procedure Coding System (HCPCS)

**Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update**

MLN Matters® Number: MM9340  
Related Change Request (CR) #: CR 9340  
Related CR Release Date: September 11, 2015  
Effective Date: January 1, 2016  
Related CR Transmittal #: R3349CP  
Implementation Date: January 4, 2016

**Provider Types Affected**

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.
Provider Action Needed

STOP – Impact to You
If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in Change Request (CR) 9340 could impact your payments.

CAUTION – What You Need to Know
CR 9340 provides the 2016 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and explains how the updates affect edits in Medicare claims processing systems. By the first week in December 2015, the new code files for Part B processing, and the new Excel and PDF files for Part A processing will be available at http://www.cms.gov/SNFConsolidatedBilling on the Centers for Medicare & Medicaid Services (CMS) website; and become effective on January 1, 2016.

GO – What You Need to Do
It is important and necessary for the provider community to read the “General Explanation of the Major Categories” PDF file located at the bottom of each year’s MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Background
The Common Working File (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid.

Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the “Medicare Claims Processing Manual,” Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Sections 20.6 and 110.4.1. You may view this manual at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf on the CMS website.

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.”

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.”
Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for Fiscal Year (FY) 2016

MLN Matters® Number: MM9301  
Related Change Request (CR) #: CR 9301  
Related CR Release Date: September 4, 2015  
Effective Date: October 1, 2015  
Related CR Transmittal #: R3345CP  
Implementation Date: October 5, 2015  

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

Provider Action Needed  
Change Request (CR) 9301 informs MACs about changes that update the hospice payment rates, hospice wage index and Pricer software for FY 2016. The CR also updates the hospice cap amount for the cap year ending October 31, 2015. Make sure your billing staffs are aware of these changes.

Background  
The law governing the payment rates for hospice care, the hospice aggregate cap amount, and the hospice wage index requires that these rates are updated annually. Section 18149(i)(1)(C)(ii) of the Social Security Act (the Act) stipulates that the payment rates for hospice care for FYs after 2002 will increase by the market basket percentage increase for the FY.

Therefore, the FY 2016 payment rates will be increased by 1.6 percent. The 1.6 percent hospice payment update is equivalent to the FY 2016 hospital market basket update (2.4 percent) less a productivity adjustment of 0.5 percentage point, less a 0.3 percentage point. The productivity adjustment and 0.3 percentage point reduction are both mandated by Section 3401(g) of the Affordable Care Act. Beginning in FY 2014, the payment rates for hospices which fail to report the required quality data are updated by the hospice payment update minus 2 percentage points.

FY 2016 Hospice Payment Rates  
Between October 1, 2015, and December 31, 2015, hospices will continue to be paid a single routine home care (RHC) per diem payment amount when routine home care is furnished. Effective January 1, 2016, two separate payment rates will replace the single RHC rate:

1) A higher RHC rate for days 1 through 60; and

2) A lower RHC rate for days 61 and beyond.

For hospice patients who are discharged and readmitted to hospice within 60 days of that discharge, a patient’s prior hospice days would continue to follow the patient and count toward his or her patient days for the new hospice election. The hospice days would continue to follow the patient solely to determine whether
the receiving hospice would receive payment at the day 1 through 60 RHC rate or day 61 and beyond RHC rate.

CMS will calculate the patient’s episode day count based on the total number of days the patient has been receiving hospice care, separated by no more than a 60 day gap in hospice care, regardless of level of care or whether those days were billable or not. This calculation includes hospice days that occurred prior to January 1, 2016.

Effective January 1, 2016, hospices will receive a SIA payment on RHC days when direct patient care is provided by a Registered Nurse (RN) or social worker during the last seven days of the patient’s life. The SIA payment will be made in addition to the per diem rate for the RHC level of care. It will equal the Continuous Home Care (CHC) hourly rate multiplied by the hours of nursing/social work service (for at least 15 minutes and up to 4 hours total), that occurred on RHC days during the last seven days of life. (For more information regarding the SIA payment policy, please refer to MLN Matters® Article MM9201 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9201.pdf).

The FY 2016 hospice payment rates are effective for care and services furnished on or after October 1, 2015, through September 30, 2016. The hospice payment rates are discussed further in the “Medicare Claims Processing Manual,” Chapter 11 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf) (Processing Hospice Claims), Section 30.2 (Payment Rates). The updated payment rates are shown in following tables and in the attachment to CR9301.

Table 1: FY 2016 Hospice Payment Rate for RHC for October 1, 2015, through December 31, 2015

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$161.89</td>
<td>$111.23</td>
<td>$50.66</td>
</tr>
</tbody>
</table>

Table 2: FY 2016 Hospice Payment Rates for RHC for January 1, 2016, through September 30, 2016

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$186.84</td>
<td>$128.38</td>
<td>$58.46</td>
</tr>
<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$146.83</td>
<td>$100.89</td>
<td>$45.94</td>
</tr>
</tbody>
</table>
Table 3: FY 2016 Hospice Payment Rates for CHC, Inpatient Respite Care IRC, and General Inpatient (GIP) Care

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>652</td>
<td>Continuous Home Care Full Rate= 24 hours of care $=39.37 hourly rate</td>
<td>$944.79</td>
<td>$649.17</td>
<td>$295.62</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$167.45</td>
<td>$90.64</td>
<td>$76.81</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$720.11</td>
<td>$460.94</td>
<td>$259.17</td>
</tr>
</tbody>
</table>

Beginning in FY 2014, hospices which fail to report quality data will have their market basket update reduced by two percentage points. Tables 4, 5, and 6 display the rates for these hospices.

Table 4: FY 2016 Hospice Payment Rate for RHC for October 1, 2015, through December 31, 2015, for Hospices That DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$158.70</td>
<td>$109.04</td>
<td>$49.66</td>
</tr>
</tbody>
</table>

Table 5: FY 2016 Hospice Payment Rates for RHC for January 1, 2016, through September 30, 2016, for Hospices That DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$183.17</td>
<td>$125.86</td>
<td>$57.31</td>
</tr>
<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$143.94</td>
<td>$98.90</td>
<td>$45.04</td>
</tr>
</tbody>
</table>

Table 6: FY 2016 Hospice Payment Rates for CHC, IRC, and GIP for Hospices That DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>652</td>
<td>Continuous Home Care Full Rate= 24 hours of care $=38.59 hourly rate</td>
<td>$926.19</td>
<td>$636.39</td>
<td>$289.80</td>
</tr>
</tbody>
</table>

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### Hospice Cap

The hospice aggregate cap amount for the 2015 cap year ending October 31, 2015, is $27,382.63. In computing the cap, CMS used the medical care expenditure category of the March 2015 Consumer Price Index for all Urban consumers, published by the Bureau of Labor Statistics (http://www.bls.gov/cpi/home.htm), which was 444.020.

### Hospice Wage Index

On February 28, 2013, the Office of Management and Budget (OMB) issued OMB Bulletin No. 13-01 (https://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf), announcing revisions to the delineation of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combines Statistical Areas, and guidance on uses of the delineation in these areas. These revisions will be incorporated into the hospice wage index for FY 2016. In order to provide a transition to the revised geographic area delineations, CMS will use a blended wage index for hospice payments for one year (FY 2016). The transition wage index is a 50/50 blend of the wage index values using OMB’s old area delineations and the wage index values using OMB’s new area delineations.

