**Communique'**

**Wisconsin Physicians Service Insurance Corporation**

**Part B**

**http://www.wpsmedicare.com**

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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: http://www.wpsmedicare.com

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WPS Medicare is pleased to offer the convenient services of our WPS Medicare eNews to all providers in our jurisdiction. WPS Medicare eNews is an electronic newsletter sent to you via email. When you subscribe, WPS Medicare eNews will bring the latest Medicare news directly to your email box, free of charge! You may unsubscribe at any time, and, as with all aspects of the WPS Medicare publications, we value your privacy and will never disclose, give, sell or transfer any personally identifiable information to third parties.

WPS Medicare eNews announces the posting of the following:
- Time-sensitive national and local Medicare news
- Medicare program changes
- Policy updates, including new, retired, and revised policies
- Training events (including seminars, teleconferences, webinars, and on demand trainings!)
- Communiqué newsletters
- Specialty- and service-specific educational articles
- Much, much more!

It is important to note that the Centers for Medicare & Medicaid Services (CMS) requires Medicare contractors (including WPS Medicare) to increase provider subscribership to their eNews every year. In addition, CMS has instructed that every Medicare provider (including physicians, nurses, and billing staff) should be subscribed to eNews. It is a common misconception that only one provider in an office can be subscribed to WPS Medicare eNews; CMS and WPS Medicare encourage and expect all Medicare providers to subscribe to eNews.

Sign up today! Visit our website at http://www.wpsmedicare.com/listserv to subscribe (it only takes a minute). And if you know a co-worker or another Medicare provider who isn't receiving WPS Medicare eNews, let them know that they're missing out on a very informative educational resource and direct them to http://www.wpsmedicare.com/listserv to sign up as well!

MEDI CARE PARTICIPATING PHYSICIANS AND SUPPLIERS DIRECTORY (MEDPARD) NOW AVAILABLE

Participating physicians and suppliers are health care providers that have entered into a contract with the Medicare Part B program. The contract states the provider must accept the Medicare Part B approved amount as payment in full for services provided. The new 2015 Medicare Part B Participating Physicians and Suppliers Directory (MEDPARD) (http://www.wpsmedicare.com/findadoctor.shtml) is now available on the WPS Medicare website.

NOTIFICATION TO PROVIDERS

Centralized billing is a process in which a provider, who provides mass immunization services for influenza virus and Pneumococcal (PPV) immunizations, can send all claims to a single
contractor for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the influenza virus and pneumococcal vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in centralized billing must contact CMS central office, in writing, at the following address by June 1 of the year they wish to begin centrally billing.

Centers for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop C4-10-07
Baltimore, Maryland 21244

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

Criteria for Centralized Billing

- To qualify for centralized billing, an individual or entity providing mass immunization services for influenza virus and pneumococcal vaccinations must provide these services in at least three payment localities for which there are at least three different contractors processing claims.

- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.

- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the influenza virus and pneumococcal benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, (i.e., beneficiaries may not incur any out-of-pocket expense). For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza virus vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. **Note:** The practice of requiring a beneficiary to pay for the vaccination upfront and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per §1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment.

- The contractor assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned contractor for this year is Novitas.
• The payment rates for the administration of the vaccinations are based on the MPFS for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.

• The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.

• Centralized billers must submit their claims on roster bills in an approved Electronic Media Claims standard format. Paper claims will not be accepted.

• Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. Novitas must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary’s Medicare HICN) as the contractor will not be able to process incomplete or incorrect claims.

• Centralized billers must obtain an address for each beneficiary so that an MSN can be sent to the beneficiary by the contractor. Beneficiaries are sometimes confused when they receive an MSN from a contractor other than the contractor that normally processes their claims which results in unnecessary beneficiary inquiries to the Medicare contractor. Therefore, centralized billers must provide every beneficiary receiving an influenza virus or pneumococcal vaccination with the name of the processing contractor. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.

• Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. Novitas can provide this information.

• Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from Novitas. This can be done by completing the Form CMS-855 (Provider Enrollment Application), which can be obtained from Novitas.

• If an individual or entity’s request for centralized billing is approved, the approval is limited to the 12 month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. Claims will not be processed for any centralized biller without permission from CMS.

• Each year the centralized biller must contact Novitas to verify understanding of the coverage policy for the administration of the pneumococcal vaccine, and for a copy of the warning language that is required on the roster bill.
• The centralized biller is responsible for providing the beneficiary with a record of the pneumococcal vaccination.

The information in items 1 through 8 below must be included with the individual or entity’s annual request to participate in centralized billing:

1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations;
2. Estimates for the number of beneficiaries who will receive pneumococcal vaccinations;
3. The approximate dates for when the vaccinations will be given;
4. A list of the States in which influenza virus and pneumococcal clinics will be held;
5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse);
6. Whether the nurses who will administer the influenza virus and pneumococcal vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza virus and pneumococcal vaccinations;
7. Names and addresses of all entities operating under the corporation’s application;
8. Contact information for designated contact person for centralized billing program.
Raising Awareness of Diabetes in November - During the month of November, the United States draws attention to diabetes and its impact on public health through several national health observances, including National Diabetes Month, Diabetic Eye Disease Month, and World Diabetes Day. Millions of Americans have diabetes and don’t know it. Left undiagnosed or untreated, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney disease, amputation, and even premature death. Read more to learn about the preventive services covered by Medicare that focus on early disease detection and disease management.

MLN Matters® Number: MM8982 Related Change Request (CR) #: CR 8982
Related CR Release Date: November 21, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R89GI Implementation Date: January 5, 2015

Update to Medicare Deductible, Coinsurance, and Premium Rates for 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 & Hospice MACs and Durable Medical Equipment MACs, for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8982 informs the MACs about the changes needed to update the claims processing system with the new Calendar Year (CY) 2015 Medicare deductible, coinsurance, and premium rates. Make sure that your billing staff are aware of these changes.

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This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
Background

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

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. The 2015 rates are as follows:

2015 PART A - HOSPITAL INSURANCE (HI)

- **Deductible:** $1,260.00

- **Coinsurance:**
  - $315.00 a day for 61st-90th day
  - $630.00 a day for 91st-150th day (lifetime reserve days)
  - $157.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)

- **Base Premium (BP):** $407.00 a month

- **BP with 10% surcharge:** $447.70 a month

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• BP with 45% reduction: $224.00 a month (for those who have 30-39 quarters of coverage)

• BP with 45% reduction and 10% surcharge: $246.40 a month

2015 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)

• Standard Premium: $104.90 a month

• Deductible: $147.00 a year

• Pro Rata Data Amount:
  • $114.99 1st month
  • $32.01 2nd month

• Coinsurance: 20 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-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?

Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article #MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and MLN Matters® Article #SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

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

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REVISED product from the Medicare Learning Network® (MLN)

- “Medicare Secondary Payer Provisions” Web-based Training (WBT)

MLN Matters® Number: MM 9018  
Related Change Request (CR) #: CR 9018

Related CR Release Date: December 12, 2014  
Effective Date: January 1, 2015

Related CR Transmittal #: R3148CP  
Implementation Date: January 5, 2015


Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9018 notifies suppliers that the spreadsheet containing an updated list of Healthcare Common Procedure Coding System (HCPCS) codes for DME MAC or MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the “Medicare Claims Processing Manual” are reflected in the recurring update notification.

The spreadsheet for the 2015 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at [http://www.cms.gov/Center/Provider-](http://www.cms.gov/Center/Provider-).
Type/Durable-Medical-Equipment-DME-Center.html on the Centers for Medicare & Medicaid Services (CMS) website. The spreadsheet is also attached to CR9018.

**Additional Information**


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

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**Seasonal Flu Vaccinations** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients.


While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community. The HealthMap Vaccine Finder is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the HealthMap Vaccine Finder database, [register](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) for an account to submit your information in the database. Also, visit the CDC [Influenza (Flu)](http://www.cdc.gov/flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.
Coding for ICD-10-CM: More of the Basics MLN Connects™ Video - In this MLN Connects™ video on Coding for ICD-10-CM: More of the Basics, Sue Bowman from the American Health Information Management Association (AHIMA) and Nelly Leon-Chisen from the American Hospital Association (AHA) provide a basic introduction to ICD-10-CM coding. The objective of this video is to enhance viewers’ understanding of the characteristics and unique features of ICD-10-CM, as well as similarities and differences between ICD-9-CM and ICD-10-CM. Run time: 36 minutes.

MLN Matters® Number: MM9035  Related Change Request (CR) #: CR 9035
Related CR Release Date: January 30, 2015  Effective Date: January 1, 2015
Related CR Transmittal #: R3182CP  Implementation Date: April 6, 2015

Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9035 informs MACs about the HCPCS codes for 2015 that are both subject to and excluded from CLIA edits. CR 9035 also includes the HCPCS codes discontinued as of December 31, 2014.

Make sure that your billing staffs are aware of these CLIA-related changes for 2015 and that you remain current with CLIA certification requirements.
**Background**

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Centers for Medicare & Medicaid Services (CMS) only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

The HCPCS codes that are considered a laboratory test under CLIA change each year, and your Medicare contractors need to be informed about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

**Discontinued HCPCS Codes**

The HCPCS codes listed in Table 1 below were discontinued on December 31, 2014.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0417</td>
<td>Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 21-40 specimens</td>
</tr>
<tr>
<td>G0418</td>
<td>Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 41-60 specimens</td>
</tr>
<tr>
<td>G0419</td>
<td>Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, &gt;60 specimens</td>
</tr>
<tr>
<td>80100</td>
<td>Drug screen, multiple drugs</td>
</tr>
<tr>
<td>80101</td>
<td>Drug screen</td>
</tr>
<tr>
<td>80102</td>
<td>Drug confirmation test</td>
</tr>
<tr>
<td>80103</td>
<td>Tissue preparation for drug analysis</td>
</tr>
<tr>
<td>80104</td>
<td>Drug screen, multiple drugs</td>
</tr>
<tr>
<td>80152</td>
<td>Amitriptyline (antidepressant) level</td>
</tr>
<tr>
<td>80154</td>
<td>Benzodiazepines level</td>
</tr>
<tr>
<td>80160</td>
<td>Desipramine level</td>
</tr>
<tr>
<td>80166</td>
<td>Assay of doxepin</td>
</tr>
<tr>
<td>80172</td>
<td>Gold level</td>
</tr>
<tr>
<td>80174</td>
<td>Imipramine level</td>
</tr>
<tr>
<td>80182</td>
<td>Nortriptyline level</td>
</tr>
<tr>
<td>80196</td>
<td>Salicylate (aspirin) level</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>80440</td>
<td>Thyrotropin releasing hormone (TRH) (hypothalamus hormone) stimulation panel</td>
</tr>
<tr>
<td>82000</td>
<td>Acetaldehyde blood test</td>
</tr>
<tr>
<td>82003</td>
<td>Acetaminophen level</td>
</tr>
<tr>
<td>82055</td>
<td>Alcohol (ethanol) level</td>
</tr>
<tr>
<td>82101</td>
<td>Urine alkaloids level</td>
</tr>
<tr>
<td>82145</td>
<td>Amphetamine or methamphetamine level</td>
</tr>
<tr>
<td>82205</td>
<td>Barbiturates level</td>
</tr>
<tr>
<td>82520</td>
<td>Cocaine (drug) level</td>
</tr>
<tr>
<td>82646</td>
<td>Dihydrocodeinone (drug) measurement</td>
</tr>
<tr>
<td>82649</td>
<td>Dihydromorphinone (drug) level</td>
</tr>
<tr>
<td>82651</td>
<td>Dihydrotestosterone (DHT) level</td>
</tr>
<tr>
<td>82654</td>
<td>Dimethadione (drug) level</td>
</tr>
<tr>
<td>82666</td>
<td>Epiandrosterone (synthetic hormone) level</td>
</tr>
<tr>
<td>82690</td>
<td>Ethchlorvynol (drug) level</td>
</tr>
<tr>
<td>82742</td>
<td>Flurazepam (drug) level</td>
</tr>
<tr>
<td>82953</td>
<td>Glucose (sugar) tolerance test</td>
</tr>
<tr>
<td>82975</td>
<td>Glutamine (amino acid by product) level</td>
</tr>
<tr>
<td>82980</td>
<td>Glutethimide (drug) level</td>
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<tr>
<td>83008</td>
<td>Guanosine monophosphate (cellular chemical) level</td>
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<tr>
<td>83055</td>
<td>Sulfhemoglobin (hemoglobin) analysis</td>
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<tr>
<td>83071</td>
<td>Hemosiderin (hemoglobin breakdown product) level</td>
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<tr>
<td>83634</td>
<td>Urine lactose (carbohydrate) analysis</td>
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<tr>
<td>83805</td>
<td>Meprobamate (sedative) level</td>
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<tr>
<td>83840</td>
<td>Methadone level</td>
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<tr>
<td>83858</td>
<td>Methsuximide (drug) level</td>
</tr>
<tr>
<td>83866</td>
<td>Mucopolysaccharides (protein) screening test</td>
</tr>
<tr>
<td>83887</td>
<td>Nicotine level</td>
</tr>
<tr>
<td>83925</td>
<td>Opiates (drug) measurement</td>
</tr>
</tbody>
</table>

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### New HCPCS Codes for 2015

The HCPCS codes listed in Table 2 below are new for 2015 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. The HCPCS codes listed in Table 2 require a facility to have either:

1. CLIA certificate of registration (certificate type code 9);
2. CLIA certificate of compliance (certificate type code 1); or
3. CLIA certificate of accreditation (certificate type code 3).

The following facilities are not permitted to be paid for these tests:

1. A facility without a valid, current, CLIA certificate;
2. A facility with a current CLIA certificate of waiver (certificate type code 2); or
3. A facility with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4).

Note: The HCPCS code 89337 [Frozen preservation of mature eggs] is new for 2015, is excluded from CLIA edits and does not require a facility to have any CLIA certificate.

### Table 2: New HCPCS Codes Subject to CLIA Edits for 2015

Note: Does not include new HCPCS codes for waived tests or provider-performed procedures.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0464</td>
<td>Colorectal cancer screening; stool-based dna and fecal occult hemoglobin (e.g., kras, ndrg4 and bmp3)</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Descriptor</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>G6030</td>
<td>Amitriptyline</td>
</tr>
<tr>
<td>G6031</td>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>G6032</td>
<td>Desipramine</td>
</tr>
<tr>
<td>G6034</td>
<td>Doxepin</td>
</tr>
<tr>
<td>G6035</td>
<td>Gold</td>
</tr>
<tr>
<td>G6036</td>
<td>Assay of imipramine</td>
</tr>
<tr>
<td>G6037</td>
<td>Nortriptyline</td>
</tr>
<tr>
<td>G6038</td>
<td>Salicylate</td>
</tr>
<tr>
<td>G6039</td>
<td>Acetaminophen</td>
</tr>
<tr>
<td>G6040</td>
<td>Alcohol (ethanol) any specimen except breath</td>
</tr>
<tr>
<td>G6041</td>
<td>Alkaloids, urine, quantitative</td>
</tr>
<tr>
<td>G6042</td>
<td>Amphetamine or methamphetamine</td>
</tr>
<tr>
<td>G6043</td>
<td>Barbiturates, not elsewhere specified</td>
</tr>
<tr>
<td>G6044</td>
<td>Cocaine or metabolite</td>
</tr>
<tr>
<td>G6045</td>
<td>Dihydrocodeinone</td>
</tr>
<tr>
<td>G6046</td>
<td>Dihydromorphinone</td>
</tr>
<tr>
<td>G6047</td>
<td>Dihydrotestosterone</td>
</tr>
<tr>
<td>G6048</td>
<td>Dimethadione</td>
</tr>
<tr>
<td>G6049</td>
<td>Epiandrosterone</td>
</tr>
<tr>
<td>G6050</td>
<td>Ethchlorvynol</td>
</tr>
<tr>
<td>G6051</td>
<td>Flurazepam</td>
</tr>
<tr>
<td>G6052</td>
<td>Meprobamate</td>
</tr>
<tr>
<td>G6053</td>
<td>Methadone</td>
</tr>
<tr>
<td>G6054</td>
<td>Methsuximide</td>
</tr>
<tr>
<td>G6055</td>
<td>Nicotine</td>
</tr>
<tr>
<td>G6056</td>
<td>Opiate(s), drug and metabolites, each procedure</td>
</tr>
<tr>
<td>G6057</td>
<td>Phenothiazine</td>
</tr>
<tr>
<td>G6058</td>
<td>Drug confirmation, each procedure</td>
</tr>
<tr>
<td>80163</td>
<td>Digoxin level</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>80165</td>
<td>Valproic acid level</td>
</tr>
<tr>
<td>80300</td>
<td>Drug screen</td>
</tr>
<tr>
<td>80301</td>
<td>Drug screen</td>
</tr>
<tr>
<td>80302</td>
<td>Drug screen</td>
</tr>
<tr>
<td>80303</td>
<td>Drug screen</td>
</tr>
<tr>
<td>80304</td>
<td>Drug screen</td>
</tr>
<tr>
<td>80320</td>
<td>Alcohols levels</td>
</tr>
<tr>
<td>80321</td>
<td>Alcohols levels</td>
</tr>
<tr>
<td>80322</td>
<td>Alcohols levels</td>
</tr>
<tr>
<td>80323</td>
<td>Alkaloids levels</td>
</tr>
<tr>
<td>80324</td>
<td>Amphetamines levels</td>
</tr>
<tr>
<td>80325</td>
<td>Amphetamines levels</td>
</tr>
<tr>
<td>80326</td>
<td>Amphetamines levels</td>
</tr>
<tr>
<td>80327</td>
<td>Anabolic steroids levels</td>
</tr>
<tr>
<td>80328</td>
<td>Anabolic steroids levels</td>
</tr>
<tr>
<td>80329</td>
<td>Analgesics levels</td>
</tr>
<tr>
<td>80330</td>
<td>Analgesics levels</td>
</tr>
<tr>
<td>80331</td>
<td>Analgesics levels</td>
</tr>
<tr>
<td>80332</td>
<td>Antidepressants levels</td>
</tr>
<tr>
<td>80333</td>
<td>Antidepressants levels</td>
</tr>
<tr>
<td>80334</td>
<td>Antidepressants levels</td>
</tr>
<tr>
<td>80335</td>
<td>Antidepressants levels</td>
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<tr>
<td>80336</td>
<td>Antidepressants levels</td>
</tr>
<tr>
<td>80337</td>
<td>Antidepressants levels</td>
</tr>
<tr>
<td>80338</td>
<td>Antidepressants levels</td>
</tr>
<tr>
<td>80339</td>
<td>Antiepileptics levels</td>
</tr>
<tr>
<td>80340</td>
<td>Antiepileptics levels</td>
</tr>
<tr>
<td>80341</td>
<td>Antiepileptics levels</td>
</tr>
<tr>
<td>80342</td>
<td>Antipsychotics levels</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>80343</td>
<td>Antipsychotics levels</td>
</tr>
<tr>
<td>80344</td>
<td>Antipsychotics levels</td>
</tr>
<tr>
<td>80345</td>
<td>Barbiturates levels</td>
</tr>
<tr>
<td>80346</td>
<td>Benzodiazepines levels</td>
</tr>
<tr>
<td>80347</td>
<td>Benzodiazepines levels</td>
</tr>
<tr>
<td>80348</td>
<td>Buprenorphine level</td>
</tr>
<tr>
<td>80349</td>
<td>Cannabinoids levels</td>
</tr>
<tr>
<td>80350</td>
<td>Cannabinoids levels</td>
</tr>
<tr>
<td>80351</td>
<td>Cannabinoids levels</td>
</tr>
<tr>
<td>80352</td>
<td>Cannabinoids levels</td>
</tr>
<tr>
<td>80353</td>
<td>Cocaine level</td>
</tr>
<tr>
<td>80354</td>
<td>Fentanyl level</td>
</tr>
<tr>
<td>80355</td>
<td>Gabapentin level nonblood</td>
</tr>
<tr>
<td>80356</td>
<td>Heroin metabolite level</td>
</tr>
<tr>
<td>80357</td>
<td>Ketamine and norketamine levels</td>
</tr>
<tr>
<td>80358</td>
<td>Methadone level</td>
</tr>
<tr>
<td>80359</td>
<td>Methylenedioxymphetamines levels</td>
</tr>
<tr>
<td>80360</td>
<td>Methylphenidate level</td>
</tr>
<tr>
<td>80361</td>
<td>Opiates levels</td>
</tr>
<tr>
<td>80362</td>
<td>Opioids levels</td>
</tr>
<tr>
<td>80363</td>
<td>Opioids levels</td>
</tr>
<tr>
<td>80364</td>
<td>Opioids levels</td>
</tr>
<tr>
<td>80365</td>
<td>Oxycodone levels</td>
</tr>
<tr>
<td>80366</td>
<td>Pregabalin level</td>
</tr>
<tr>
<td>80367</td>
<td>Propoxyphene level</td>
</tr>
<tr>
<td>80368</td>
<td>Sedative hypnotics (nonbenzodiazepines) levels</td>
</tr>
<tr>
<td>80369</td>
<td>Skeletal muscle relaxants levels</td>
</tr>
<tr>
<td>80370</td>
<td>Skeletal muscle relaxants levels</td>
</tr>
<tr>
<td>80371</td>
<td>Synthetic stimulants levels</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>80372</td>
<td>Tapentadol level</td>
</tr>
<tr>
<td>80373</td>
<td>Tramadol level</td>
</tr>
<tr>
<td>80374</td>
<td>Stereoisomer (enantiomer) drug analysis</td>
</tr>
<tr>
<td>80375</td>
<td>Drugs or substances measurement</td>
</tr>
<tr>
<td>80376</td>
<td>Drugs or substances measurement</td>
</tr>
<tr>
<td>80377</td>
<td>Drugs or substances measurement</td>
</tr>
<tr>
<td>81246</td>
<td>Test for detecting genes associated with blood cancer</td>
</tr>
<tr>
<td>81288</td>
<td>Test for detecting genes associated with colon cancer</td>
</tr>
<tr>
<td>81313</td>
<td>Test for detecting genes associated with prostate cancer</td>
</tr>
<tr>
<td>81410</td>
<td>Test for detecting genes associated with heart disease</td>
</tr>
<tr>
<td>81411</td>
<td>Test for detecting genes associated with heart disease</td>
</tr>
<tr>
<td>81415</td>
<td>Test for detecting genes associated with diseases</td>
</tr>
<tr>
<td>81416</td>
<td>Test for detecting genes associated with disease</td>
</tr>
<tr>
<td>81417</td>
<td>Reevaluation test for detecting genes associated with disease</td>
</tr>
<tr>
<td>81420</td>
<td>Test for detecting genes associated with fetal disease</td>
</tr>
<tr>
<td>81425</td>
<td>Test for detecting genes associated with disease</td>
</tr>
<tr>
<td>81426</td>
<td>Test for detecting genes associated with disease</td>
</tr>
<tr>
<td>81427</td>
<td>Reevaluation test for detecting genes associated with disease</td>
</tr>
<tr>
<td>81430</td>
<td>Test for detecting genes causing hearing loss</td>
</tr>
<tr>
<td>81431</td>
<td>Test for detecting genes causing hearing loss</td>
</tr>
<tr>
<td>81435</td>
<td>Test for detecting genes associated with colon cancer</td>
</tr>
<tr>
<td>81436</td>
<td>Test for detecting genes associated with colon cancer</td>
</tr>
<tr>
<td>81440</td>
<td>Test for detecting genes associated with cancer of body organ</td>
</tr>
<tr>
<td>81445</td>
<td>Test for detecting genes associated with cancer of body organ</td>
</tr>
<tr>
<td>81450</td>
<td>Test for detecting genes associated with blood related cancer</td>
</tr>
<tr>
<td>81455</td>
<td>Test for detecting genes associated with cancer</td>
</tr>
<tr>
<td>81460</td>
<td>Test for detecting genes associated with disease</td>
</tr>
<tr>
<td>81465</td>
<td>Test for detecting genes associated with disease</td>
</tr>
<tr>
<td>81470</td>
<td>Test for detecting genes associated with intellectual disability</td>
</tr>
</tbody>
</table>

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### HCPCS Code | Descriptor
--- | ---
81471 | Test for detecting genes associated with intellectual disability
81519 | Test for detecting genes associated with breast cancer
87505 | Detection test for digestive tract pathogen;
87506 | Detection test for digestive tract pathogen;
87507 | Detection test for digestive tract pathogen
83006 | Test for detecting genes associated with growth stimulation
87623 | Detection test for human papillomavirus (hpv)
87624 | Detection test for human papillomavirus (hpv)
87625 | Detection test for human papillomavirus (hpv)
87806 | Detection test for HIV1
88341 | Special stained specimen slides to examine tissue
88344 | Special stained specimen slides to examine tissue
88364 | Cell examination
88366 | Cell examination
88369 | Microscopic genetic examination manual
88373 | Microscopic genetic examination using computerassisted technology
88374 | Microscopic genetic examination using computerassisted technology
88377 | Microscopic genetic examination manual.

On November 19, 2014, CMS released CR 8871 which mentioned that effective for services performed on or after June 2, 2014, the new HCPCS G0472, HCV screening, will be recognized as a covered service. G0472 is a code that:

- Is considered a test under CLIA;
- Is subject to CLIA edits; and
- Would require a facility to have either:
  - A CLIA certificate of registration (certificate type code 9),
  - A CLIA certificate of compliance (certificate type code 1), or
  - A CLIA certificate of accreditation (certificate type code 3).

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.

| Seasonal Flu Vaccinations | For information on coverage and billing of the influenza vaccine and its administration, please refer to MLN Matters® Article #MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and MLN Matters® Article #SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

Also, check out the following resources from the Centers for Disease Control and Prevention (CDC): Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources. Review the CDC’s Antiviral Drugs website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated “Influenza Antiviral Medications: Summary for Clinicians.” A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at [http://emergency.cdc.gov/HAN/han00375.asp](http://emergency.cdc.gov/HAN/han00375.asp) on the Internet. |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM8951  Related Change Request (CR) #: CR 8951
Related CR Release Date: December 12, 2014  Effective Date: January 1, 2015
Related CR Transmittal #: R3149CP  Implementation Date: January 5, 2015

New Waived Tests

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8951 informs MACs about the new Clinical Laboratory Improvement Amendments of 1998 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so that they can accurately process claims. There are four newly added waived complexity tests.

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The CPT codes that the CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. If you do not have a valid, current, CLIA certificate and submit a claim to your MAC for a Current Procedural Terminology (CPT)
code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted. Make sure that your billing staffs are aware of these changes.

**Background**

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the FDA as waived tests under CLIA. CPT codes for the following new tests must have the modifier QW to be recognized as a waived test. Tests with CPT codes shown on the first page of the attachment to CR8951 (81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>87807QW</td>
<td>March 18, 2014</td>
<td>BD Veritor System for Rapid Detection of RSV (For use with nasopharyngeal specimens) {Includes a reader}</td>
</tr>
<tr>
<td>G0434QW</td>
<td>May 12, 2014</td>
<td>Native Diagnostics International, DrugSmart Dip Single/Multi-Panel Drug Screen Dip Card Tests</td>
</tr>
<tr>
<td>87807QW</td>
<td>May 30, 2014</td>
<td>Sofia RSV</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen THC One Step Marijuana Test Strip</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen THC One Step Marijuana Test Cassette</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen THC One Step Marijuana Test Cup</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen THC One Step Marijuana Test Dip Card</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen mAMP One Step Methamphetamine Test Strip</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen mAMP One Step Methamphetamine Test Cassette</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen mAMP One Step Methamphetamine Test Cup</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen mAMP One Step Methamphetamine Test Dip Card</td>
</tr>
<tr>
<td>87880QW</td>
<td>June 11, 2014</td>
<td>Poly stat Strep A Strip Test {Specimen type (Throat Swab)}</td>
</tr>
</tbody>
</table>

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MACs will not search their files to either retract payment or retroactively pay claims processed prior to implementation of CR8951; however, they should adjust claims if you bring such claims to your MAC’s attention.

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.

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MLN Connects™ National Provider Call: National Partnership to Improve Dementia Care in Nursing Homes - Tuesday, December 9; 1:30-3pm ET - During this MLN Connects Call, speakers will discuss innovative efforts from State-based Alzheimer’s Association Chapters related to train-the-trainer programs, as well as the implementation of the Comfort First Approach in nursing homes. CMS subject matter experts will provide National Partnership updates and discuss next steps for the initiative. Register or visit the December 9 call web page for more information.

MLN Matters® Number: MM8908
Related Change Request (CR) #: CR 8908
Related CR Release Date: November 26, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3132CP
Implementation Date: April 6, 2015

Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 21.1, Effective April 1, 2015

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

Provider Action Needed
Change Request (CR) 8908 informs MACs about the release of the latest package of CCI edits, Version 21.1, which will be effective April 1, 2015. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control...
improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association’s Current Procedural Terminology manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of NCCI edits, Version 21.1, effective April 1, 2015, will be available to the MACs via the CMS Data Center on or about January 31, 2015, and a final file will be available to them on or about February 14, 2015.

Version 21.1 will include all previous versions and updates from January 1, 1996, to the present. In the past, NCCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the Outpatient Code Editor (OCE). It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits. CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file. Refer to the CMS NCCI webpage for additional information at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html 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.
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

REVISED products from the MLN


MLN Matters® Number: MM8806 Revised
Related Change Request (CR) #: CR 8806
Related CR Release Date: November 3, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3103CP
Implementation Date: Claims with a receipt date on or after April 1, 2015

Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims

Note: This article was revised on November 6, 2014, to reflect the revised CR8806 issued on November 3. The CR was revised to change the effective and implementation dates. Also, in the article, the CR release date, transmittal number, and the Web address for accessing the article are revised. All other information remains the same.

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

Provider Action Needed
This article is based on Change Request (CR) 8806, which provides guidance for physicians and suppliers billing anti-markup and reference laboratory claims. Effective for anti-markup and reference laboratory claims submitted with a receipt date on and after April 1, 2015, billing physicians and suppliers are required to report the name, address, ZIP code, and the National Provider Identifier (NPI) of the performing physician or supplier when the article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
performing physician or supplier is enrolled in a different contractor’s jurisdiction. Make sure your billing staffs are aware of this update.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all covered health care entities follow the same standard for submitting and processing electronic claims transactions. According to the instructions for use of the American National Standards Institute (ANSI) X12 837 professional electronic claim transaction, suppliers must submit the NPI that matches the name and address of the servicing provider/supplier identified on the claim.

On anti-markup and reference laboratory claims, physicians and other suppliers are required to identify the supplier's name, address, and ZIP code in Item 32 of the CMS-1500 claim, or the corresponding loop and segment of the ANSI X12 837 professional electronic claim format. The NPI of the physician or supplier who actually performed the service is required in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the ANSI X12 837 professional electronic claim transaction.