That is, for each county, a blended wage index is calculated equal to fifty percent of the FY 2016 wage index using the old labor market area delineation and fifty percent of the FY 2016 wage index using the new labor market area delineation. This results in an average of the two values. The hospice floor calculation is applied to the wage index values prior to blending.

Because of how the transition wage index is calculated, some Core Based Statistical Areas (CBSAs) and statewide rural areas will have more than one transition wage index value associated with that CBSA or rural area. However, each county will have only one transition wage index. For counties located in CBSAs and rural areas that correspond to more than one transition wage index value, the CBSA number will not be able to be used for FY 2016 claims. These CBSA numbers are listed in Table 7, which follows.

**Table 7: List of CBSA codes that are invalid for Hospice for FY 2016 because of the wage index transition (these areas need to use 50xxx codes)**

<table>
<thead>
<tr>
<th>CBSA Code</th>
<th>CBSA Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>10380</td>
<td>Aguadilla-Isabela, PR</td>
</tr>
<tr>
<td>11100</td>
<td>Amarillo, TX</td>
</tr>
<tr>
<td>12060</td>
<td>Atlanta-Sandy Springs-Roswell, GA</td>
</tr>
<tr>
<td>12260</td>
<td>Augusta-Richmond County, GA-SC</td>
</tr>
<tr>
<td>13140</td>
<td>Beaumont-Port Arthur, TX</td>
</tr>
<tr>
<td>13740</td>
<td>Billings, MT</td>
</tr>
<tr>
<td>13980</td>
<td>Blacksburg-Christsburg-Radford, VA</td>
</tr>
<tr>
<td>Code</td>
<td>City, State</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------</td>
</tr>
<tr>
<td>14010</td>
<td>Bloomington, IL</td>
</tr>
<tr>
<td>14540</td>
<td>Bowling Green, KY</td>
</tr>
<tr>
<td>15764</td>
<td>Cambridge-Newton-Framingham, MA</td>
</tr>
<tr>
<td>16740</td>
<td>Charlotte-Concord-Gastonia, NC-SC</td>
</tr>
<tr>
<td>36260</td>
<td>Ogden-Clearfield, UT</td>
</tr>
<tr>
<td>37460</td>
<td>Panama City, FL</td>
</tr>
<tr>
<td>38660</td>
<td>Ponce, PR</td>
</tr>
<tr>
<td>39660</td>
<td>Rapid City, SD</td>
</tr>
<tr>
<td>40340</td>
<td>Rochester, MN</td>
</tr>
<tr>
<td>40380</td>
<td>Rochester, NY</td>
</tr>
<tr>
<td>41540</td>
<td>Salisbury, MD-DE</td>
</tr>
<tr>
<td>41980</td>
<td>San Juan-Carolina-Caguas, PR</td>
</tr>
<tr>
<td>43340</td>
<td>Shreveport-Bossier City, LA</td>
</tr>
<tr>
<td>43580</td>
<td>Sioux City, IA-NE-SD</td>
</tr>
<tr>
<td>43900</td>
<td>Spartanburg, SC</td>
</tr>
<tr>
<td>44060</td>
<td>Spokane-Spokane Valley, WA</td>
</tr>
<tr>
<td>46220</td>
<td>Tuscaloosa, AL</td>
</tr>
<tr>
<td>47260</td>
<td>Virginia Beach-Norfolk-Newport News, VA-NC</td>
</tr>
<tr>
<td>47380</td>
<td>Waco, TX</td>
</tr>
<tr>
<td>47894</td>
<td>Washington-Arlington-Alexandria, DC-VA-MD-WV</td>
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<tr>
<td>48620</td>
<td>Wichita, KS</td>
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<tr>
<td>49180</td>
<td>Winston-Salem, NC</td>
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</tr>
<tr>
<td>99926</td>
<td>Missouri</td>
</tr>
<tr>
<td>99934</td>
<td>North Carolina</td>
</tr>
<tr>
<td>99936</td>
<td>Ohio</td>
</tr>
<tr>
<td>99945</td>
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</tr>
<tr>
<td>99949</td>
<td>Virginia</td>
</tr>
<tr>
<td>99951</td>
<td>West Virginia</td>
</tr>
</tbody>
</table>

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In these cases, a number other than the CBSA number will be needed to identify the appropriate wage index value for claims for hospice care provided in FY 2016. These numbers are five digits in length and begin with “50”. These special 50xxx codes are shown in the last column of the FY 2016 hospice wage index file (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html). For counties located in CBSAs and rural areas that still correspond to only one wage index value, the CBSA number will still be used.

Additional Information

Implementation of the Hospice Payment Reforms

MLN Matters® Number: MM9201 Revised
Related CR Release Date: August 14, 2015
Related Transmittal #: R3326CP
Change Request (CR) #: CR 9201
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Note: This article was revised on August 26, 2015, to remove an incorrect phrase regarding add-on payments in the first two days of hospice care. There are no Service Intensity Add-On payments during the first two days of admission. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for providers of hospice care, including routine home care, who submit claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
If you provide hospice care, the implementation of hospice payment reforms found in this article may impact your Medicare payments.

CAUTION – What You Need to Know
Change Request (CR) 9201 implements service intensity add-on payments for hospice social worker and nursing visits provided during the last 7 days of life when provided during routine home care. CR9201 also will implement two routine home care rates, paying a higher rate in the first 60

GO – What You Need to Do
Make sure that your billing staffs are aware of these reforms and additions to hospice and routine home care payments.

Background
Section 3132(a) of the Patient Protection and Affordable Care Act of 2010 (Pub. L 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L 11-152) (collectively referred to as the “Affordable Care Act”) amended Section 1814(i)(6) of the Social Security Act. This amendment required that, no earlier than October 1, 2013, revisions be made to the methodology for determining the payment rate for routine home care and other services. Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of hospice care.

Analysis of recent Medicare hospice utilization data demonstrates that hospice costs are markedly higher both at the beginning and the end of a hospice episode. In 2014, the Medicare Payment Advisory Commission (MedPAC) presented a report to Congress regarding its summary of analyses of the Medicare hospice benefit. In summary, the report concluded that because short-stay hospice episodes may lead to financial losses and reduced margins, providers might be seeking ways to maximize long stays in their beneficiary population and mechanisms to avoid the costliness of both the early and late portions of hospice episodes. You may access the entire report to Congress at http://www.medpac.gov/documents/reports/mar14_entirereport.pdf on the MedPAC website.

The Centers for Medicare & Medicaid Services (CMS) has found through its own analyses of recent claims data that hospice decedents receiving care at home received few skilled visits the last two to four days of life. CMS found some hospice providers did not provide any skilled visits in the last two days of life to more than 50 percent of their patients.