However, prior to the implementation of the Provider Enrollment, Chain, and Ownership System (PECOS), MACs used systems that were specific to each MAC and did not allow MACs from one State to view provider enrollment information from another State. This systems limitation prevented MACs from being able to share information about existing providers/suppliers, and increased the potential for fraud. As a result, physicians and suppliers that were enrolled in another MAC’s jurisdiction could not validate the NPI in Item 32a of the CMS-1500 claim form or on the ANSI X12 837 professional electronic claim format, because the function was not available in PECOS.

Since the NPI of the physician/supplier that actually performed the test may not be available to the billing physician or supplier, the "Medicare Claims Processing Manual" currently instructs physicians and suppliers to submit their own NPI with the name and address of the actual performing physician or supplier in Item 32a (and its electronic equivalent) when billing for reference laboratory services, or services subject anti-markup, when the performing physician or supplier is enrolled in another contractor’s jurisdiction.

Effective April 1, 2015, changes to PECOS will allow MACs the ability to verify all physician and supplier NPIs, regardless of the jurisdiction in which they are enrolled. Therefore, beginning with claims received on or after April 1, 2015, physicians and suppliers billing anti-markup and reference laboratory claims must report the NPI of the physician or supplier who actually performed the service in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the American National Standards Institute (ANSI) X12 837 professional electronic claim format. This new

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requirement applies to all claims, including claims for services where the performing physician/supplier is out of the processing MAC’s jurisdiction.

Anti-mark up claims will be identified by the presence of the “Yes” indicator in Item 20 of the CMS-1500 or its electronic equivalent. Reference laboratory claims will be identified by the presence of 90 on any service line.

MACs will return as unprocessable a claim:

- Where the NPI in Item 32a (or its electronic equivalent) does not belong to the entity whose name and address are identified in Item 32 (or its electronic equivalent)
- For a reference laboratory or anti-markup service that is performed outside the MAC’s billing jurisdiction when submitted without the name, address, and ZIP code of the performing physician/supplier in Item 32, and the NPI of the performing physician/supplier in Item 32a of the CMS-1500 claim form, or on the ANSI X12 837 professional electronic claim format, in the appropriate loops/segments
- For a reference laboratory or anti-markup service performed outside the contractor’s billing jurisdiction when the NPI in Item 32A (or its electronic equivalent) does not match the name and address of a valid servicing physician/supplier identified on the existing table in PECOS.

MACs use the following codes for claims returned as unprocessable:

- Claim Adjustment Reason Code (CARC) 16 - Claim/service lacks information which is needed for adjudication.
- For reference lab claims, Remittance Advice Remarks Code (RARC) N270 - Missing/incomplete/invalid other provider primary identifier.
- For anti-markup claims, RARC N283 - Missing/incomplete/invalid purchased service provider identifier.
- Group Code: Contractual Obligation (CO)

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.

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CODING AND BILLING FOR INJECTAFER ® (FERRIC CARBOXYMALTOSE INJECTION)

Effective January 1, 2015, HCPCS code J1439 Injection, ferric carboxymaltose, 1mg should be used for Injectafer.

Injectafer ® (ferric carboxymaltose injection) is an iron replacement product indicated for adult patients for treatment of iron deficiency anemia and

- who have intolerance to oral iron or have had unsatisfactory response to oral iron
  - OR
- who have non-dialysis dependent chronic renal failure.

Medical records should be legible, contain relevant history and physical findings and results of pertinent diagnostic tests or procedures and support the medical necessity for the use of Injectafer. Medical records must be available for submission upon request.

Review may be required to substantiate the need for the use of Injectafer in patients with iron deficiency anemia who have intolerance to oral iron or have had unsatisfactory response to oral iron. The medical record documentation must also support the need for Injectafer by containing the specific issues with intolerance to oral iron or the details of previous oral iron use leading up to the decision that there is unsatisfactory response to oral iron.

CPT Drug Administration Codes for Injectafer ®

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96374</td>
<td>Therapeutic, prophylactic, or diagnostic injection (specify substance or drug) Intravenous Push single or initial substance/drug</td>
</tr>
<tr>
<td>96365</td>
<td>Intravenous Infusion for therapy, prophylaxis, or diagnosis, (specify substance or drug); initial up to 1 hour</td>
</tr>
</tbody>
</table>

References:
HCPCS
CPT
Prescribing Information

DENOSUMAB (PROLIA™) AND (XGEVA™): ARE YOU CODING CORRECTLY?

The FDA has approved the use of denosumab (PROLIA™) and (Xgeva™). Medicare has determined under Section 1861(t) that this drug may be paid when it is administered incident to a physician's service and is determined to be reasonable and necessary. Such determination of reasonable and necessary is currently left to the discretion of the Medicare contractors.
Indications:

Indications for denosumab (PROLIA™):

- For the treatment of postmenopausal women with osteoporosis at high risk for fracture defined as a history of osteoporotic fracture, or multiple risk factors for fracture;
- For the treatment of postmenopausal women with osteoporosis who have failed or are intolerant to other available osteoporosis therapy.
- Indicated as a treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer.
- Indicated as a treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer.
- For treatment in men to increase bone mass with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy.

Indications for denosumab (Xgeva™):

- Xgeva™ is approved for the treatment of patients with bone metastases from solid tumors for the prevention of skeletal-related events.
- Xgeva™ is approved for the treatment of adult and skeletally mature adolescent patients with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity.
- Xgeva™ is approved for the treatment of hypercalcemia of malignancy (HCM) refractory to bisphosphonate therapy.

Limitations:

- Denosumab (PROLIA™) is contraindicated in patients with hypocalcemia.
- Denosumab (PROLIA™) is contraindicated in patients with pregnancy.
- Denosumab (Xgeva™) is not approved for patients with multiple myeloma or other cancers of the blood.

Documentation Requirements:

The patient's medical record should contain documentation that fully supports the medical necessity for the administration of the denosumab (PROLIA™). Such documentation should include 1 through 5 for postmenopausal women with osteoporosis at high risk for fracture and for men; the documentation should include 2 through 5, but is not limited to:

1. Patient's age, sex, and menopausal status.
2. Documentation supporting the diagnosis of osteoporosis.
3. Previous treatment of osteoporosis, agents used, outcomes and adverse reactions if any.
4. History of previous fractures, including type of fracture, cause, and time since occurrence.
5. Risk fractures for future fracture including preventive measures.

For the treatment of cancer treatment-induced bone loss (CTIBL) due to hormone ablation such documentation should include, but is not limited to:
1. Documentation supporting the diagnosis of breast cancer (in women) or nonmetastatic prostate cancer.
2. Use of adjuvant aromatase inhibitor (AI) therapy (in women) or androgen deprivation therapy (ADT).
3. Additional diagnoses for risk factors, if any.

The patient's medical record should contain documentation that fully supports the medical necessity for the administration of the denosumab (Xgeva™). Such documentation should include, but is not limited to:

1. Documentation of bone metastasis from a solid tumor and adequate calcium levels as well as the use of Vitamin D if indicated.
2. Documentation of giant cell tumor in an adult or skeletally mature adolescent and adequate calcium levels as well as the use of Vitamin D if indicated.

**Administration:**

The recommended dose of Denosumab (Prolia™) for the treatment of osteoporosis in postmenopausal women is 60 milligrams (mg) subcutaneously once every 6 months, plus calcium 1000 mg orally once daily and at least vitamin D 400 international units orally once daily. Administer Denosumab (Prolia™) via subcutaneous injection in the upper arm, the upper thigh, or the abdomen. Denosumab (Prolia™) is supplied in a single-use prefilled syringe with a safety guard or in a single-use vial.

Denosumab (Xgeva™) is administered at a dose of 120mg every four weeks as a subcutaneous injection in the upper arm, upper thigh, or abdomen for bone metastasis from solid tumors. Denosumab (Xgeva™) is administered at a dose of 120mg every four weeks with an additional 120mg dose on day 8 and 15 of the first month of therapy as a subcutaneous injection in the upper arm, upper thigh, or abdomen for Giant Cell Tumor of the bone. Administer calcium and vitamin D as necessary to treat or prevent hypocalcemia. Denosumab (Xgeva™) is administered at a dose of 120 mg every 4 weeks with additional 120 mg doses on Days 8 and 15 of the first month of therapy for hypercalcemia of malignancy. Administer subcutaneously in the upper arm, upper thigh, or abdomen

**Coding Guidelines:**

- Effective January 1, 2014, for claims submitted to the contractor, denosumab (PROLIA™, Xgeva™) should be billed using HCPCS code J0897, Injection, denosumab, 1mg.
- Denosumab may not be billed using a chemotherapy administration code. The administration of the product should be billed using CPT code 96372, (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular).

**DRUG ADMINISTRATION CODING**

WPS Medicare has determined in review of submitted claims that there is inappropriate use of CPT codes 96401-96449 for chemotherapy and other highly complex drug or highly complex biologic agent administration.
The Current Procedural Terminology CPT®2015 Professional Edition, page 624 contains the following information and direction for the Administration of Chemotherapy CPT® codes:

“Chemotherapy Administration codes 96401-96549 apply to parenteral administration of non-radiouclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g. cyclophosphamide for auto-immune conditions) or to substances such as certain monoclonal antibody agents, and other biologic response modifiers. The highly complex infusion of chemotherapy or other drug or biologic agents requires physician or other qualified health care professional work and/or clinical staff monitoring well beyond that of therapeutic drug agents (96360-96379) because the incidence of severe adverse patient reactions are typically greater. These services can be provided by any physician or other qualified health care professional. Chemotherapy services are typically highly complex and require direct supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intraservice supervision of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage, or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of the nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician or other qualified health care professional about these issues. When performed to facilitate the infusion of injection, preparation of chemotherapy agent(s), highly complex agent(s), or other highly complex drugs is included and is not reported separately. To report infusions that do not require this level of complexity, see 96360-96379. Codes 96401-96402, 96409-96425, 96521-96523 are not intended to be reported by the individual physician or other qualified health care professional in the facility setting.”

Medicare has determined under Section 1861(t) that these drugs may be paid when they are administered incident to a physician’s service and determined to be medically reasonable and necessary. Such determination of reasonable and necessary is currently left to the discretion of the Medicare contractors. The documentation in the patient’s medical record must support the drugs as being medically reasonable and necessary.

As stated in the Internet Only Manual, CMS Pub 100-04-Medicare Claims Processing Manual, Chapter 12-Physicians/Nonphysician Practitioners, Section 30.5 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf), Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions, Part D-Chemotherapy Administration, “local carriers may provide additional guidance as to which drugs may be considered to be chemotherapy drugs under Medicare.”

The list below is not an all-inclusive list and may be subject to further revision.

The administration of the following drugs in their subcutaneous forms should not be billed using a chemotherapy administration code. Instead, the administration of the following drugs in their subcutaneous forms should be billed using CPT code 96372, (therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular).

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>abatacept</td>
<td>Orencia®</td>
<td>J0129</td>
</tr>
<tr>
<td>canakinumab</td>
<td>Ilaris®</td>
<td>J0638</td>
</tr>
<tr>
<td>certolizumab pegol</td>
<td>Cimzia®</td>
<td>J0717</td>
</tr>
<tr>
<td>Generic Name</td>
<td>Trade Name</td>
<td>HCPCS Code</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td>denosumab</td>
<td>Prolia/Xygeva®</td>
<td>J0897</td>
</tr>
<tr>
<td>golimumab</td>
<td>Simponi®</td>
<td>J3590</td>
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<tr>
<td>omalizumab</td>
<td>Xolair®</td>
<td>J2357</td>
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<tr>
<td>rilonacept</td>
<td>Arcalyst®</td>
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<td>tocilizumab</td>
<td>Actemra®</td>
<td>J3262</td>
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<tr>
<td>ustekinumab</td>
<td>Stelera®</td>
<td>J3357</td>
</tr>
</tbody>
</table>
MLN Matters® Articles Index: Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at [http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/](http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/) on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search on a keyword(s) and you will find articles that contained those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.

MLN Matters® Number: MM8739 Revised

Related Change Request (CR) #: CR 8739

Related CR Release Date: January 8, 2015

Effective Date: June 11, 2013

Related CR Transmittal #: R3162CP, R168NCD

Implementation Dates: May 19, 2014 - MAC Non-Shared System Edits; July 7, 2014 - CWF development/testing, FISS requirement development; October 6, 2014 - CWF, FISS, MCS Shared System Edits

Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) for Solid Tumors (This Change Request (CR) rescinds and fully replaces MM 8468, dated February 6, 2014.)

Note: This article was revised on January 12, 2015, to reflect the revised CR8739 issued on January 8. In the article, reference to an attachment at the bottom of page 2 has been replaced with a Web link to the list of appropriate diagnosis codes. Note that 793.11 has been added to that list. Also, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

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

**Provider Action Needed**

This article is based on Change Request (CR) 8739, which advises MACs, effective for dates of service on or after June 11, 2013, to cover three FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by your MAC. Make sure your billing staffs are aware of these changes.

**Background**

The Centers for Medicare & Medicaid Services (CMS) has reconsidered Section 220.6, of the “National Coverage Determinations (NCD) Manual” to end the prospective data collection requirements across all oncologic indications of FDG PET in the context of CR8739. The term FDG PET includes PET/computed tomography (CT) and PET/magnetic resonance (MRI).

CMS is revising the “NCD Manual”, Section 220.6, to reflect that CMS has ended the coverage with evidence development (CED) requirement for (2-[F18] fluoro-2-deoxy-D-glucose) FDG PET, PET/CT, and PET/MRI for all oncologic indications contained in Section 220.6.17 of the “NCD Manual”. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (Healthcare Common Procedure Coding System (HCPCS) Code A9552) only.

**NOTE:** For clarification purposes, as an example, each different cancer diagnosis is allowed one (1) initial treatment strategy (-PI modifier) FDG PET Scan and three (3) subsequent treatment strategy (-PS modifier) FDG PET Scans without the -KX modifier. The fourth FDG PET Scan and beyond for subsequent treatment strategy for the same cancer diagnosis will always require the -KX modifier. If a different cancer diagnosis is reported, whether reported with a -PI modifier or a -PS modifier, that cancer diagnosis will begin a new count for subsequent treatment strategy for that beneficiary. A beneficiary's file may or may not contain a claim for initial treatment strategy with a -PI modifier. The existence or non-existence of an initial treatment strategy claim has no bearing on the frequency count of the subsequent treatment strategy (-PS) claims.


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Effective for claims with dates of service on or after June 11, 2013, Medicare will accept and pay for FDG PET oncologic claims billed to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors for all oncologic conditions without requiring the following:

- Q0 modifier: Investigational clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);
- Q1 modifier: routine clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);
- V70.7: Examination of participant in clinical research; or
- Condition code 30 (institutional claims only).

Effective for dates of service on or after June 11, 2013, MACs will use the following messages when denying claims in excess of three for PET FDG scans for subsequent treatment strategy when the –KX modifier is not included, identified by CPT codes 78608, 78811, 78812, 78813, 78814, 78815, or 78816, modifier –PS, HCPCS A9552, and the same cancer diagnosis code:

- Claim Adjustment Reason Code (CARC) 96: “Non-Covered Charge(s). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- Remittance Advice Remarks Code (RARC) N435: “Exceeds number/frequency approved/allowed within time period without support documentation.”
- Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

MACs will not search their files to adjust claims processed prior to implementation of CR8739. However, if you have such claims and bring them to the attention of your MAC, the MAC will adjust such claims if appropriate.

**Synopsis of Coverage of FDG PET for Oncologic Conditions**

Effective for claims with dates of service on and after June 11, 2013, the chart below summarizes national FDG PET coverage for oncologic conditions:

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<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Initial Treatment Strategy (formerly “diagnosis” &amp; “staging”)</th>
<th>Subsequent Treatment Strategy (formerly “restaging” &amp; “monitoring response to treatment”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Esophagus</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Head and Neck (not thyroid, CNS)</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Non-small cell lung</td>
<td>Cover</td>
<td>Cover</td>
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<tr>
<td>Ovary</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Brain</td>
<td>Cover</td>
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<tr>
<td>Cervix</td>
<td>Cover with exceptions *</td>
<td>Cover</td>
</tr>
<tr>
<td>Small cell lung</td>
<td>Cover</td>
<td>Cover</td>
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<tr>
<td>Soft tissue sarcoma</td>
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<tr>
<td>Pancreas</td>
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<td>Testes</td>
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<td>Prostate</td>
<td>Non-cover</td>
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<tr>
<td>Thyroid</td>
<td>Cover</td>
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<tr>
<td>Breast (male and female)</td>
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<td>Cover</td>
</tr>
<tr>
<td>Melanoma</td>
<td>Cover with exceptions *</td>
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<tr>
<td>All other solid tumors</td>
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<td>Cover</td>
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<tr>
<td>Myeloma</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>All other cancers not listed</td>
<td>Cover</td>
<td>Cover</td>
</tr>
</tbody>
</table>

*Cervix: Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.

*Breast: Nationally non-covered for initial diagnosis and/or staging of axillary lymph nodes. Nationally covered for initial staging of metastatic disease. All other indications for initial anti-tumor treatment strategy for breast cancer are nationally covered.

*Melanoma: Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.

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REVISED product from the Medicare Learning Network® (MLN)

- “Medicare Enrollment and Claim Submission Guidelines” Booklet (ICN 906764), Hard copy

**MLN Matters® Number: MM9051**

**Related Change Request (CR) #: CR 9051**

**Related CR Release Date: December 31, 2014**

**Effective Date: September 19, 2014**

**Related CR Transmittal #: R202BP and R3159CP**

**Implementation Date: February 2, 2015**

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

**Provider Types Affected**

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

**Provider Action Needed**

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

**Background**


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idx?SID=85dbd4eb6820b751fe58a6c58988df&node=se42.2.410_157&rgn=div8) authorize Medicare coverage under Part B for pneumococcal vaccine and its administration. For services furnished on or after May 1, 1981, through September 18, 2014, the Medicare Part B program covered pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. Coverage included an initial vaccine administered only to persons at high risk of serious pneumococcal disease (including all people 65 and older; immunocompetent adults at increased risk of pneumococcal disease or its complications because of chronic illness; and individuals with compromised immune systems), with revaccination administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years had passed since the previous dose of pneumococcal vaccine.

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

The Centers for Medicare & Medicaid Services (CMS) is updating the Medicare coverage requirements to align with the updated ACIP recommendations. Effective for dates of service on or after September 19, 2014, (and upon implementation of CR9051), Medicare will cover:

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

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

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

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

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Additional Information


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

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

Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit [MLN Matters® Article MM8890](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html), “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and [MLN Matters® Article SE1431](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html), “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

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

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Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8954 is a follow-up to CR8757, Transmittal 2959 and Transmittal 167 (Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)). CR8757 was effective on January 9, 2014, and provided for percutaneous image-guided decompression (PILD) when provided in a clinical study through Coverage with Evidence Development (CED) for beneficiaries with LSS.

MLN Matters® Number: MM8954
Related Change Request (CR) #: CR 8954
Related CR Release Date: January 30, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3175CP
Implementation Date: March 2, for local system edits; July 6, 2015 for Medicare Shared System edits

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Background

CR8954 provides additional direction specifically for PILD, procedure code G0276, when performed in a randomized, blinded clinical trial ONLY, for claims with dates of service on or after January 1, 2015. Healthcare Common Procedure Coding System (HCPCS) G0276 - Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD), or placebo control, performed in an approved coverage with evidence development (CED) clinical trial, is to be used only when the CED PILD trial is blinded, randomized, and controlled and contains a placebo procedure control arm. It appears in the January 2015 updates of the Medicare Physician Fee Schedule Database and the Integrated Outpatient Code Editor (IOCE).

Payment for HCPCS G0276 under the hospital Outpatient Prospective Payment System (OPPS) is available in the latest OPPS Addendum B at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) on the Centers for Medicare & Medicaid Services (CMS) website.

ALL PILD for LSS claims with dates of service December 31, 2014, and earlier, should be processed with procedure code 0275T ONLY and are not subject to reprocessing regardless of the type of trial in which the services were rendered.

NOTE: Beginning with PILD for LSS claims with dates of service on and after January 1, 2015, there are 2 distinct procedure codes that are to be used: G0276 for clinical trials that are blinded, randomized, and controlled, and contain a placebo procedure control arm (use this CR 8954 for claims processing instructions), and 0275T for all other clinical trials (use CR 8757 for claims processing instructions).


Billing Requirements

Medicare will accept HCPCS code G0276 for PILD for LSS claims received with dates of service on and after January 1, 2015, when those services are provided in a blinded, randomized, controlled trial with a placebo procedure control arm under CED only.

Claims for PILD for LSS with dates of service on and after January 1, 2015, will be accepted when billed in a place of service (POS) 22 (outpatient) or 24 (ambulatory surgical center), using HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03, or,
• ICD-10 diagnosis range M48.05-M48.07 (when ICD-10 is implemented)

Only when billed with:
• Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) either in the primary/secondary positions;
• Modifier -Q0; and
• An 8-digit clinical trial identifier number listed on the CMS CED website.

Medicare will return claims for PILD for LSS claims, HCPCS G0276, as unprocessable when billed with a diagnosis code other than 724.01-724.03 (ICD-9), or, M48.05-M48.07 (ICD-10) (when ICD-10 is implemented) using:
• Claim Adjustment Reason Code (CARC) B22: “This payment is adjusted based on the diagnosis.”
• Remittance Advice Remark Code (RARC) N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
• Group Code-Contractual Obligation (CO).

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable when billed in a POS other than 22 or 24 using:
• CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.”
• RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
• Group Code- CO.

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable if they do not contain the required clinical trial diagnosis code V70.7 (ICD-9) or Z00.6 (ICD-10) (once ICD-10 is implemented) in either the primary/secondary positions with the following:
• CARC B22: “This payment is adjusted based on the diagnosis.”
• RARC M76: “Missing/incomplete/invalid diagnosis or condition”
• RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
• Group Code- CO.

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable when billed without a -Q0 modifier with the following:
• CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing.”
• RARC N657: “This should be billed with the appropriate code for these services."
• RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
• Group Code – CO.

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Also, remember that you must submit the numeric, 8-digit clinical trial identifier number in the electronic 837P in Loop 2300 REF02 (REF01=P4) or preceded by "CT" when placed in Field 19 of paper claim form CMS-1500. This requirement is further discussed in MLN Matters® Article MM8401 available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf) on the CMS website.

For hospital outpatient procedures on type of bill (TOB) 13X or 85X, on or after January 1, 2015, Medicare will allow payment for PILD for LSS, HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03; or,
- ICD-10 diagnosis range M48.05-M48.07 (once ICD-10 is implemented)

Only when billed with:

- Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) and condition code 30 either in the primary/secondary positions;
- Modifier -Q0; and
- An 8-digit clinical trial identifier number listed on the CMS CED website.

For hospital outpatient procedures on TOB 13X or 85X, on or after January 1, 2015, MACs will line-level deny claims for PILD for LSS, HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03; or,
- ICD-10 diagnosis range M48.05-M48.07 (once ICD-10 is implemented);

When billed without diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) and condition code 30 either in the primary/secondary positions, Modifier -Q0, or an 8-digit clinical trial identifier number listed on the CMS CED website, with the following:

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

**Additional Information**


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Also, check out the following resources from the Centers for Disease Control and Prevention (CDC): [Influenza (Flu)](http://www.cdc.gov/flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources. Review the CDC’s [Antiviral Drugs](http://www.cdc.gov/flu) website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated “Influenza Antiviral Medications: Summary for Clinicians.” A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at [http://emergency.cdc.gov/HAN/han00375.asp](http://emergency.cdc.gov/HAN/han00375.asp) on the Internet.

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NEW product from the Medicare Learning Network® (MLN)

- “Affordable Care Act Provider Compliance Programs: Getting Started”
  Web-Based Training (WBT)

MLN Matters® Number: MM8874 Revised
Related Change Request (CR) #: CR 8874
Related CR Release Date: January 7, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3160CP
Implementation Date: January 5, 2015

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

Note: This article was revised on January 8, 2015, to reflect the revised CR8874 issued on January 7. In the article, the CR release date, transmittal number, and the Web address for accessing CR8874 are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8874 is an update from the Centers for Medicare & Medicaid Services (CMS) to ensure accurate program payment for three screening services. The coinsurance and deductible for these services are currently waived, but due to coding

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changes and additions, the payments for Calendar Year (CY) 2015 would not be accurate without updated CR8874 for intensive behavioral group therapy for obesity, digital breast tomosynthesis, and anesthesia associated with screening colonoscopy. Make sure billing staffs are aware of these updates.

Background

The following outlines the CMS updates:

**Intensive Behavioral Therapy for Obesity**

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

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

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

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

- **Claim Adjustment Reason Code (CARC) 167:** This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- **Remittance Advice Remarks Code (RARC) N386:** This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.mcd.search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

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

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

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

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

• CARC 8: The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
• RARC N95: This provider type/provider specialty may not bill this service.
• Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

Further, effective for dates of service on or after January 1, 2015, claim lines with G0473 are only payable for the following Places of Service (POS) codes:

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

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

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

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

• CARC 119: Benefit maximum for this time period or occurrence has been reached.
• RARC N362: The number of days or units of service exceeds our acceptable maximum.

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• Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

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

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

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

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

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

Digital Breast Tomosynthesis

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

Effective January 1, 2015, HCPCS code 77063 (Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)), must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2D imaging only).

Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with 77063 (Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure).

Payment for 77063 is made only when billed with an ICD-9 code of V76.11 or V76.12 (and when ICD-10 is effective with ICD-10 code Z12.31). When denying claim lines for 77063 that are submitted without the appropriate diagnosis code, the claim lines are denied using the following messages:

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• CARC 167: This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

• RARC N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.mcd.search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

• Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

On institutional claims:

• MACs will pay for tomosynthesis, HCPCS code 77063, on TOBs 12X, 13X, 22X, 23X based on MPFS, and TOB 85X with revenue code other than 096x, 097x, or 098x based on reasonable cost. TOB 85X claims with revenue code 096x, 097x, or 098x are paid based on MPFS (115% of the lesser of the fee schedule amount and submitted charge).

• MACs will pay for tomosynthesis, HCPCS code 77063 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the fee schedule amount or submitted charge.

• MACs will return to the provider any claim submitted with tomosynthesis, HCPCS code 77063 when the TOB is not 12X, 13X, 22X, 23X, or 85X.

• MACs will pay for tomosynthesis, HCPCS code 77063, on institutional claims TOBs 12X, 13X, 22X, 23X, and 85X when submitted with revenue code 0403 and on professional claims TOB 85X when submitted with revenue code 096X, 097X, or 098X.

• Effective for claims with dates of service on or after January 1, 2015, MACs will RTP claims for HCPCS code 77063 that are not submitted with revenue code 0403, 096X, 097X, or 098X.

Anesthesia Furnished in Conjunction with Colonoscopy

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

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

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

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

### Additional Information


If you have any questions, please contact 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.

### Seasonal Flu Vaccinations

- Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients.


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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Revised product from the Medicare Learning Network® (MLN)

MLN Matters® Number: MM8871 Revised
Related Change Request (CR) #: CR 8871
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Effective Date: June 2, 2014
Related CR Transmittal #: R3127CP and R177NCD
Implementation Date: January 5, 2015, for non-shared MAC edits and CWF analysis; April 6, 2015, for remaining shared R177NCD system edits

Screening for Hepatitis C Virus (HCV) in Adults

Note: This article was revised on November 26, 2014, in order to (1) make editorial changes, (2) add TOBs 71X & 77X and clarify payment methodology, (3) add POS 50, 72 & 81, (4) clarify MAC claims processing prior to January 1, 2015, (5) clarify remittance codes, and (6) revise implementation information. All other information remains the same.

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8871 states, effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) will cover screening for Hepatitis C Virus (HCV) consistent with the grade B recommendations by the United States Preventive Services Task Force (USPSTF) for the prevention or early detection of an illness or disability and is appropriate

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for individuals entitled to benefits under Medicare Part A or enrolled under Part B. Make sure your billing staffs are aware of these changes.

Background

Hepatitis C Virus (HCV) is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the Western World.

Prior to June 2, 2014, CMS did not cover screening for HCV in adults. Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of “additional preventive services” through the National Coverage Determination (NCD) process.

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices) when ordered by the beneficiary’s primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. adults at high risk for HCV infection. “High risk” is defined as persons with a current or past history of illicit injection drug use, and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.

2. adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965. A single, once-in-a-lifetime screening test is covered for these individuals.

The determination of “high risk for HCV” is identified by the primary care physician or practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

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General Claims Processing Requirements for Claims with Dates of Service on and After June 2, 2014:

1. New HCPCS G0472, short descriptor - Hep C screen high risk/other and long descriptor - Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used. HCPCS G0472 will appear in the January 2015 recurring updates of the Medicare Physician Fee Schedule Data Base (MPFSDB) and the Integrated Outpatient Code Editor (IOCE) with a June 2, 2014 effective date. Contractors shall apply contractor pricing to claims with dates of service June 2, 2014, through December 31, 2014, that contain HCPCS G0472.

2. Beneficiary coinsurance and deductibles do not apply to HCPCS G0472.

3. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:
   - HCPCS G0472

4. For those determined to be high-risk initially, claims must be submitted with:
   - HCPCS G0472; and
   - ICD-9 diagnosis code V69.8, other problems related to lifestyle/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented)

5. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
   - HCPCS G0472;
   - ICD diagnosis code V69.8/Z72.89; and
   - ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented).

NOTE: Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

Institutional Billing Requirements

Effective for claims with dates of service on and after June 2, 2014, institutional providers may use types of bill (TOB) 13X, 71X, 77X, and 85X when submitting claims for HCV screening, HCPCS G0472. Medicare will deny G0472 service line-items on other TOBs using the following messages:

- Claim Adjustment Reason Code (CARC) 170 -Payment denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
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- Remittance Advice Remarks Code (RARC) N95 - This provider type/provider specialty may not bill this service.
- Group Code CO (contractual obligation) – If claim received without a GZ modifier.

The service is paid on the following basis:

- Outpatient hospitals – TOB 13X - based on Medicare Physician Fee Schedule (MPFS).
- Rural Health Clinics (RHCs) - TOB 71X - and Federally Qualified Health Centers (FQHCs) - 77X - technical component paid based on the MPFS. For RHCs and FQHCs that are authorized to bill under the reasonable cost system, payment for the professional component is included in the RHC/FQHC all-inclusive rate (AIR). HCV screening is not a stand-alone payable visit for RHCs and FQHCs.
- Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost; and
- CAH Method II – TOB 85X - based on 115% of the lesser of the MPFS amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

**Note:** Separate guidance shall be issued for FQHCs that are authorized to bill under the prospective payment system.

**Professional Billing Requirements**

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCPCS G0472, only when services are submitted by the following provider specialties found on the provider’s enrollment record:

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

Medicare will deny claims submitted for these services by providers other than the specialty types noted above. When denying such claims, Medicare will use the following messages:

- CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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MLN Matters® Number: MM8871

- RARC N574 - Our records indicate the ordering/referring provider is of a type/specialty that cannot order/refer. Please verify that the claim ordering/referring information is accurate or contact the ordering/referring provider.
- Group Code CO if claim received without GZ modifier.