Routine Home Care (RHC) Per Diem Rates
In order to address these concerns, two different RHC per diem rates have been created for the RHC level of care, depending on the timing of the day within the patient’s episode of care. CMS considers a hospice “episode” of care to be a hospice election period or series of election periods. Days 1 through 60 will be paid at the RHC ‘High’ Rate while days 61+ will be paid at the RHC ‘Low’ Rate. These differing rates will serve to capture varying levels of resource intensity during the course of hospice care, as the beginning portion of the stay is generally more costly than the later segment.
Effective for hospice services with dates of service on or after January 1, 2016, a hospice day billed at the RHC level of care will be paid one of two RHC rates based upon the following:

1. The day is billed as an RHC level of care day.

2. If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC ‘High’ Rate.

3. If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC ‘Low’ Rate.

4. For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for the receiving hospice in the determination of whether the receiving hospice may bill at the high or low RHC rate, upon hospice election.

5. For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient’s 60-day window, paid at the RHC ‘High’ Rate upon the new hospice election.

**Service Intensity Add-On Payment (SIA)**

Effective for hospice services with dates of service on and after January 1, 2016, a hospice claim will be eligible for an end of life (EOL) Service Intensity Add-On (SIA) payment if the following criteria are met:

1. The day is an RHC level of care day.

2. The day occurs during the last seven days of life (and the beneficiary is discharged dead).

3. Service is provided by a Registered Nurse (RN) or social worker that day for at least 15 minutes and up to 4 hours total.

4. The service is not provided by a social worker via telephone.

The SIA Payment amount shall equal:

- The number of hours (in 15 minute increments) of service provided by an RN or social worker during the last seven days of life for a minimum of 15 minutes and up to 4 hours total per day;

- Multiplied by the current hospice Continuous Home Care (CHC) hourly rate per 15 minutes x visit units (not greater than 16).

- Adjusted for geographic differences in wages.

The SIA policy necessitates the creation of two new G codes for nursing that distinguish between nursing care provided by a RN and nursing care provided by a Licensed Practical Nurse (LPN). During periods of crisis such as the precipitous decline before death, patient needs typically surge and more intensive services are warranted. The Medicare Conditions of Participation (CoPs) at 42 CFR 418.56(a) state that an RN is responsible for ensuring that the needs of the patient and family are continually assessed. CMS would
expect that at end of life the needs of the patient and family would need to be frequently assessed and thus the skills of an RN are required. RNs are more highly trained clinicians with commensurately higher wage rates.

Since the existing codes do not distinguish between services provided by an RN and a LPN, CMS will obtain new codes to distinguish between RN services and LPN services by January 1, 2016.

The SIA daily payment calculated by the Hospice PRICER will be entered on the first applicable visit line item for each date of service payable.

**Routine Home Care (RHC) Per Diem Rates**

**Example:**
- Patient elected hospice for the first time on 01/10/16.
- The patient revoked hospice on 01/30/16.
- The patient re-elected hospice on 02/16/16.
- The patient discharged deceased from hospice care on 03/28/16.

Since the break in hospice care from 01/30 to 02/16 was less than 60 days the patient day count continues on the second admission.

RHC provided during first election from 01/10/16 to 01/30/16 accounts for 21 days that the high RHC rate would apply. The 60 day count continues with second admission on 2/16/16 and the high RHC rate would apply for an additional 39 days. Day 61 begins the low RHC rate on 3/27/16.

Multiple RHC days are reported on a single line item on the claim. The line item date of service represents the first date at the level of care and the units represent the number of days. As a result, both high and low RHC rates may apply to a single line item.

Extending the example above, if the March claim for this patient consisted entirely of RHC days at home, the payment line item would look like this:

- Revenue Code - 0651
- HCPCS - Q5001
- Line Item Date of Service - 03/01/16
- Units - 31

Medicare systems would:
- calculate the dates from 3/01 to 3/26 at the high RHC rate,
- calculate the dates from 3/27 to 3/31 at the low RHC rate, and...
• sum these two amounts in the payment applied to this line item.

Service Intensity Add-On Payment (SIA)

Example:
Billing Period: 12/01/XX – 12/09/XX, Patient Status: 40
RHC in home, discharged deceased.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Line Item Date of Service</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>0651</td>
<td>Q5001</td>
<td>12/01/XX</td>
<td>9</td>
</tr>
<tr>
<td>0551</td>
<td>G0154</td>
<td>12/01/XX</td>
<td>4</td>
</tr>
<tr>
<td>0571</td>
<td>G0156</td>
<td>12/02/XX</td>
<td>6</td>
</tr>
<tr>
<td>0561</td>
<td>G0155</td>
<td>12/05/XX</td>
<td>4</td>
</tr>
<tr>
<td>0571</td>
<td>G0156</td>
<td>12/05/XX</td>
<td>3</td>
</tr>
<tr>
<td>0551</td>
<td>G0154</td>
<td>12/06/XX</td>
<td>3</td>
</tr>
<tr>
<td>0571</td>
<td>G0156</td>
<td>12/06XX</td>
<td>4</td>
</tr>
<tr>
<td>0551</td>
<td>G0154</td>
<td>12/09/XX</td>
<td>4</td>
</tr>
<tr>
<td>0561</td>
<td>G0155</td>
<td>12/09/XX</td>
<td>6</td>
</tr>
<tr>
<td>0571</td>
<td>G0156</td>
<td>12/09/XX</td>
<td>2</td>
</tr>
</tbody>
</table>

*Visits reported prior to 12/03/XX are not included in the EOL 7 day SIA.
Day 1 of 7, 12/03/XX, no qualifying units reported for the EOL SIA.
Day 2 of 7, 12/04/XX, no qualifying units reported for the EOL SIA.
Day 3 of 7, 12/05/XX, qualifying units are 4. Day 3 of the EOL SIA payment is stored on the first applicable visit line for that date: 0561 G0155 12/05/XX UNITS 4
Day 4 of 7, 12/06/XX, qualifying units are 3. Day 4 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G015412/06/XX UNITS 3
Day 5 of 7, 12/07/XX, no qualifying units reported for the EOL SIA.
Day 6 of 7, 12/08/XX, no qualifying units reported for the EOL SIA.
Day 7 of 7, 12/09/XX, qualifying units are 10. Day 7 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551G0154 12/09/XX UNITS 4.

For the guidelines above and in completing the uniform bill for hospice election, the hospice enters the admission date, which must be the start date of the benefit period in all cases except when a transfer occurs. In transfer situations, the hospice should use their own admission date. When a new hospice admission occurs after a hospice revocation or discharge that resulted in termination of the hospice benefit, the election date cannot be the same as the revocation or discharge date.

To ensure accuracy and prevent a delay in posting the hospice notice of election, hospices should validate Certificate/Social Security Number and Health Insurance Claim/Identification Number using the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS). Only in the
event that the HETS data is not available should the hospice show the number as it appears on the patient’s HI Card, Social Security Award Certificate, Utilization Notice, Explanation of Medicare Benefits (EOMB), Temporary Eligibility Notice, and so forth, or as reported by the Social Security Office.

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?

October 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters® Number: MM9298 Revised
Related Change Request (CR) #: CR 9298
Related CR Release Date: September 15, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3352CP
Implementation Date: October 5, 2015

Note: This article was revised on September 17, 2015, to reflect the revised CR9298, issued on September 15. In the article, information on HCPCS Code Q5101 has been added via subsection g. and Table 6 on pages 5-6. 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 providers and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9298 describes changes to and billing instructions for various payment policies implemented in the October 2015 OPPS update. Make sure that your billing staffs are aware of these changes.

Background
The October 2015 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR9298.