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCV screening, HCPCS G0472, only when submitted with one of the following place of service (POS) codes:

- 11 - Physician’s Office
- 22 - Outpatient Hospital
- 49 - Independent Clinic
- 50 - FQHC
- 71 - State or Local Public Health Clinic
- 72 - RHC
- 81 - Independent Laboratory

Medicare will deny claims submitted without one of the POS codes noted above with the following messages:

- CARC 171 - Payment denied when performed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428 - Not covered when performed in this place of service.
- Group Code – CO if claim received without GZ modifier.

Other Billing Information for Both Professional and Institutional Claims

On both institutional and professional claims, Medicare will deny claims line-items for HCPCS G0472 with dates of service on or after June 2, 2014, where it is reported more than once-in-a-lifetime for beneficiaries born from 1945 through 1965 and who are not high risk. Medicare will also line-item deny when more than one HCV screening is billed for the same high-risk beneficiary prior to their annual eligibility criteria being met. In denying these claims, Medicare will use:

- CARC 119 - Benefit maximum for this time period or occurrence has been reached.
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp) on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code - CO if claim received without GZ modifier.

When applying the annual frequency limitation, MACs will allow both a claim for a professional service and a claim for a facility fee.

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In addition, remember that the initial HCV screening for beneficiaries at high risk must also contain ICD-9 diagnosis code V69.8 (ICD-10 code Z72.89 once ICD-10 is implemented). Then, for the subsequent annual screenings for high risk beneficiaries, you must include ICD-9 code V69.8 and 304.91 (ICD-10 of Z72.89 and F19.20 once ICD-10 is implemented). Failure to include the diagnosis code(s) for high risk beneficiaries will result in denial of the line item. In denying these payments, Medicare will use the following:

- CARC 119 - Benefit maximum for this time period or occurrence has been reached. (for initial high risk screening), or,
- CARC 167 - This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (for subsequent annual high risk screening)
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code CO if claim received without GZ modifier.

### 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.
NEW product from the Medicare Learning Network® (MLN)

- “Complying With Medical Record Documentation Requirements” Fact Sheet, ICN 909160, Downloadable

MLN Matters® Number: MM9002
Related Change Request (CR) #: CR 9002
Related CR Release Date: December 5, 2014
Effective Date: August 7, 2014
Related CR Transmittal #: R178NCD and R3142CP
Implementation Date: April 6, 2015

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

Provider Types Affected

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

Provider Action Needed

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

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

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Background

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

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

On August 7, 2014, CMS issued a final decision memorandum covering TMVR for MR under CED for the treatment of MR when furnished for an FDA-approved indication with an FDA-approved device as follows:

- Treatment of significant, symptomatic, degenerative MR when furnished according to an FDA-approved indication, and all CMS coverage criteria are met; and

- TMVR for MR uses not expressly listed as FDA-approved indications but only within the context of an FDA-approved, randomized clinical trial that meets all CMS coverage criteria.

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

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

CR9002 revises the “Medicare Claims Processing Manual,” Chapter 32, Section 340 (Transcatheter Mitral Valve Repair (TMVR)), and the “National Coverage Determinations
(NCD) Manual,” Chapter 20, Section 20.33 (Transcatheter Mitral Valve Repair (TMVR) which are included in CR9002.

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

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

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

- A surgical program that performs ≥25 total mitral valve surgical procedures for severe MR per year of which at least 10 must be mitral valve repairs;
- An interventional cardiology program that performs ≥1000 catheterizations per year, including ≥400 Percutaneous Coronary Interventions (PCIs) per year, with acceptable outcomes for conventional procedures compared to National Cardiovascular Data Registry (NCDR) benchmarks;
- The heart team must include:

  1. An interventional cardiologist(s) who:

     - performs ≥50 structural procedures per year including Atrial Septal Defects (ASD), Patent Foramen Ovale (PFO) and trans-septal punctures; and,

     - must receive prior suitable training on the devices to be used; and,

     - must be board-certified in interventional cardiology or board-certified/eligible in pediatric cardiology or similar boards from outside the United States;

  2. Additional members of the heart team, including cardiac echocardiographers, other cardiac imaging specialists, heart valve and heart failure specialists,

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electrophysiologists, cardiac anesthesiologists, intensivists, nurses, nurse practitioners, physician assistants, data/research coordinators, and a dedicated administrator.

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

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

Coding Requirements/Claims Processing Requirements

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

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

- 0343T - Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; initial prosthesis. (Note: 0343T will be replaced by CPT code 33418 effective January 1, 2015.)
- 0344T - Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure). (Note: 0344T will be replaced by CPT code 33419 effective January 1, 2015.)
- 0345T - Transcatheter mitral valve repair percutaneous approach via the coronary sinus
- 33418 - Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis. (Note: CPT code 33418 is effective January 1, 2015.)

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

ICD-9/ICD-10 Codes for TMVR for MR Claims
The ICD-9 (and upon ICD-10 implementation)/ ICD-10 codes are:

• ICD-9 Procedure Code - 35.97 - Percutaneous mitral valve repair with implant - and ICD-10 procedure code is 02UG3JZ – Supplement mitral valve with synthetic substitute, percutaneous approach

• ICD-9 Diagnosis Code for TMVR for MR Claims is - 424.0 – Mitral valve disorder and ICD-10 diagnosis codes are I34.0 – Nonrheumatic mitral (valve) insufficiency or I34.8 – Other nonrheumatic mitral valve disorders

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

• Claim Adjustment Reason Code (CARC) 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

• Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file.)

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

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

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• CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

• Remittance Advice Remarks Code (RARC) N517: “Resubmit a new claim with the requested information.“

• Group Code: CO

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

• CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

• RARC N517: “Resubmit a new claim with the requested information.“

• Group Code: CO

**Professional Clinical Trial Diagnostic Coding for TMVR for MR Claims**

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with CPT codes 0343T, 0344T, and 0345T in a clinical trial when billed with ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6). (Effective January 1, 2015, CPT codes 33418 and 33419 replace CPT codes 0343T and 0344T, respectively.) TMVR for MR claim lines in a clinical trial billed without ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6) will be denied.

MACs will supply the following messages when denying TMVR for MR claim lines in a clinical trial billed without secondary ICD-9 diagnosis code V70.7(ICD-10=Z00.6) as unprocessable:

• CARC 50: “These are non-covered services because this is not deemed a “medical necessity” by the payer.”

• RARC N386: “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [http://www.cms.hhs.gov/mcd/search.asp](http://www.cms.hhs.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.”

• Group Code: CO
Mandatory National Clinical Trial (NCT) Number for TMVR for MR Claims

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

- CARC 16: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)”

- RARC MA50: “Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.”

- Group Code: CO

Claims Processing Requirements for TMVR for MR on Inpatient Hospital Claims

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

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

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

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

- Group Code - Contractual Obligation (CO)

### Additional Information


If you have any questions, please contact your MAC at their toll-free number, which is available at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

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**Seasonal Flu Vaccinations** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients.


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

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**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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I NFORMATION ON WEBSITE

WPS Medicare publishes Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs), as well as retired LCDs for Medicare Part B, on its website:

J8 MAC (IN, MI):  http://www.wpsmedicare.com/j8macpartb/policy/

If you cannot gain access to the Internet from your office or home, you might try one of the many public libraries that offer Internet access. You may request a hard copy of a retired LCD by writing to our Freedom of Information (FOI) Unit.

WPS Medicare Part B
Attn: Freedom of Information Act (FOIA)
P.O. Box 8810
Marion, IL 62959-0900

NEW POLICIES

The following are new policies. Be sure to note the effective date of the new policy, as the policy will not appear as an active policy until the effective date. Prior to the effective date, the policy can be found by selecting the link "Display Future Effective Documents" within the CMS Medicare Coverage Database (MCD):

Visit our website at the appropriate link below for more information:
J5 MAC:  http://www.wpsmedicare.com/j5macpartb/policy/updates/new/
J8 MAC:  http://www.wpsmedicare.com/j8macpartb/policy/updates/new/

January 2015

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
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<tbody>
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<td>J5/J8</td>
<td>Removal of Benign Skin Lesions</td>
<td>L35496</td>
<td>DERM-011</td>
<td>02/16/2015</td>
</tr>
</tbody>
</table>

February 2015

There are no new policies for February 2015.
March 2015

There are no new policies for March 2015.

RETIRED POLICIES

The following are retired policies. Be sure to note the effective date of the retired policy, as the policy will not appear as retired until the effective date.

Visit our website at the appropriate link below for more information:
J5 MAC: http://www.wpsmedicare.com/j5macpartb/policy/updates/retired/
J8 MAC: http://www.wpsmedicare.com/j8macpartb/policy/updates/retired/

| January 2015 |
|-----------------|-----------------|-----------------|-----------------|
| **Contract** | **Policy Title** | **CMS MCD Policy #** | **WPS Policy #** | **Effective Date** |
| J5 | Category III Codes | L32569 | PHYS-082 | 02/15/2015 |
|  |  | This LCD is being retired; please see an LCD with the same name; Category III Codes, new LCD # L35488, PHYS-084. |  |  |
| J8 | Category III Codes | L32789 | PHYS-882 | 02/15/2015 |
|  |  | This LCD is being retired; please see an LCD with the same name; Category III Codes, new LCD # L35488, PHYS-084. |  |  |
| J5/J8 | Mohs Micrographic Surgery | L30713 | DERM-004 | 02/15/2015 |
|  |  | This LCD is being retired and replace by an LCD with the same name of Mohs Micrographic Surgery. New LCD ICD# is L35492, DERM-010. |  |  |
| J5/J8 | Removal of Benign Skin Lesions | L30330 | DERM-008 | 02/15/2015 |
|  |  | This LCD is being retired. See our new Removal of Benign Skin Lesions policy, LCD ID L35496. DERM-011 |  |  |

February 2015

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<tbody>
<tr>
<td>J5A/J8A</td>
<td>Drugs of Abuse Testing</td>
<td>DL34677</td>
<td>PATH-038</td>
<td>02/01/2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This Proposed Draft LCD is being retired, it will not be finalized. Please see the active LCD L32450- Drug Testing for coverage guidance.</td>
<td></td>
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</tr>
</tbody>
</table>

March 2015

There are no retired policies for March 2015.

REVISED POLICIES

The following are revised policies. Be sure to note the effective date of the revised policy, as the policy will not appear as an active policy until the effective date. Prior to the effective date, the policy can be found by selecting the link "Display Future Effective Documents" within the CMS Medicare Coverage Database (MCD):

Visit our website at the appropriate link below for more information:
**January 2015**

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
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<td>2015 CPT/HCPCS Code Update</td>
<td>NA</td>
<td>NA</td>
<td>01/01/2015</td>
</tr>
</tbody>
</table>

The following Procedure Codes have been added or deleted from the listed Local Coverage Determination (LCD) Policies for 2015. The new codes are effective for services performed on or after 01/01/2015; the deleted are effective until 12/31/2014 and will not include a 90 day grace period.

<table>
<thead>
<tr>
<th>Policy Name &amp; Number</th>
<th>Added Codes</th>
<th>Deleted Codes</th>
<th>Description Changed</th>
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<td>L30135</td>
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<td>Q4119, Q4147</td>
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<tr>
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<td>L31620</td>
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<tr>
<td>Brachytherapy</td>
<td>77316, 77317, 77318, G6001</td>
<td>77326, 77327, 77328, 76950</td>
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<td>L30320</td>
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<tr>
<td>Category III Codes</td>
<td>0073T, 0197T, 0245T, 0246T, 0247T, 0248T, 0319T, 0320T, 0321T, 0322T, 0323T, 0324T, 0325T, 0326T, 0327T, 0328T</td>
<td>0075T, 0076T, 0191T</td>
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<tr>
<td>L32569</td>
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<tr>
<td>Chemotherapy Drugs and their Adjuncts</td>
<td>A9606, C9027, C9442, J9267, J9301</td>
<td>A9699, C9021, *J9010, J9265</td>
<td>Coverage indicator changed to not payable by Medicare</td>
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<tr>
<td>L28576</td>
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<tr>
<td>Contract</td>
<td>Policy Title</td>
<td>CMS MCD Policy #</td>
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<tr>
<td></td>
<td>Colonscopy and Sigmoidoscopy-Diagnostic</td>
<td>G6019, G0620, G0622-G6025, 45346, 45347, 45349</td>
<td>44393, 44397, 45339, 45345, 45355, 45383, 45387</td>
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<td>Cranial Stereotactic Radiosurgery (SRS) and Cranial Stereotactic Radiotherapy (SRT)</td>
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<td>Endoscopic Treatment of GERD</td>
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<td></td>
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<td>J0887, J0888</td>
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<td></td>
<td>Hemophilia Clotting Factors</td>
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<td>C9133, C9135</td>
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<td>Immunizations</td>
<td>L31084</td>
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<tr>
<td></td>
<td>Independent Diagnostic Testing Facilities (IDTF’s)</td>
<td>76641, 76642, 77061-77063, 77085, 77086, 91200, 93260, 93261, 93644, 93895</td>
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<td><strong>Appendix A</strong></td>
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<td>Intra-articular Injections of Hyaluronan</td>
<td>J7327, 20611</td>
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<td></td>
<td>Molecular Diagnostic Testing</td>
<td>88341, 88342</td>
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<td></td>
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<td></td>
<td>Drug Testing</td>
<td>G6058, 80300, 80301, 80100, 80101, 80102</td>
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<tr>
<td>Contract</td>
<td>Policy Title</td>
<td>CMS MCD Policy #</td>
<td>WPS Policy #</td>
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<tr>
<td></td>
<td><strong>Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT)</strong></td>
<td>80302, 80303, 80304</td>
<td>77305, 77310, 77315, 77326, 77327, 77328, 77402-77416, 77418, 77421, 76950, 0197T, 0073T</td>
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<tr>
<td></td>
<td>L30316</td>
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<tr>
<td></td>
<td><strong>Sacroiliac Joint Injections</strong></td>
<td>20611</td>
<td>20610</td>
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<td>L31359</td>
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<tr>
<td></td>
<td><strong>Stereotactic Body Radiation Therapy</strong></td>
<td></td>
<td>G0251</td>
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<td></td>
<td><strong>Vertebroplasty (Percutaneous) and Vertebral Augmentation including cavity creation</strong></td>
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<td>22520, 22521, 22522, 22523, 22524, 22525, 72291, 72292</td>
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<td>L30516</td>
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<td></td>
<td><strong>Wound Care</strong></td>
<td>97607, 97608</td>
<td>G0456, G0457</td>
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<td>L28572</td>
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<tr>
<td></td>
<td><strong>J5/J8 Erythropoiesis Stimulating Agents - Epoetin alfa, Epoetin beta, Darbepoetin alfa, Peginesatide</strong></td>
<td>L31074</td>
<td>INJ-023</td>
</tr>
</tbody>
</table>

The following information was added to the policy:

**Coverage Indications, Limitations, and/or Medical Necessity Section**
2. Epoetin beta is a man-made form of the human protein erythropoietin.

4. Peginesatide: Peginesatide was subject to a nationwide voluntary recall of all lots of Omontys ® (peginesatide) injection on February 23, 2013 by Affymax, Inc. and Takedo Pharmaceutical Company Limited along with the FDA. The companies have also issued a letter to health care professional indicting that no new or existing patients should receive Omontys ® (peginesatide).