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

**New Separately Payable Procedure Code**
Effective October 1, 2015, a new HCPCS code C9743 has been created. See Table 1 below which provides the short and long descriptors and the APC placement for this new code.

### Table 1 – New Separately Payable Procedure Code Effective October 1, 2015

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9743</td>
<td>Bulking/spacer material impl</td>
<td>Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies)</td>
<td>S</td>
<td>0310</td>
<td>10/01/2015</td>
</tr>
</tbody>
</table>

**Compounded Drugs**
Effective June 30, 2015, modifier JF (Compounded drug) was discontinued and replaced with HCPCS code Q9977 (Compounded Drug, Not Otherwise Classified) effective July 1, 2015. HCPCS code Q9977 should be used to report compounded drug combinations.

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

As stated in the Calendar Year (CY) 2015 National Correct Coding Initiative (NCCI) Policy Manual (Chapter VIII, section D, item 20; see [http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/](http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/)), injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable. Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.
According to the “Medicare Claims Processing Manual” (Chapter 17, Section 90.2; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf), the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code Q9977, regardless of the site of service of the surgery, and are packaged as surgical supplies in both the Hospital Outpatient Department (HOPD) and the Ambulatory Surgical Center (ASC). Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399.

According to the “Medicare Claims Processing Manual” (Chapter 30, Section 40.3.6; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf), physicians or facilities should not give Advance Beneficiary Notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare. Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2015
For CY 2015, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2015, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective October 1, 2015 and drug price restatements can be found in the October 2015 update of the OPPS Addendum A and Addendum B at http://www.cms.gov/HospitalOutpatientPPS/ on the CMS website.

b. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates
Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be accessible on the first date of the quarter at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

c. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2015
Two drugs and biologicals have been granted OPPS pass-through status effective October 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 2 below.
Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2015

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9456</td>
<td>Injection, isavuconazonium sulfate, 1 mg</td>
<td>9456</td>
<td>G</td>
</tr>
<tr>
<td>C9457</td>
<td>Injection, sulfur hexafluoride lipid microsphere, per ml</td>
<td>9457</td>
<td>G</td>
</tr>
</tbody>
</table>

d. New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Biosimilar Biological Products Effective October 1, 2015 a new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. This new code is listed in Table 3 below.

Table 3 – New HCPCS Code Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9979</td>
<td>Injection, alemtuzumab, 1 mg</td>
<td>K</td>
<td>1809</td>
</tr>
</tbody>
</table>

e. Corrected Dosage Descriptor for HCPCS Code Q9976
The correct dosage descriptor for Q9976 is 0.1 mg of iron. The short and long descriptor are included in Table 4 below.

Table 4 – Corrected Dosage Descriptor for HCPCS Code Q9976

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Revised Short Descriptor</th>
<th>Revised Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>9976</td>
<td>Inj Ferric Pyrophosphate Cit</td>
<td>Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron</td>
</tr>
</tbody>
</table>

f. Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group
One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. This product is listed in Table 5 below.

Table 5 – Updated Skin Substitute Product Assignment to High Cost Status Effective October 1, 2015

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Status Indicator</th>
<th>Low/High Cost Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4151</td>
<td>AmnioBand, guardian 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

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g. Revised Status Indicator for HCPCS Code Q5101

Effective September 3, 2015, the status indicator for HCPCS code Q5101 (Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (Paid under OPPS; separate APC payment). APC 1822 is assigned to Q5101 as shown in Table 6 below. If you had claims for Q5101 for dates of service on or after September 3, 2015, that were processed prior to the installation of the October 2015 OPPS Pricer, your MAC will adjust those claims if you bring them to the attention of your MAC.

Table 6 – Drug and Biological with Revised Status Indicator
Effective September 3, 2015

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5101</td>
<td>Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram</td>
<td>1822</td>
<td>K</td>
</tr>
</tbody>
</table>

Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

Additional Information


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

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM9276
Related Change Request (CR) #: CR 9276
Related CR Release Date: August 28, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3344CP
Implementation Date: January 4, 2016

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) 9276 informs MACs about the changes to the Claim Status Category and Claim Status Codes.

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

The 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 codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/ on the Internet. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.

All code changes approved during the September/October 2015 committee meeting will be posted on those sites on or about November 1, 2015. MACs must complete entry of all applicable code text changes, add new codes, and terminate use of deactivated codes by the implementation date of CR9276.

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 CR9276.

Additional Information

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

MLN Matters® Number: MM9270
Related Change Request (CR) #: CR 9270
Related CR Release Date: August 21, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3335CP
Implementation Date: January 4, 2016

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) 9270 instructs MACs to update systems based on the CORE 360 Uniform Use of CARC and RARC Rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2015.

Background
The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set, required by January 1, 2014, by the Affordable Care Act.

CR9270 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 October 1, 2015. This update is based on July 1, 2015 Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) updates as posted at the Washington Publishing Company (WPC) website. (Visit http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.)

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

**Healthcare Provider Taxonomy Codes (HPTCs) October 2015 Code Set Update**

MLN Matters® Number: MM9260  
Related CR Release Date: August 21, 2015  
Related Transmittal #: R3336CP  
Change Request (CR) #: 9260  
Effective Date: October 1, 2015  
Implementation Date: January 4, 2016 - Contractors with the capability to do so shall implement this CR effective October 1, 2015.

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

**What You Need to Know**  
Change Request (CR) 9260 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

**Background**  
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides, which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use;
2. Terminated codes are not approved for use after a specific date;
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears; and
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR 9260 implements the NUCC HPTC code set that is effective on October 1, 2015, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes on the Internet.

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

**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.

**ICD-10 INFORMATION**

**Claims Submission Alternatives for Providers Who Have Difficulties Submitting ICD-10 Claims**

MLN Matters® Number: SE1522
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A
Provider Types Affected
This article is intended for all physicians, providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs) and Durable Medical Equipment MACs (DME MACs), for services provided to Medicare beneficiaries.

Provider Action Needed
This MLN Matters® Special Edition article offers physicians, providers, and suppliers information that will assist them in avoiding claims processing disruptions after implementation of International Classification of Diseases, Tenth Edition (ICD-10) on October 1, 2015. It provides information for providers who have difficulties submitting ICD-10 claims due to being unable to complete necessary systems changes or having issues with billing software, vendor(s), or clearinghouse(s).

Background
For FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use ICD-10 code sets adopted under HIPAA.

ICD-10 Claims Submission Alternatives
If you have difficulties submitting ICD-10 claims due to being unable to complete the necessary systems changes or having issues with your billing software, vendor(s), or clearinghouse(s), the following claims submission alternatives are available:

• Free billing software;

• Provider internet portals;

• Direct Data Entry (DDE); and

• Paper claims.

Each claims submission alternative is discussed in more detail below.

Please note that these claims submission alternatives REQUIRE THE USE OF ICD-10 code sets for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015.

FREE BILLING SOFTWARE

Providers Who Submit Claims to MACs
You may download the free billing software that the Centers for Medicare & Medicaid Services (CMS) A/B MACs offer on their web pages. The software has been updated to support ICD-10 codes and requires either a Network Service Vendor (NSV) or dial-up or both to transmit claims. The software download is free, but there may be fees associated with submitting claims through an NSV or dial-up. The MAC web pages also provide information about NSVs.
This billing software only works for submitting Fee-For-Service (FFS) claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Information about the free billing software is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors’ ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be rejected by Medicare.