**Added the following in the CPT/HCPCS Codes:**
Group 1 Codes:
J0887 Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)
J0888 Injection, epoetin beta, 1 microgram, (for non ESRD use)

**Non-covered CPT/HCPCS Codes**
Group 2 Codes:
J0890 Injection, peginesatide, 0.1 mg (for ESRD on Dialysis)

In the ICD -9 Codes section added CPT/HCPCS Codes J0887 to Group 1, added J0888 to Group 2, Group 4, Group6, Group 8, and Group 10.
Contract | Policy Title | CMS MCD Policy # | WPS Policy # | Effective Date
--- | --- | --- | --- | ---
J5/J8 | Qualitative Drug Testing | L32450 | PATH-035 | 01/01/2015
- The title of the policy has been changed to Drug Testing. Qualitative has been removed from the title.
- Reference to qualitative has been changed to qualitative/presumptive throughout the policy to reflect the terminology in the 2015 CPT book.

J5/J8 | Wound Care | L28572 | GSURG-051 | 01/01/2015
- Under Coverage Indications, Limitations and/or Medical Necessity: the title Ultrasonic Wound Debridement for CPT code 97610 was changed to the description of the CPT code, “low frequency, non-contact, non-thermal ultrasound.”
- Low Frequency, Non-contact, Non-thermal Ultrasound (CPT guidelines):
  - Low frequency, non-contact, non-thermal ultrasound: (CPT code 97610) is a system that uses continuous low frequency ultrasonic energy to atomize a liquid and deliver continuous low frequency ultrasound to the wound bed. Mist Therapy or other similar products are included in the payment for the treatment of the same wound with other active wound care management CPT codes (97597-97606) or wound debridement CPT codes (e.g., CPT codes 11042-11047, 97597, 97598). Therefore, MIST Therapy or other similar treatments would be separately billable if other active wound management and/or wound debridement is not performed.

February 2015

Contract | Policy Title | CMS MCD Policy # | WPS Policy # | Effective Date
--- | --- | --- | --- | ---
J5/J8 | Category III Codes | L35488 | PHYS-084 | 02/01/2015
- CPT Code 0376T has been added to the policy as an appropriate add-on code when used in conjunction with primary CPT Code 0191T.

J5/J8 | Chemotherapy Drugs and their Adjuncts | L28576 | HONC-010 | 02/01/2015
- **C. These drugs are covered for the following indications:**
  1. ado-trastuzumab emtansine, 1mg (KADCYLA™)(J9354)
     - Is covered as a single agent, for the treatment of patients with HER2-positive, recurrent or metastatic trastuzumab-exposed disease. The patient therefore should previously have been treated with trastuzumab (174.0-174.9, 175.0-175.9). Effective 01/01/2015
  31. Ipilimumab (Yervoy™) 1mg, (J9228)
     - For the treatment of unresectable or metastatic melanoma 184.0-184.4, 187.1, 187.2, 187.4, 187.7
  37. Obinutuzumab (GAZYVA) (J9301) is a CD20-directed cytolytic antibody and is indicated, in combination with chlorambucil, for the treatment of patients with previously untreated chronic lymphocytic leukemia (204.10). Effective FDA approval date (11/01/2013).
     - Small lymphocytic lymphoma 200.10 -200.18-effective 02/01/2015
     - Used in combination with chlorambucil as first-line therapy for patients with...
<table>
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<tr>
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<tbody>
<tr>
<td>J5/J8</td>
<td>Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT)</td>
<td>L30316</td>
<td>RAD 014</td>
<td>03/18/2015</td>
</tr>
</tbody>
</table>

The following information was done for 01/01/2015 but was not included in the January article.

Effective 01/01/2015 CPT codes 77385 and 77386 were added to Group 4

Group 4 Paragraph: Codes for use in OPPS for IMRT. See attached Billing and Coding Guidelines for additional information.

Group 4 Codes:
77385 IMRT Radiation therapy delivery
77386 IMRT Radiation therapy delivery complex

CPT code 77014 was included in to Group 1 Codes. It was in indications and in the Billing and Coding Guidelines but not in the CPT codes table. This change will become effective 03/18/2015.

Group 1 Paragraph: Radiation Therapy

Group 1 Codes:

---

stage II-IV disease

41. Paclitaxel (Taxol) 30mg (J9267)  
Angiosarcoma 171.2

D. Not otherwise Classified Agents (NOC) (A9699, J3590, J9999, C9399)

2. Ramucirumab (Cyramza) (J9999, C9025)  
Covered in combination with paclitaxel for treatment of advanced gastric or gastro-esophageal junction adenocarcinoma, with disease progression on or after prior fluoropyrimidine- or platinum-containing chemotherapy. Effective 11/05/2014-FDA approval date. (150.0-150.8, 151.0-151.9)

Covered in combination with docetaxel, for treatment of metastatic nonsmall cell lung cancer with disease progression on or after platinum-based chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving CYRAMZA. (162.0, 162.2-162.5, 162.8, 162.9) Effective –12/12/2014-FDA approval Date

5. Nivolumab (OPDIVO) (J9999, C9399)  
Covered for the treatment of patients with unresectable or metastatic melanoma and disease progression following ipilimumab and, if BRAF V600 mutation positive (172.0-172.9). Effective 12/22/2014-FDA approval date.

6. Blinatumomab (BLINCYTO™) (J9999, C9399)  
For the treatment of Philadelphia chromosome-negative relapsed or refractory B cell precursor acute lymphoblastic leukemia (ALL) 204.02. Effective 12/03/2014-FDA approval date.
<table>
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<tr>
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<tbody>
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<td>Ablative Therapy</td>
<td>L30312</td>
<td>GSURG-033</td>
<td>04/15/2015</td>
</tr>
</tbody>
</table>

Under documentation section, further clarified by adding:

Under documentation section, further clarified by adding:

Adequate documentation is essential for high-quality patient care and to demonstrate the reasonableness and medical necessity of the procedure(s). Documentation must support the criteria for coverage as described in the Coverage Indications, Limitations, and/or Medical Necessity section of this LCD. The diagnosis justifying the procedure performed needs to be clearly documented in the record. Note: A payable diagnosis alone does not support medical necessity of ANY service. There should be a permanent record of the description of the procedure(s) performed including any contrast media and/or radiopharmaceuticals (including
specific administration activities, concentration, volume, and route of administration when applicable), medications, catheters, or devices used. Any known significant patient reaction or complications should be recorded. The report should address or answer any specific clinical questions. If there are factors that prevent answering the clinical questions, this should be explained in the documentation. Retention of the record should be consistent both with clinical need and with relevant legal and local health care facility requirements. (Practice parameters from ACR).

Under Utilization Guidelines, added the following statement to clarify: It is expected that these services would be performed as indicated by current medical literature and/or standards of practice for the patient's condition.

<table>
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<tbody>
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<td>Cardiovascular Stress Testing</td>
<td>L28563</td>
<td>CV-004</td>
<td>04/15/2015</td>
</tr>
</tbody>
</table>

Added diagnosis codes 402.11, 404.10-404.13, and 412 to covered diagnosis effective 03/01/2015. See below:

Group 1 Paragraph: Note: ICD-9 codes must be coded to the highest level of specificity

Group 1 Codes:

**402.11 Benign hypertensive heart disease with heart failure**

**404.10-404.13 Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage i through stage iv, or unspecified - Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage v or end stage renal disease**

410.02 - 410.82

Acute myocardial infarction of anterolateral wall subsequent episode of care - acute myocardial infarction of other specified sites subsequent episode of care

411.0 Postmyocardial infarction syndrome

411.1 Intermediate coronary syndrome

411.81 Acute coronary occlusion without myocardial infarction

411.89 Other acute and subacute forms of ischemic heart disease other

**412 Old myocardial infarction**

Added information to the Overview section expanding the definition of cardiovascular stress testing:

Cardiovascular STRESS TESTING or Exercise Stress Test (EST) consists of the continuous monitoring of an electrocardiogram (generally a 12-lead system) with frequent 3-lead or 12-lead recordings taken according to clinical circumstances, frequent blood pressure determinations and continuous patient observation before, during and after exercise of progressively increasing intensity (usually with a treadmill or cycle ergometer) to any of a number of test end points. Usually, the heart rate, blood pressure, and EKG are recorded at the end of each stage of exercise, immediately before and immediately after stopping exercise, and for each minute for at least 5-10 minutes in the recovery stage. A minimum of three leads should be displayed continuously on the cathode ray screen during the test.

Normally, the systolic blood pressure increases with exercise and the diastolic
remains essentially unchanged. An exercise test is considered negative when the patient does not exhibit significant symptoms, arrhythmias, or other ECG abnormalities at 85% of maximum heart rate predicted for age and sex.

Added to Indications:
I. Metabolic disorders known to cause CAD:
   1. Diabetes mellitus

Added to Limitations:
The following services are considered not medically necessary:

5. The results of the test have no potential to affect the treatment of the patient such as a patient having a severe comorbidity, limited life expectancy, and/or not being a candidate for revascularization.

Added to Documentation section to clarify what is required:

Adequate documentation is essential for high-quality patient care and to demonstrate the reasonableness and medical necessity of the procedure(s). Documentation must support the criteria for coverage as described in the Coverage Indications, Limitations, and/or Medical Necessity section of this LCD. There should be a permanent record of the cardiovascular stress test and its interpretation. The documentation should include a description of the test and/or procedures performed and any contrast media and/or radiopharmaceuticals (including specific administration activities, concentration, volume, and route of administration when applicable), medications, catheters, or devices used. Any known significant patient reaction or complications should be recorded. Exercise-induced changes in the ST-T segment of the ECG are measured and correlated with each level of cardiac stress achieved during the test. Comparison with prior relevant stress tests needs to be addressed in the documentation along with results, both normal and abnormal. The report should address or answer any specific clinical questions. If there are factors that prevent answering the clinical questions, this should be explained in the documentation. An official interpretation (final report) of the cardiovascular stress test should be included in the patient's medical record. Retention of the stress test should be consistent both with clinical need and with relevant legal and local health care facility requirements. (Practice parameters from ACR).

. Note: A payable diagnosis alone does not support medical necessity of ANY service.

Added to Utilization Guidelines to clarify:

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice for the patient's condition. Cardiovascular stress testing which exceeds the frequency or duration indicated by the accepted standards of medical practice, are not covered unless there are special circumstances which justify the medical necessity for the additional cardiovascular stress testing. The routine and repetitive monitoring of such patients beyond the first cardiac stress test, in the absence of a documented change in condition (i.e. new
<table>
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<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
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<tbody>
<tr>
<td>J5/J8</td>
<td>Chemotherapy Drugs and their Adjuncts</td>
<td>L28576</td>
<td>HONC-010</td>
<td>03/01/2015</td>
</tr>
</tbody>
</table>

The following information has been added to the policy:

**C. These drugs are covered for the following indications:**

7. Bendamustine hydrochloride (Treanda™), 1 mg (J9033)
   Adult T-cell Leukemia/Lymphoma (204.80-204.82 )-Effective 03/01/2015

12. Carfilzomib 1 mg (KYPROLIS™ ) (J9047)
   Used in combination with lenalidomide and dexamethasone for transplant candidates with progressive solitary plasmacytoma or smoldering myeloma (asymptomatic) that has progressed to active (symptomatic) myeloma as primary chemotherapy (203.00-203.02). Effective 03/01/2015

46. Pemetrexed (Alimta), 10 mg (J9305)
   Primary CNS Lymphoma 200.50, 200.51

**E. Monoclonal Antibodies that are useful in chemotherapeutic regimens:**

3. Ofatumumab (Arzerra) 10 mg (J9302)
   Used in combination with chlorambucil for the treatment of previously untreated patients with CLL for whom fludarabine-based therapy is considered inappropriate (204.10, 204.12, 200.10-200.18). Effective 04/17/2014-date of FDA approval.

**J5/J8**  
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<tbody>
<tr>
<td>Hemophilia Clotting Factors</td>
<td>L31078</td>
<td>INJ-003</td>
<td>03/01/2015</td>
</tr>
</tbody>
</table>

Added Obizur as a covered medication effective 10/23/2014 date it was approved by the FDA for this use.

Group 4 Paragraph: J7199 when used for OBIZUR, Antihemophilic Factor (Recombinant), Porcine Sequence,

Group 4 Codes:

286.7 Acquired coagulation factor deficiency

Also added this medication to the list found in the Billing and Coding Guideline. J7199 HEMOPHILIA CLOTTING FACTOR, NOT OTHERWISE CLASSIFIED,

Elocate (C9136) Obizur

Removed the following diagnosis 286.2 Congenital factor XI deficiency from the policy since Factor XI is not addressed in this policy.
<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
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<tbody>
<tr>
<td>J5/J8</td>
<td>Immunizations</td>
<td>L31084</td>
<td>ALGR-003</td>
<td>03/01/2015</td>
</tr>
</tbody>
</table>

Added the new codes 90620 (Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use) and 90621 (Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use) to the non-covered list of codes. Clarified Group 1 CPT codes are covered and Group 2 CPT codes are non-covered. Moved the non-covered code table from the narrative section to the coding section. Removed code 90630 because this LCD does not apply to influenza. Made formatting changes. Updated sources of information.

**Group 1 Paragraph: Covered codes**

**Group 1 Codes:**
- 90296 Diphtheria antitoxin
- 90632-90634 Hep a vaccine adult im-Hep a vacc ped/adol 3 dose
- 90675 - 90738 Rabies vaccine im - Inactivated je vacc im

**Group 2 Paragraph: Non-covered codes**

The following procedure codes represent immunizations that are considered routine preventative immunizations or they are not a disease entity endemic in the United States and therefore are not covered by Medicare:

**Group 2 Codes:**
- 90476, 90477 Adenovirus
- 90581 Anthrax
- 90585, 90586 BCG
- 90636 Hepatitis A/Hepatitis B
- 90620-90621 Menb rp w/omv vaccine im-Menb rlp vaccine im
- 90644 Vaccine for meningococcal and hemophilus influenza b (4-dose schedule) injection into muscle, children 2-15 months of age
- 90645-90648 Hemophilus influenza
- 90649 HPV
- 90650 HPV Vaccine , Types 16, 18, Bivalent 3 dose schedule for IM use
- 90680 Rotavirus
- 90681 Rotavirus, live attenuated, 2 dose schedule, oral
- 90690-90693 Typhoid
- 90696 DTaP-IPV
- 90698 DTaP -HiB -HIB IPV
- 90700 DTaP vaccine <7 yrs IM
- 90704 Mumps
- 90705 Measles
- 90706 Rubella
- 90707 MMR
<table>
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<th>Contract</th>
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<th>WPS Policy #</th>
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<tbody>
<tr>
<td></td>
<td>90708 Measles and rubella</td>
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<td>90710 MMRV</td>
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<td></td>
<td>90712, 90713 Poliovirus</td>
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<td></td>
<td>90715 Tdap</td>
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<td></td>
<td>90716 Varicella</td>
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<td></td>
<td>90717 Yellow fever</td>
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<td></td>
<td>90719 Diphtheria toxoid</td>
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<td>90720 DTP-Hib</td>
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<tr>
<td></td>
<td>90721 Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP/Hib), for intramuscular use</td>
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<tr>
<td></td>
<td>90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use</td>
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<td></td>
<td>90725 Cholera</td>
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<td></td>
<td>90727 Plague</td>
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<td>90733 Meningococcal any group S</td>
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<td></td>
<td>90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent, for intramuscular use</td>
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<tr>
<td></td>
<td>90735 Japanese encephalitis</td>
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<td></td>
<td>90736 Zoster, (shingles) vaccine, live</td>
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<tr>
<td></td>
<td>90738 Japanese encephalitis virus vaccine inactivated, for IM use (Status I code will deny as not a valid code for Medicare)</td>
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<tr>
<td></td>
<td>90748 HepB-Hib (Status I code will deny as not valid codes for Medicare)</td>
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<tr>
<td></td>
<td>90749 Unlisted vaccine/toxoid</td>
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<tr>
<td>J5/J8</td>
<td>Nerve Conduction Studies and Electromyography</td>
<td>L31346</td>
<td>NEURO-005</td>
<td>04/15/2015</td>
</tr>
</tbody>
</table>

Changed the wording from screening to not medically necessary under the sections about performing nerve conduction studies alone and testing for polyneuropathy of diabetes or endstage renal disease. The change is after a 45 day notice period, effective 04/15/2015.

In most instances, both NCS and usually EMG are necessary to perform diagnostic testing. While a provider may choose to perform just a NCS, when performed alone it is usually considered not medically necessary. The only exception to this is a situation when a provider may consider it appropriate to perform a NCS without doing an EMG for the diagnosis of carpal tunnel syndrome with a high pre-test probability.

Routine testing for polyneuropathy of diabetes or endstage renal disease (ESRD) is not considered medically necessary and is not covered. Testing for the sole purpose of monitoring disease intensity or treatment efficacy in these two conditions is also not covered.

| J5/J8    | Percutaneous Coronary Interventions | L34139 | L34139 | 04/15/2015 |

Added an Overview section to define Percutaneous Coronary Interventions

Percutaneous coronary intervention (PCI), commonly known as coronary angioplasty or simply angioplasty, is a non-surgical procedure used to treat the stenotic (narrowed) coronary arteries of the heart found in coronary heart disease. These stenotic segments are due to the buildup of the cholesterol-laden plaques.
that form due to atherosclerosis. During PCI, a cardiologist feeds a deflated balloon or other device on a catheter from the inguinal femoral artery or radial artery up through blood vessels until they reach the site of blockage in the heart. X-ray imaging is used to guide the catheter threading. At the blockage, the balloon is inflated to open the artery, allowing blood to flow. A stent is often placed at the site of blockage to permanently open the artery.

Percutaneous transluminal coronary angioplasty (PTCA) is a minimally invasive procedure to open up blocked coronary arteries, allowing blood to circulate unobstructed to the heart muscle.

Under Indications, added information about a diagnostic cardiac catheterization:

A diagnostic cardiac catheterization to assess the nature of the lesion(s) prior to the intervention is a covered service. The diagnostic cardiac catheterization may be performed at any time prior to the PCI, including the same day as the PCI. Performance of a diagnostic cardiac catheterization and interventional procedure on the same day is increasingly the standard of practice. If the diagnostic catheterization is done within 30 days of the PCI, it is usually not necessary to repeat the catheterization unless there is a documented change in the patient’s condition. While there may be reasons for delaying the interventional procedure (e.g., transfer from a community hospital to a tertiary center, excessive dye load, further treatment planning or evaluation of angiography, etc.), it is recommended that both procedures be performed during the same encounter when medically appropriate, with detailed discussion of benefits and risks of PCI. Separation of these procedures for the purpose of circumventing the multiple surgery pricing, or for the convenience of physician or hospital scheduling, is considered an inappropriate practice and may subject the services to review and denial for medical necessity. The decision to stage these procedures is deferred to the judgment of the interventional cardiologist, and individualized only to the clinical needs of the patient. (e.g., dye load already received; need to correlate findings with other test results, etc.). Reasons for delaying an indicated percutaneous coronary intervention should be documented in the medical record. Unless there is a new clinical event, a change in symptomatology, abnormal examination or other test results, a repeat diagnostic catheterization within three months of the last diagnostic catheterization and prior to the percutaneous coronary intervention is generally not reimbursable and is considered not reasonable and necessary.

Under Limitations, formatted the information into an outline and moved all billing information to the Billing and Coding Guidelines:

Generally PCI is not indicated for:
1. Patients that can be managed medically.
2. Right heart catheterization and insertion of a Swan - Ganz catheter are not generally medically necessary for a PCI and will be denied, unless medically necessary when performed incident to a diagnostic catheterization prior to the intervention.
3. Standby services of a surgeon or anesthesiologist are not covered services.
4. Patients at high risk for complications from the PCI as indicated by advanced age, diabetes, chronic kidney disease, heart failure, ACS, and multivessel CAD.
Complications can include but are not limited to PCI-related MI, PCI-related stroke, emergency CABG, coronary perforation, death. (Levine)

5. Patients with stable CAD.

Under Documentation clarified the information:

The patient's medical record must contain documentation that fully supports the medical necessity for coverage as stated in the Indications, Limitations, and/or Medical Necessity section of the policy. This documentation includes but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. There should be a permanent record of the procedure. The documentation should include a description of the procedure(s) performed and any contrast media, medications, catheters, stents, or devices used. Any known significant patient reaction or complication should be recorded. Comparison with prior relevant studies or procedure(s) needs to be addressed in the documentation. The report should address or answer any specific clinical questions or findings. If there are factors that prevent answering the clinical questions, this should be explained in the documentation. If there are factors that prevent the completion of the procedure, this should be explained in the documentation. Retention of angiographic documentation (film or digital) as well as intravascular sonographic recording(s) should be consistent both with clinical need and with relevant legal and local health care facility requirements.

If the provider performing the procedure is other than the ordering/referring physician/nonphysician practitioner, that provider must maintain a copy of the procedure report and interpretation, along with copies of the ordering/referring physician/nonphysician practitioner's order for the procedure. The physician/nonphysician practitioner must state the clinical indication/medical necessity for the procedure in his/her order for the procedure. Results of all procedures must be shared with the referring physician.

Each claim must be submitted with diagnosis codes that reflect the condition of the patient, and indicate the reason(s) for which the test was performed. Note: A payable diagnosis alone does not support medical necessity of ANY service.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as "not reasonable and necessary" under Section 1862(a)(1) of the Social Security Act.

Under Utilization Guidelines, added:

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice for the patient's condition. PCI testing
which exceeds the frequency or duration indicated by the accepted standards of medical practice are not covered unless there are special circumstances which justify the medical necessity for the additional PCI. The routine and repetitive monitoring of patients in the absence of a documented change in condition (i.e. new symptoms or progression of existing symptoms) is not considered medically necessary.

Preventive and/or screening services unless covered in Statute are not covered by Medicare.

Billing and Coding Guidelines is new with Medicare excerpts and billing information moved from the policy.

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<tr>
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<tbody>
<tr>
<td>J5/J8</td>
<td>Removal of Benign Skin Lesions</td>
<td>L35496</td>
<td>DERM-011</td>
<td>02/16/2015</td>
</tr>
</tbody>
</table>

Added Diagnosis code 701.9 to the list of covered diagnosis codes:

ICD-9 Codes that Support Medical Necessity
Group 1 Paragraph:
701.9 Unspecified hypertrophic and atrophic conditions of the skin
**Electronic Data Interchange (EDI)**

**EDI ASK-THE-CONTRACTOR TELECONFERENCE (ACT) REMINDER**

WPS Medicare will be hosting EDI Ask the Contractor Teleconferences, at 1:00 pm CT for J5 and J8 providers, billers, clearinghouses and trading partners. During the session, EDI will present some EDI information. The presentations will be available at: [http://www.wpsic.com/edi/med_edi_act.shtml](http://www.wpsic.com/edi/med_edi_act.shtml). The calls are an open forum and advance registration is not required for this teleconference.

April 9, 2015 Call 800-305-2862 passcode: 43410098  
June 11, 2015 passcode: 43410099  
August 13, 2015 passcode: 43410100  
October 8, 2015 passcode: 43410101  
December 10, 2015 passcode: 43410102

**EDI TRAINING CLOSURES**

In order to ensure the quality and consistency of the service we provide, our EDI lines will be closed at specific times during business hours. All EDI staff handling calls for EDI will be unavailable during the closures.

**EDI will be unavailable from 8:30 am to 12:30 pm on the second to last Friday of each month.**

WPS will also be closed in observance of the following holidays:

- New Year’s Day
- Good Friday – Closed for the second half of the day.
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving – Closed Thursday and Friday
- Christmas – Closed Christmas Eve, Christmas Day.

If you are interested in learning more about submitting your claims electronically or setting up electronic remittance advice (ERA) and electronic funds transfer (EFT) online, please go to our [https://www.wpsic.com/edi/tools.shtml](https://www.wpsic.com/edi/tools.shtml) section of the EDI website where you will find our online enrollment.

For further updates visit our website at [https://www.wpsic.com/edi/index.shtml](https://www.wpsic.com/edi/index.shtml). We also encourage you to contact your clearinghouse, billing service, or software vendor to discuss transition related issues.

**MEDICARE REMIT EASY PRINT JANUARY 2015**

The Latest Version of the Medicare Remit Easy Print (MREP) software (version 4.3) is available to download from the CMS website listed below. This version includes the latest Code Group

If you are an electronic biller who does not receive the Electronic Remittance Advice (ERA) and would like to, please complete the ERA information sheet at https://www.wpsic.com/edi/files/era_agreement.pdf

If you already receive the ERA and want to try the MREP software, please download the MREP software at http://cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessstoDataApplication/MedicareRemitEasyPrint.html

If you are not an electronic biller and want to receive ERA to use in the MREP software, you will need to complete an online Registration for Submitter number, an EDI enrollment form, and ERA Authorization Agreement. Please label MREP only. You can download these forms from the following website list:
   https://corp-ws.wpsic.com/apps/wtps-web/unauth/RegistrationLoadAction.do
   https://www.wpsic.com/edi/files/era_agreement.pdf

If you have questions about this or any other Medicare electronic billing issue, please contact EDI:
J5 Iowa, Nebraska, Kansas, Missouri (866) 518-3285
J8 Indiana and Michigan (866) 234-7331

Take advantage of this software. Begin using MREP today.
REVISED product from the Medicare Learning Network® (MLN)
  • “Safeguarding Your Medical Identity” Web-based Training (WBT)

MLN Matters® Number: MM8994  Related Change Request (CR) #: CR 8994
Related CR Release Date: December 5, 2014  Effective Date: April 1, 2015
Related CR Transmittal #: R3143CP  Implementation Date: April 6, 2015

Claim Status Category and Claim Status Codes Update

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8994 informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing staff are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care payers 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 format adopted as the standard for National use under HIPAA. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 to report...

These pages have previously been referenced at [http://www.wpc-edi.com/codes](http://www.wpc-edi.com/codes) on the Internet. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the January 2015 committee meeting shall be posted on the previously mentioned websites on or about February 1, 2015. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 8994.

These code changes are to be used in the editing of all ASC X12 276 transactions processed on or after the date of implementation and are to be reflected in ASC X12 277 transactions issued on and after the date of implementation of CR 8994.

**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.

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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

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8983 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of CARCs and RARCs (835) Rule. CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2015, and CR8983 instructs the MACs to use that list as of April 1, 2015. This update is based on November 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website.

**Background**

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

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

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

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [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?

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Cervical Health Awareness Month - January is Cervical Health Awareness Month - a time to draw attention to cervical cancer, cervical cancer screening, prevention, and treatment. Read more about Medicare coverage of cervical cancer screening.

International Classification of Diseases, Tenth Revision (ICD-10) Limited End to End Testing with Submitters for 2015

Provider Types Affected

This MLN Matters® Article is intended for providers and clearinghouses wishing to submit test claims with ICD-10 codes to Medicare Administrative Contractors (MACs).

What You Need to Know

Change Request (CR) 8867 directs MACs to test with a limited number of providers and clearinghouses to ensure claims with ICD-10 codes can be processed from submission to remittance. This additional testing effort will help ensure a successful transition to ICD-10.
The Centers for Medicare & Medicaid Services (CMS) defines successful end-to-end testing as being able to demonstrate that:

- Testing entities are able to successfully submit ICD-10 claims to the shared systems,
- Software changes made to support ICD-10 result in appropriately adjudicated claims based on the pricing data employed for testing purposes; and
- Remittance advices are produced.

Make sure your billing staffs are aware of this update.

**Background**

The International Classification of Disease, Tenth Revision, (ICD-10) must be implemented by October 1, 2015. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS. CR8867 will allow a small subset of submitters to test with MACs and the Common Electronic Data Interchanges (CEDIs) in three testing periods to demonstrate to the industry that CMS systems are ready for the ICD-10 implementation. MACs and CEDI shall conduct three limited End-to-End testing weeks with a small subset of submitters.

To facilitate this testing, CR8867 requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26 – 30, 2015, April 27 – May 1, 2015, and July 20 – 24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC Jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers. At least five, but not more than fifteen of the testers will be a clearinghouse, and submitters should be a mix of provider types.
- MACs and CEDIs will post a volunteer form to their website to collect volunteer information with which to select volunteers.
  - Form verifies testers are ready to test, meet the requirements to test, and collect data about the tester. (How they submit claims, what types of claims they will submit, and so forth.)
  - MACs and CEDIs will post the form to their website by March 13, 2015, for the July 2015 testing.
  - Volunteers must submit completed forms to the MACs and CEDIs by April 17, 2015, for the July 2015 testing.
- By May 8, 2015, for the July 2015 testing, the MACs and CEDIs (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
  - How to submit test claims (for example, what test indicators should be set);
  - What dates of service may be used for testing;

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o How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files);

○ Request for National Provider Identifiers (NPIs) and Health Insurance Claim Numbers (HICNs) that will be used in testing (no more than five NPIs and 10 HICNs per submitter);

○ Notice that if more than 50 claims are submitted, they may not be processed;

○ Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed; and

○ Notice of potential Protected Health Information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).

• MACs and CEDIs (for the DME MACs) will collect information from the testers after they have been notified of their selection, using a form provided by CMS. This form will specifically request the Health Insurance Claim Numbers (HICNs), Provider Transaction Access Number (PTANs), and National Provider Identifiers (NPIs) the tester will use during testing. Testers shall submit these forms back to the MAC/CEDI by February 20, 2015, for the April 2015 testing, and by May 29, 2015, for the July 2015 testing. Notification will warn testers that if forms are not received timely, they may lose their opportunity to test.

• Testers selected in the January 2015 Testing may participate in the April 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 testers of this option 30 days prior to the start of the April 2015 testing, using language provided by CMS.

• Testers selected in the January 2015 and April 2015 Testing may participate in the July 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 and April 2015 testers of this option 30 days prior to the start of the July 2015 testing, using language provided by CMS.

• MACs and CEDI will work with the testers selected to ensure they are prepared to test, and understand the requirements for testing.

• MACs and CEDI will instruct the testers to submit up to a total of 50 test claims during the testing period. This may be submitted in one to three files, but the total number of test claims cannot exceed 50.

• CEDI will instruct suppliers to submit claims with ICD-10 code with Dates of Service October 1, 2015, through October 15, 2015. They may also submit claims with ICD-9 codes with Dates of Service before October 1, 2015.

• MACs will instruct testers to submit test claims with ICD-10 code with Dates of Service on or after October 1, 2015. They may also submit test claims with ICD-9 codes with Dates of Service before October 1, 2015.

• MACs and CEDIs will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the ERAs from testing.
• MACs and CEDIs will provide information to the testers on who to contact for testing questions. This may be separate contacts for front end questions and remittance questions.
• MACs and CEDIs will post an announcement about the testing to their websites. The announcement will be provided by CMS.