Providers Who Submit Claims to DME MACs
DME suppliers may download the free billing software that CMS offers via the Common Electronic Data Interchange (CEDI) website. The software has been updated to support ICD-10 codes and requires NSV connectivity to transmit Medicare DME claims to CEDI. The software download is free, but there may be fees associated with submitting claims through an NSV. The list of approved NSVs and an NSV Frequently Asked Questions document is available at http://www.ngscedi.com/nsv on the CEDI website. You must also have a CEDI Trading Partner/Submitter ID to use the free billing software to submit claims to CEDI.

• If you currently do not have a CEDI Trading Partner ID (begins with A08, B08, C08, or D08) to submit claims directly to CEDI (for example, you submit claims through a clearinghouse or billing service), you will need to complete the necessary CEDI enrollment forms to obtain a CEDI Trading Partner ID.

• If you currently have a CEDI Trading Partner ID, you will use that to submit claims with the free billing software.

You can find CEDI enrollment forms at http://www.ngscedi.com/forms/formsindex.htm on the CEDI website. You should submit the forms to CEDI as soon as possible, but no later than September 15, 2015, to allow CEDI time to process your request and for any testing you might want to do prior to the October 1, 2015, ICD-10 implementation. You will also need to allow for any additional time to sign up and establish connectivity to CEDI through the NSV that you choose.

This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Information about the free billing software is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors’ ICD-10 Claims Submission Alternatives Web Pages on the CMS website.
Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected by Medicare.

**PROVIDER INTERNET PORTALS**

In some cases, you may be able to use your MAC’s provider internet portal to submit ICD-10 compliant professional claims. All MACs offer the portals, and a subset of these MAC portals offer claims submission. Provider portal internet claim submission is not available for institutional or supplier claims.


Please note that claims submitted via our provider portal must contain ICD-10 codes for FROM dates of service on or after October 1, 2015. Those submitted containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected through normal claims editing processes. ICD-9 codes will still be accepted for FROM dates prior to October 1, 2015.

**DDE**

Providers that bill institutional claims are also permitted to submit claims electronically via DDE screens. DDE requires a connectivity service provided by an external company to establish the connection.

Information about registering to submit claims via DDE and lists of DDE service vendors is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled *Contractors’ ICD-10 Claims Submission Alternatives Web Pages* ([https://www.cms.gov/Medicare/Coding/ICD10/Downloads/Contractors-ICD-10-Claims-Submission-Alternatives-Web-Pages.pdf](https://www.cms.gov/Medicare/Coding/ICD10/Downloads/Contractors-ICD-10-Claims-Submission-Alternatives-Web-Pages.pdf)) on the CMS website.

Please note that claims submitted via DDE must contain ICD-10 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015. Those submitted containing ICD-9 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015, will be Returned to Provider (RTP).

**PAPER CLAIMS**

In limited situations, you may submit paper claims with ICD-10 codes to Medicare. To find more information on when you may submit paper claims, visit [http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCAWaiver.html](http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCAWaiver.html) on the CMS website. Please note that to submit paper claims, you must meet the requirements to qualify for a waiver of the Administrative Simplification Compliance Act (ASCA) provisions.

Information about submitting paper claims and ordering claim forms is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled...

Waivers Subject to MAC Evaluation
Providers must apply for and meet all of the following requirements to qualify for a waiver of the ASCA provisions:

- Your software vendor is not ICD-10 ready, and it will cause a financial hardship for you to switch to another vendor; or
- Your software is not ICD-10 ready, and it will cause a financial hardship for you to switch to new software; and
- Your MAC’s provider internet portal does not support electronic claims submissions; and
- It would cause financial hardship for you to procure the services of a billing agent/clearinghouse.

It is the provider’s responsibility to submit all of the following documentation to the MAC to establish the validity of a waiver request:

- A letter from the vendor stating that their software is not ICD-10 compliant; or
- Attestation from the provider stating that your software is not ready for ICD-10; and
- Attestation of provider financial hardship; and
- Acknowledgement that paper claims must be submitted in a machine scannable format.

If the MAC determines that the waiver request meets the criteria described above and proper documentation has been provided, the MAC will grant the waiver request.

Corrective Action Plan (CAP)
A provider who qualifies for a waiver to submit paper claims will be placed on a CAP not to exceed 120 days and must submit a CAP detailing the steps, with associated timelines, being taken to become ICD-10 compliant.

Please note that submitting paper claims to Medicare, even if approved for an ASCA waiver, does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any paper claims containing ICD-9 codes for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be returned as unprocessable by Medicare.
Information and Resources
Visit the following web pages to find information and resources that will assist you in submitting ICD-10 codes to Medicare:

- General ICD-10-CM/PCS information: [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html);
- ICD-10 Fee-For-Service provider resources including claims processing and billing, coding, unspecified ICD-10-CM codes, home health provider information, NCDs and LCDs, testing and results, features and benefits, and calls and background: [https://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html](https://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html);

Additional Information

**INFLUENZA VACCINE INFORMATION**

**2015-2016 Influenza (Flu) Resources for Health Care Professionals**

MLN Matters® Number: SE1523
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

**Provider Types Affected**
All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

**What You Need to Know**

- Keep this Special Edition MLN Matters® article and refer to it throughout the 2015 - 2016 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
• Remember to immunize yourself and your staff.

Introduction
The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (*Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.*)

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare’s coverage of the annual flu shot.

As a reminder, please help prevent the spread of flu by immunizing yourself and your staff!

Know What to Do About the Flu!

Payment Rates for 2015-2016
Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and Current Procedure Terminology (CPT) codes and payment rates for personal influenza (flu) and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the Average Wholesale Price (AWP), except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Effective for services provided on August 1, 2015, through those provided on July 31, 2016, the following Medicare Part B payment allowances for HCPCS and CPT codes apply.

CPT Codes:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Effective Dates</th>
<th>Payment Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>90630</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$23.467</td>
</tr>
<tr>
<td>90654</td>
<td>8/1/2015 – 7/31/2016</td>
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</tr>
<tr>
<td>90655</td>
<td>8/1/2015 – 7/31/2016</td>
<td>Pending</td>
</tr>
<tr>
<td>90656</td>
<td>8/1/2015 – 7/31/2016</td>
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</tr>
<tr>
<td>90657</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$6.022</td>
</tr>
<tr>
<td>90661</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$22.288</td>
</tr>
<tr>
<td>90662</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$36.315</td>
</tr>
<tr>
<td>90672</td>
<td>8/1/2015 – 7/31/2016</td>
<td>Pending</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Effective Dates</td>
<td>Payment Allowance</td>
</tr>
<tr>
<td>----------</td>
<td>----------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>90673</td>
<td>9/26/2015 – 7/31/2016</td>
<td>$37.193</td>
</tr>
<tr>
<td>90685</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$24.596</td>
</tr>
<tr>
<td>90686</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$18.155</td>
</tr>
<tr>
<td>90687</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$9.134</td>
</tr>
<tr>
<td>90688</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$18.269</td>
</tr>
</tbody>
</table>

HCPCS Codes:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Effective Dates</th>
<th>Payment Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2035</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$13.025</td>
</tr>
<tr>
<td>Q2036</td>
<td>8/1/2015 – 7/31/2016</td>
<td>Pending</td>
</tr>
<tr>
<td>Q2037</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$15.830</td>
</tr>
<tr>
<td>Q2038</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$12.044</td>
</tr>
<tr>
<td>Q2039</td>
<td>8/1/2015 – 7/31/2016</td>
<td>Flu Vaccine Adult – Not Otherwise Classified: Payment allowance is to be determined by the local claims processing contractor.</td>
</tr>
</tbody>
</table>

The above pricing, and any required updates, will be available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) on the CMS website.

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

1. MLN Influenza Related Products for Health Care Professionals


2. Other CMS Resources

3. Other Resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2015 – 2016 flu season:

- Other sites with helpful information include:
  - Centers for Disease Control and Prevention - http://www.cdc.gov/flu;
  - Food and Drug Administration - http://www.fda.gov;
  - Immunization Action Coalition - http://www.immunize.org;
  - Indian Health Services - http://www.ihs.gov;
  - National Alliance for Hispanic Health - http://www.hispanichealth.org;
  - National Foundation For Infectious Diseases - http://www.nfid.org/influenza;
  - National Network for Immunization Information - http://www.immunizationinfo.org;
  - National Vaccine Program - http://www.hhs.gov/nvpo;
• Partnership for Prevention - http://www.prevent.org; and

• World Health Organization - http://www.who.int/en

Beneficiary Information
For information to share with your Medicare patients, please visit http://www.medicare.gov on the Internet.

LEARNING AND EDUCATION INFORMATION

Quarterly Updates, Changes, and Reminders Webcast –December 10, 2015

Palmetto GBA will host the Home Health and Hospice Quarterly Updates Webcast on Thursday, December 10, 2015, at 10 a.m. ET.

This 60-minute webcast is designed to provide pertinent updates, changes and reminders to assist the provider community in staying compliant with Medicare rules and regulations and will include:

• Comprehensive Error Rate Testing (CERT)

• Medicare Updates and Changes

• Hot Topics

• Reminders

• News to Use!

• Resources

Registration is required. To register for this webcast, please go to the Event Registration Portal under the Learning & Education section of Palmetto GBA website at www.PalmettoGBA.com/hhh. Note: A Provider Transaction Access Number (PTAN) and National Provider Identifier (NPI) are required to register. You should only enter ‘n/a’ if you do not have an NPI or PTAN.

Audio
The audio for this presentation will be broadcasting through your computer. For best results, it is recommended that you utilize/headphones. You should not use your telephone to dial into the conference.

Handouts
A copy of the presentation will be available through the event portal once the session begins.
2015 Palmetto GBA Home Health Medicare Workshop Series – The Golden Years – Medicare at 50!

Palmetto GBA is pleased to announce our 2015 Home Health workshop series, ‘The Golden Years – Medicare at 50!’ These workshops are designed for home health providers and their staff to equip them with the tools they need to be successful with Medicare billing, coverage and documentation requirements.

These workshops will provide insight for home health agency staff at all levels; however, we suggest that providers who are new to Medicare or have new staff attend our online learning courses for beginners at www.PalmettoGBA.com/hhh. Basic billing and other online educational resources can be found in the Self-Paced Learning section under the Learning and Education link on the left navigation. During the workshop series, Palmetto GBA will provide information related to the most common errors identified through a variety of data analysis and some hints and tips on the reasons why these errors occur. Palmetto GBA’s ultimate goal is to have educated and astute providers who know how to accurately and skillfully apply the information they learn to their documentation and billing practices!

Home Health Topics:

- Statistics
  - Length of Stay (LOS)
  - Disbursement
- Review Findings – Palmetto GBA and CERT Reviews
- Improving Your Practice
  - Health Information Supply Chain (HISC)
- Home Health (HH) Plans of Care (POCs)
  - Diabetes and the Home Health (HH) Benefit
- Medicare Program Changes for 2015
  - Reporting Principal Diagnosis Code(s)
    - Etiology vs. Manifestation codes
- Data Analysis
  - Appeals
  - Provider Contact Center (PCC)
  - Claims
• Tying It All Together
  
  o Define, Measure, Analyze, Improve, and Control (DMAIC) Process

• Provider Resources

Note: CMS requires that Medicare contractors track all educational activities, which consists of capturing the provider’s six-digit Provider Transaction Access Number (PTAN) and National Provider Identifier (NPI). Attendees are asked to be prepared to provide this information when they attend the workshop.

For workshops that are sponsored by Palmetto GBA, attendees can provide the information during the registration process. Attendees are also encouraged to dress in layers or bring a sweater or jacket to ensure comfort.

As a reminder, providers are encouraged to telephone the Provider Contact Center (PCC) at 855-696-0705 with any claim specific questions they may have as these will not be able to be addressed in the workshop.

Featured speakers will be the Provider Outreach and Education (POE) staff that specializes in clinical, as well as billing and coverage experience.

The schedule of workshops and registration information listed below. To reserve your seat or find out more about the workshops in your area, please make sure you:

1. Create a profile at the new Event Registration Portal to create an account. Your existing Workshops database profile is not linked to the new portal as the profile creation process is different.

2. Log in your Event Registration Portal account and you will be able to register yourself or other people for any workshops hosted in the portal before registration closes. Each workshop will have a separate registration link. For the workshops that Palmetto GBA sponsors, Palmetto GBA’s registration page will be displayed. If the state Association is sponsoring the workshop, the link will take you directly to the Association’s registration page.

2015 Palmetto GBA Hospice Medicare Workshop Series – The Golden Years – Medicare at 50!

Palmetto GBA is pleased to announce our 2015 Hospice workshop series, ‘The Golden Years – Medicare at 50!’ These workshops are designed for hospice providers and their staff to equip them with the tools they need to be successful with Medicare billing, coverage and documentation requirements.

These workshops will provide insight for hospice agency staff at all levels; however, we suggest that providers who are new to Medicare or have new staff attend online learning courses for beginners offered at www.PalmettoGBA.com/hhh. Basic billing and other online educational resources can be found in the Self-Paced Learning section under the Learning and Education link on the left navigation. During the workshop series, Palmetto GBA will provide information related to the most common errors identified.
through a variety of data analysis and some hints and tips on the reasons why these errors occur. Palmetto GBA’s ultimate goal is to have educated and astute providers who know how to accurately and skillfully apply the information they learn to their documentation and billing practices!

**Hospice Topics:**

- Related versus Non-Related Conditions
- Hospice Data
- Improving Your Practice
  - Health Information Supply Chain (HISC)
- Identifying Improper Payments – Palmetto GBA and CERT Reviews
- General Inpatient Care (GIP)
- Pulmonary Patients
- Medicare Program Changes for 2015
  - Principal Diagnoses Coding
  - Hospice Notice of Election (NOE) Submission
- Data Analysis
- Tying It All Together
  - Define, Measure, Analyze, Improve, and Control (DMAIC)
- Provider Resources

**Note:** CMS requires that Medicare contractors track all educational activities, which consists of capturing the provider’s six-digit Provider Transaction Access Number (PTAN) and National Provider Identifier (NPI). Attendees are asked to be prepared to provide this information when they attend the workshop. For workshops that are sponsored by Palmetto GBA, attendees can provide the information during the registration process. Attendees are also encouraged to dress in layers or bring a sweater or jacket to ensure comfort.

As a reminder, providers are encouraged to telephone the Provider Contact Center (PCC) at 855-696-0705 with any claim specific questions they may have as these will not be able to be addressed at the workshop.

Featured speakers will be Provider Outreach and Education (POE) staff that specializes in clinical, as well as billing and coverage experience.
How to Register

The schedule of workshops and registration information listed below. To reserve your seat or find out more about the workshops in your area, please make sure you:

1. Create a profile at the new Event Registration Portal to create an account. Your existing Workshops database profile is not linked to the new portal as the profile creation process is different.

2. Log in your Event Registration Portal account and you will be able to register yourself or other people for any workshops hosted in the portal before registration closes. Each workshop will have a separate registration link. For the workshops that Palmetto GBA sponsors, Palmetto GBA’s registration page will be displayed. If the state Association is sponsoring the workshop, the link will take you directly to the Association’s registration page.

MEDICAL AFFAIRS INFORMATION

Update to Pub. 100-03, National Coverage Determination Manual, Chapter 1, Part 1, Section 50.1 Speech Generating Device

MLN Matters® Number: MM9281
Related Change Request (CR) #: CR 9281
Related CR Release Date: August 21, 2015
Effective Date: July 29, 2015
Related CR Transmittal #: R184NCD
Implementation Date: September 21, 2015

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

Provider Action Needed
Change Request (CR) 9281 updates the Medicare “National Coverage Determinations Manual” to add a revised scope of benefit National Coverage Determination (NCD) for Speech Generating Devices (SGDs) covered under the Medicare benefit category for Durable Medical Equipment (DME). Please make sure that your billing staff are aware of these changes.

Background
Key information in the revised NCD in Chapter 1 of the Manual is as follows:

SGDs are considered to fall within the Durable Medical Equipment (DME) benefit category established by Section 1861(n) of the Social Security Act. They are covered for patients who suffer from a severe speech impairment and have a medical condition that warrants the use of a device based on the following definitions.
SGDs are defined as DME that provide an individual who has a severe speech impairment with the ability to meet his or her functional, speaking needs. Speech Generating Devices are devices or software that generate speech and are used solely by the individual who has a severe speech impairment. The speech is generated using one of the following methods:

- digitized audible/verbal speech output, using prerecorded messages;
- synthesized audible/verbal speech output which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques;
- synthesized audible/verbal speech output which permits multiple methods of message formulation and multiple methods of device access; or
- software that allows a computer or other electronic device to generate audible/verbal speech.

Other covered features of the device include the capability to generate email, text, or phone messages to allow the patient to “speak” or communicate remotely, as well as the capability to download updates to the covered features of the device from the manufacturer or supplier of the device.

If an SGD is limited to use by a patient with a severe speech impairment and is primarily used for the purpose of generating speech, it is not necessary for the device to be dedicated only to audible/verbal speech output to be considered DME. Computers and tablets are generally not considered DME because they are useful in the absence of an illness or injury.

**Nationally Non-Covered Indications**

Internet or phone services or any modification to a patient’s home to allow use of the SGD are not covered by Medicare because such services or modifications could be used for non-medical equipment such as standard phones or personal computers. In addition, specific features of an SGD that are not used by the individual who has a severe speech impairment to meet his or her functional speaking needs are not covered. This would include any computing hardware or software not necessary to allow for generation of speech, email, text or phone messages, such as hardware or software used to create documents and spreadsheets or play games or music, and any other function a computer can perform that is not directly related to meeting the functional speaking communication needs of the patient, including video communications or conferencing. These features of a speech generating device do not fall within the scope of Section 1861(n) of the Social Security Act and the cost of these features are the responsibility of the beneficiary. Suppliers of SGDs are encouraged to furnish the beneficiary with a voluntary Advance Beneficiary Notice (ABN) which informs that these features are not covered by Medicare and the beneficiary is liable for the expense of these features.

**Other**

MACs acting within their respective jurisdictions have discretion to cover or not cover speech generating devices based on their individual reasonable and necessary determinations.

**Additional Information**

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

This advisory should be shared with all health care practitioners and managerial members of the provider/supplier staff. Medicare Advisories are available at no cost from the Palmetto GBA website at www.PalmettoGBA.com/hhh.

Address Changes

Have you changed your address or other significant information recently? To update this information, please complete and submit a CMS 855A form. The most efficient way to submit your information is by Internet-based Provider Enrollment, Chain and Ownership System (PECOS). To make a change in your Medicare enrollment information via the Internet-based PECOS, go to https://pecos.cms.hhs.gov on the CMS website. To obtain the hard copy form plus information on how to complete and submit it, visit the Palmetto GBA website (www.PalmettoGBA.com/hhh).
TOOLS THAT YOU CAN USE

Interactive Part A Remittance Advice

The Remittance Advice (RA) is a notification sent to providers, billers and suppliers after a claim has been received and processed by a Medicare contractor. The RA explains the reasons for payments and adjustments of processed claims.

This interactive guide provides an overview of the Institutional Standard Paper Remittance (SPR) Advice.

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Welcome to Online Provider Services

Palmetto GBA is pleased to offer secure and fast access to your Medicare information through our Online Provider Services System. Through this system, you can view beneficiary eligibility, claims status, online remittances and financial information.

Palmetto GBA offers our Online Provider Services program to providers who have an EDI Enrollment Agreement on file with us. One Provider Administrator is allowed to register for each enrollment agreement on file. Once Provider Administrators successfully register, they can grant access to their associates.
### HELPFUL INFORMATION

#### Contact Information for Palmetto GBA Home Health and Hospice

<table>
<thead>
<tr>
<th>Department</th>
<th>Contact Information</th>
<th>Type of Inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals</td>
<td>Palmetto GBA</td>
<td>• Request for Redeterminations</td>
</tr>
<tr>
<td></td>
<td>HHH Appeals</td>
<td>• Redetermination Form</td>
</tr>
<tr>
<td></td>
<td>Mail Code: AG-630</td>
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<tr>
<td></td>
<td>P.O. Box 100238</td>
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<td></td>
<td>Columbia, SC 29202-3238</td>
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<td></td>
<td>Fax: (803) 699-2425</td>
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</tbody>
</table>

**Fed Ex/UPS/Certified Mail Address**

Palmetto GBA  
HHH Appeals  
Mail Code: AG-630  
Building One  
2300 Springdale Drive  
Camden, SC 29020

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Contact Center (Providers)

Palmetto GBA
HHH PCC
Mail Code: AG-840
P.O. Box 100238
Columbia, SC 29202-3238
Provider Contact Center: 855-696-07050

Our PCC representatives are ready to answer your questions about billing problems and other issues. Please see the following links for more guidance about the HHH Interactive Voice Response (IVR) and contacting the Contact Center:


IVR Conversion Tool
http://www.palmettogba.com/palmetto/ivrt.nsf/Main?OpenForm

HHH PCC Hours: 8 a.m. to 5 p.m. ET

Email HHH to have your inquiry answered. Please do not include any Protected Health Information.
| Cost Report | Cost Report Filing | • Cost Reports  
| • Checks |

**Mailing Address**
Palmetto GBA  
Attn: Cost Report Acceptance  
Mail Code: AG-330  
P.O. Box 100144  
Columbia, SC 29202-3144

**Fed Ex/UPS/Certified Mail Address**
Palmetto GBA  
Attn: Cost Report Acceptance  
Mail Code: AG-330  
2300 Springdale Drive  
Building One  
Camden, SC 29020-1728

**Cost Report Overpayments Address (checks only)**
Palmetto GBA  
Medicare Finance  
Mail Code: AG-260  
P.O. Box 100277  
Columbia, SC 29202-3277

| Credit Balance Reporting | Regular and Certified Mail | • Questions or  
| • concerns regarding credit balance reports |

**Credit Balance Reporting**
Palmetto GBA  
Attn: Credit Balance Reporting  
P.O. Box 100277  
Columbia, SC 29202-3277

**Fed Ex/UPS/Overnight Courier**
Palmetto GBA  
Credit Balance Reporting  
2300 Springdale Drive  
Building One  
Camden, SC 29020

**Reports may be faxed to:**
MCBR Receipts  
Attn: Credit Balance Reporting  
(803) 419-3277

Telephone Number: (803) 763-6418

All email inquiries may be sent to: Credit.Balance@PalmettoGBA.com
Customer Service Center (Beneficiary)

1-800-Medicare (1-800-633-4227)
TTY: 877-486-2048

Visit the Medicare website at www.medicare.gov.

Electronic Data Interchange (EDI)

Palmetto GBA
HHH Part A EDI
Mail Code: AG-420
P.O. Box 100145
Columbia, SC 29202-3145

Provider Contact Center: 855-696-0705

All questions related to the Medicare Program

EDI enrollment
Administrative Simplification and Compliance Act (ASCA)
Electronic Remittance Advice (ERA)
PC-ACE Pro 32 (billing software)
Direct Data Entry (billing software)
Other EDI-related issues
Monday to Friday 6 am - 9 pm ET
Saturday 6 am - 4 pm ET
Sunday** 6 am - 8 am and 12 to 4 pm ET

**Not available on Quarterly Release weekends

Freedom of Information Act (FOIA) Requests

Palmetto GBA – HHH
FOIA Coordinator
Mail Code: AG-615
P.O. Box 100190
Columbia, SC 29202-3190

Send emails to A.Policy@palmettogba.com.

Medicare Affairs

Palmetto GBA
HHH Medical Affairs
Mail Code: AG-300
P.O. Box 100238
Columbia, SC 29202-3238

• Local coverage determinations (LCDs)
<table>
<thead>
<tr>
<th>Medical Review</th>
<th>Palmetto GBA</th>
<th>• Responding to Additional Documentation Requests (ADRs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HHH Medical Review</td>
<td>• Responses to our requests for medical records</td>
</tr>
<tr>
<td></td>
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<td>P.O. Box 100238</td>
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<td>Columbia, SC 29202-3238</td>
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<td></td>
<td>Please call the Provider Contact Center (PCC) at 855-696-0705 for Medical Review questions.</td>
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<tr>
<td>Fed Ex/UPS/Overnight Courier</td>
<td>Palmetto GBA</td>
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<td>Mail Code: AG-230</td>
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<tr>
<td></td>
<td>2300 Springdale Drive, Building One</td>
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<tr>
<td>Medicare</td>
<td>For Coordination of Benefits Contractor (COBC)</td>
<td>• MSP questions</td>
</tr>
<tr>
<td>Secondary Payer (MSP)</td>
<td>questions, call 800-999-1118 or TTY/TDD at 800-318-8782 for the hearing and speech impaired. Customer Service Representatives are available to provide you with quality service Monday through Friday from 8 a.m. to 8 p.m. ET, except holidays. Address for general written inquiries: Medicare - Coordination of Benefits P.O. Box 33847 Detroit, MI 48232</td>
<td>• Questions regarding beneficiary’s primary or secondary records</td>
</tr>
<tr>
<td></td>
<td>Provider Inquiries</td>
<td>• The COB Contractor’s trained staff will help you with COB questions</td>
</tr>
<tr>
<td>Overpayments</td>
<td>Palmetto GBA</td>
<td>• Overpayments</td>
</tr>
<tr>
<td></td>
<td>HHH Overpayments</td>
<td>• Checks for cost reports and credit balances</td>
</tr>
<tr>
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<td>Mail Code: AG-340</td>
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<td></td>
<td>P.O. Box 100277</td>
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<td>Columbia, SC 29202-3277</td>
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<tr>
<td>Fax Numbers</td>
<td>For inquiries regarding overpayments, please call the Provider Contact Center at 855-696-0705.</td>
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<tr>
<td></td>
<td>• To send any financial correspondence to the overpayment department by fax, please fax this information to (803) 419-3275</td>
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<td>• To request an immediate offset, fax your request to (803) 462-2574</td>
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</tr>
</tbody>
</table>

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• Issues related to cost reports, desk reviews, audits and settlements
• Issues related to the filing of cost report appeals and reopenings
Provider Enrollment

Palmetto GBA
HHH Provider Enrollment
Mail Code: AG-331
P.O. Box 100144
Columbia, SC 29202-3144

For inquiries regarding provider enrollment, please call the Provider Contact Center at 855-696-0705.

• Enrollment (credentialing) questions
• Request CMS-855 B, I or R forms
• Change address, add a location, add a new member to a provider group
• Independent Diagnostic testing facility (IDTF) enrollment
• Electronic Funds Transfer (EFT) CMS 588 form
• Medicare Participating Physician or Supplier Agreement (PAR) CMS 460 form
• How to obtain a National Provider Identifier (NPI)
• Participation corrections
• IRS 1099 tax form corrections
• Consent forms
• Educational training requests
• Request a speaker for association meetings in your state

Provider Outreach and Education (POE)

Palmetto GBA
HHH POE
Mail Code: AG-830
P.O. Box 100238
Columbia, SC 29202-3238

For education, please complete the Education Request Form. To access this document, go to the Forms Web Page at www.PalmettoGBA.com/hhh/forms.
**Provider Reimbursement**

Palmetto GBA
Provider Reimbursement
Mail Code: AG-330
P.O. Box 100144
Columbia, SC 29202-3144

Provider inquiries, please call (803) 382-6104.

Fax updated certificates for diabetes education to the reimbursement department at (803) 935-0262.

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**Zone Program Integrity Contractor (ZPIC)**

**Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina and Tennessee home health and hospice providers**

AdvanceMed, an NCI Company
520 Royal Parkway, Suite 100
Nashville, TN 37214
Phone Number: (615) 871-2361
Website: [www.nciinc.com/about-us/advancemed](http://www.nciinc.com/about-us/advancemed)

**New Mexico, Oklahoma and Texas home health and hospice providers**

Health Integrity, LLC
Website: [www.healthintegrity.org](http://www.healthintegrity.org)
Phone Number: (972) 383-0000

**Florida home health and hospice providers**

SafeGuard Services
3450 Lakeside Drive, Suite 201
Miramar, FL 33027
Phone Number: (954) 433-6200

- Submission of interim rate information
- Reimbursement issues
- Reimbursement specialist
- Submission of certificates
- Fraud
- Abuse
- Questionable billing practices

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