Additional Information


You may also want to review MLN Matters® Article SE1409, which discusses ICD-10 testing. That article is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1409.pdf on the CMS website.

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

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Get Your Patients Off to a Healthy Start in 2015 with the Medicare Annual Wellness Visit – a yearly office visit that focuses on preventive health, and the Initial Preventive Physical Examination, commonly known as the "Welcome to Medicare" Preventive Visit – a one-time service for newly-enrolled beneficiaries. Read more.

MLN Matters® Number: MM9004 Related Change Request (CR) #: CR 9004
Related CR Release Date: January 9, 2015 Effective Date: April 1, 2015
Related CR Transmittal #: R3161CP Implementation Date: April 6, 2015

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9004 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists that are effective April 1, 2015. The CR instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes for 2015 and that they obtain the updated MREP or PC Print software if they use that software.

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Background

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

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

SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR9004, MACs will implement on the date specified on the WPC website. The WPC website is available at [http://www.wpc-edi.com/Reference](http://www.wpc-edi.com/Reference) on the Internet.

CR9004 lists only the changes that have been approved since the last code update CR (CR8855, Transmittal 2996, issued on July 25, 2014, with a related MLN Matters® article available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8855.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8855.pdf)), and does not provide a complete list of codes for these two code sets.

The complete list for both CARC and RARC from the WPC website is updated three times a year – around March 1, July 1, and November 1. The WPC website, which has four listings available for both CARC and RARC, is available at [http://www.wpc-edi.com/Reference](http://www.wpc-edi.com/Reference) on the Internet.

Changes in CARC List since CR8855

These are changes in the CARC database since the last code update in CR8855.

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New Codes – CARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>262</td>
<td>Adjustment for delivery cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>263</td>
<td>Adjustment for shipping cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>264</td>
<td>Adjustment for postage cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>265</td>
<td>Adjustment for administrative cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>266</td>
<td>Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>267</td>
<td>Claim spans multiple months. Rebill separate claim/service.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>268</td>
<td>Claim spans 2 calendar years. Please resubmit one claim per calendar year.</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>

Modified Codes – CARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>133</td>
<td>The disposition of the claim/service is pending further review. (Use only with Group Code OA). This change effective 11/01/2014: The disposition of this service line is pending further review. (Use only with Group Code OA). NOTE: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>201</td>
<td>Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>

Deactivated Codes – CARC –None

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Changes in RARC List since CR8855

These are changes in the RARC database since the last code update CR 8855.

**New Codes – RARC:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N729</td>
<td>Missing patient medical/dental record for this service.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N730</td>
<td>Incomplete/invalid patient medical/dental record for this service.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N731</td>
<td>Incomplete/Invalid mental health assessment.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N732</td>
<td>Services performed at an unlicensed facility are not reimbursable.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N733</td>
<td>Regulatory surcharges are paid directly to the state.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N734</td>
<td>The patient is eligible for these medical services only when unable to work or perform normal activities due to an illness or injury.</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>

**Modified Codes – RARC:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N42</td>
<td>Missing mental health assessment.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>MA118</td>
<td>Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. Coinsurance and/or deductible are applicable.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>MA09</td>
<td>Claim submitted as unassigned but processed as assigned in accordance with our current assignment/participation agreement.</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>

**Deactivated Codes – RARC**

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N483</td>
<td>Missing Periodontal Charts</td>
<td>05/01/2015</td>
</tr>
<tr>
<td>N484</td>
<td>Incomplete/invalid Periodontal Charts.</td>
<td>5/1/2015</td>
</tr>
</tbody>
</table>

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

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The official instruction, CR9004, issued to your MAC regarding this change, is available at [CMS website](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3161CP.pdf) on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at [CMS website](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.
This MLN Matters® Article is intended for physicians and eligible professionals who prescribe Medicare Part D drugs, and for providers and suppliers that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

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

Key Points of CR8901

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

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

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

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

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

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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.

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Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and MLN Matters® Article SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

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

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New Timeframe for Response to Additional Documentation Requests

Note: This article was revised on February 9, 2015, to reflect the revised CR8583 issued on February 4. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8583, which instructs MACs and Zone Program Integrity Contractors (ZPICs) to produce pre-payment review Additional Documentation Requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

Background

In certain circumstances, CMS review contractors (MACs, ZPICs, Recovery Auditors, the Comprehensive Error Rate Testing contractor and the Supplemental Medical Review Contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare's Common Working File (CWF).
In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an ADR. The requirements for additional documentation are as follows:

- The Social Security Act, Section 1833(e) - Medicare contractors are authorized to collect medical documentation. The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.

- According to the "Medicare Program Integrity Manual," Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions), when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. The reviewer should not grant extensions to the providers who need more time to comply with the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

**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.
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

REVISED product from the Medicare Learning Network® (MLN)
- “Medicare Fraud and Abuse: Prevention, Detection, and Reporting” Fact Sheet, ICN 006827, Downloadable

MLN Matters® Number: MM8810  Related Change Request (CR) #: CR 8810
Related CR Release Date: November 26, 2014  Effective Date: December 29, 2014
Related CR Transmittal #: R556PI  Implementation Date: December 29, 2014

Revisions to Pub. 100-08, Program Integrity Manual (PIM), Chapter 15

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

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8810 to make several clarifications to Chapter 15 of the “Medicare Program Integrity Manual”. Most of these changes were editorial in nature to clarify other Medicare manuals being referenced in Chapter 15. The revised Chapter 15 is attached to CR8810.

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Provider Education

EDUCATION SCHEDULE

If you are a MAC J5 Part B provider in Iowa, Kansas, Missouri, or Nebraska, please be sure to visit the WPS Medicare Education Schedule at http://events.r20.constantcontact.com/register/event?oeidk=a07e8ugual6db717ee1&llr=pijq86oab to learn more about the educational events we have scheduled for the upcoming months.

- Medicare Secondary Payer (MSP) – This seminar will include an overview of the MSP provisions, MSP categories, Medicare and liability insurance, and physician and patient responsibilities.
- Outpatient Rehabilitation Therapy – Coverage Criteria and Documentation – This seminar will include the Medicare coverage guidelines along with information on the necessary documentation.
- Outpatient Rehabilitation Therapy – Billing and Payment - This will include information on the functional reporting guidelines and the appropriate use of the Advance Beneficiary Notice of Non-Coverage (ABN).
- Evaluation and Management Services (E/M) – This seminar will discuss the key components, incident to guidelines, and many other E/M billing specifics.
- Preventive Services – We will discuss the many Medicare covered preventive services identifying the frequency requirements, who can perform what services, and the “carve out” process.

We are finalizing our plans for teleconferences. Please watch the eNews and the website listing above for more information.

WPS Medicare will provide a webinar to showcase our WPS Medicare website. This will go into detail on the different areas of the website and the information available.

If you are a MAC J8 Part B provider in Indiana or Michigan, please be sure to visit the WPS Medicare Education Schedule at http://events.r20.constantcontact.com/register/event?oeidk=a07e8uly004d53d81a9&llr=pijq86oab to learn more about the educational events we have scheduled for the upcoming months.

- Outpatient Rehabilitation Therapy – Coverage Criteria and Documentation – This seminar will include the Medicare coverage guidelines along with information on the necessary documentation.
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**MEDI CARE LEARNIN G NETWORK (MLN)**

We encourage you to visit the Medicare Learning Network ([http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html)) – the place for official CMS Medicare fee-for-service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. A full array of other educational products (including Web-based training courses, hard copy and downloadable publications, and CD-ROMs) are also available and can be accessed at: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html). You can also find other important physician Web sites by visiting the Physician Center Web page at: [http://www.cms.gov/Center/Provider-Type/Physician-Center.html](http://www.cms.gov/Center/Provider-Type/Physician-Center.html).

In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls, held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit [http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html](http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html).

**QUARTERLY PROVIDER UPDATE**

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

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

We encourage you to bookmark this website and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update Email Updates at https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_460.
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Subscribe to the MLN Connects™ Provider eNews: a weekly electronic publication with the latest Medicare program information, including MLN Connects™ National Provider Call announcements, claim and pricer information, and Medicare Learning Network® educational product updates.

MLN Matters® Number: MM9084 Related Change Request (CR) #: CR 9084
Related CR Release Date: January 30, 2015 Effective Date: April 1, 2015
Related CR Transmittal #: R3180CP Implementation Date: April 6, 2015

April 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

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

Provider Action Needed
Change Request (CR) 9084 informs Medicare MACs to download and implement the April 2015 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the January 2015, October 2014, July 2014, and April 2014, ASP drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 6, 2015, with dates of service April 1, 2015, through June 30, 2015. MACs will not search and adjust claims that have already been processed unless you bring such claims to their attention. Make sure that your billing staffs are aware of these changes.

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Background

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

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

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015 ASP and ASP NOC</td>
<td>April 1, 2015, through June 30, 2015</td>
</tr>
<tr>
<td>January 2015 ASP and ASP NOC</td>
<td>January 1, 2015, through March 31, 2015</td>
</tr>
<tr>
<td>October 2014 ASP and ASP NOC</td>
<td>October 1, 2014, through December 31, 2014</td>
</tr>
<tr>
<td>July 2014 ASP and ASP NOC</td>
<td>July 1, 2014, through September 30, 2014</td>
</tr>
<tr>
<td>April 2014 ASP and ASP NOC</td>
<td>April 1, 2014, through June 30, 2014</td>
</tr>
</tbody>
</table>

NOTE: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.

Additional Information


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

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NEW product from the Medicare Learning Network® (MLN)

- “Medicare Appeals Process” Podcast, ICN 909016, downloadable only.

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

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

Provider Types Affected

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

Provider Action Needed

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

Background

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Affordable Care Act of 2010, the annual update to the local clinical laboratory fees for CY 2015 is (-

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0.25) percent. The annual update to local clinical laboratory fees for CY 2015 reflects an additional multi-factor productivity adjustment and a (-1.75) percentage point reduction as described by the Affordable Care Act.

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

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

Key Points of CR9028

National Minimum Payment Amounts

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2015 national minimum payment amount is $14.38 ($14.42 plus (-0.25) percent update for CY 2015).

The affected codes for the national minimum payment amount are 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, and P3000.

National Limitation Amounts (Maximum)

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

Access to Data File

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

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Public Comments

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

Pricing Information

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

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

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

Organ or Disease Oriented Panel Codes

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

Mapping Information

Existing code 83516QW is priced at the same rate as code 83516.
New code 80163 is priced at the same rate as code 80162.
New code 80165 is priced at the same rate as code 80164.

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New codes to be gap filled are 81161, 81246, 81287, 81288, 81313, 81410, 81411, 81415, 81416, 81417, 81420, 81425, 81426, 81427, 81430, 81431, 81435, 81436, 81440, 81445, 81450, 81455, 81460, 81465, 81470, and 81471.

New code 83006 is priced at the same rate as code 82777.
New code 87505 is priced at the same rate as code 87631.
New code 87506 is priced at the same rate as code 87632.
New code 87507 is priced at the same rate as code 87633.
New code 87623 is priced at the same rate as code 87621.
New code 87624 is priced at the same rate as code 87621.
New code 87625 is priced at the same rate as code 87621.
New code 87626 is priced at the same rate as code 87626.
New code 87627 is priced at the same rate as code 87627.
New code 87806 is priced at the same rate as code 87389.
New code G6030 is priced at the same rate as code 80152.
New code G6031 is priced at the same rate as code 80154.
New code G6032 is priced at the same rate as code 80160.
New code G6034 is priced at the same rate as code 80166.
New code G6035 is priced at the same rate as code 80172.
New code G6036 is priced at the same rate as code 80174.
New code G6037 is priced at the same rate as code 80182.
New code G6038 is priced at the same rate as code 80196.
New code G6039 is priced at the same rate as code 82003.
New code G6040 is priced at the same rate as code 82055.
New code G6041 is priced at the same rate as code 82101.
New code G6042 is priced at the same rate as code 82145.
New code G6043 is priced at the same rate as code 82205.
New code G6044 is priced at the same rate as code 82520.
New code G6045 is priced at the same rate as code 82646.
New code G6046 is priced at the same rate as code 82649.
New code G6047 is priced at the same rate as code 82651.
New code G6048 is priced at the same rate as code 82654.
New code G6049 is priced at the same rate as code 82666.
New code G6050 is priced at the same rate as code 82690.
New code G6051 is priced at the same rate as code 82742.
New code G6052 is priced at the same rate as code 83805.
New code G6053 is priced at the same rate as code 83840.
New code G6054 is priced at the same rate as code 83858.

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New code G6055 is priced at the same rate as code 83887.
New code G6056 is priced at the same rate as code 83925.
New code G6057 is priced at the same rate as code 84022.
New code G6058 is priced at the same rate as code 80102.
New code G0464 is priced at the same rate as sum of codes 81315, 81275, and 82274.

The following existing codes are to be deleted: 80440, 82000, 82055, 82055QW, 82953, 82975, 82980, 83008, 83055, 83071, 83634, 83866, 84127, 87001, 87620, 87621, 87622, 80102, 80152, 80154, 80160, 80166, 80172, 80174, 80182, 80196, 82003, 82101, 82145, 82205, 82520, 82646, 82649, 82651, 82654, 82666, 82690, 82742, 83805, 83840, 83858, 83887, 83925, and 84022.

**Laboratory Costs Subject to Reasonable Charge Payment in CY 2011**

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


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

**Blood Product Codes**


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

Transfusion Medicine Codes

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

Reproductive Medicine Procedures

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

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

Additional Information


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

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Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens

Note: This article was revised on February 13, 2015, to reflect a revised CR9066 that was issued on February 5. The CR release date, transmittal number, implementation date, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9066 informs MACs about the revisions to the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) Code P9603 and when billed on a flat rate basis using HCPCS Code P9604 for Calendar Year (CY) 2015. These changes are also made to Chapter 16, Section 60.2 of the “Medicare Claims Processing Manual.” Make sure that your billing staffs are aware of these changes.

CR9066 revises the payment of travel allowances when billed on a per mileage basis using HCPCS Code P9603 and when billed on a flat rate basis using HCPCS Code P9604 for CY 2015. Medicare Part B, allows payment for a specimen collection fee and travel allowance,
when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act. Payment for these services is made based on the clinical laboratory fee schedule.

**Travel Allowance**

Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician’s salary and travel expenses. MACs have the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the MAC.

**Per Mile Travel Allowance (P9603)**

The per mile travel allowance is to be used in situations where the average trip to the patients’ homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using the Federal mileage rate of $0.575 per mile plus an additional $0.45 per mile to cover the technician’s time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $1.03 per mile if local conditions warrant it (actual total of $1.025 rounded up to reflect systems capabilities). Medicare reviews and updates the minimum mileage rate throughout the year, as well as in conjunction with the Clinical Laboratory Fee Schedule (CLFS), as needed. At no time may a laboratory bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

**Per Flat-Rate Trip Basis Travel Allowance (P9604)**

The per flat-rate trip basis travel allowance is $10.30.

**Additional Information**

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.


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NEW product from the Medicare Learning Network® (MLN)

- “Complying With Medical Record Documentation Requirements” Fact Sheet, ICN 909160, Downloadable

MLN Matters® Number: MM9081
Related Change Request (CR) #: CR 9081
Related CR Release Date: January 16, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3166CP
Implementation Date: January 5, 2015

Emergency Update to the Calendar Year (CY) 2015 Medicare Physician Fee Schedule Database (MPFSDB)

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9081, to announce an emergency update to payment files issued to contractors based on the CY 2015 MPFS Final Rule. CR9081 amends those payment files, including an updated conversion factor of $35.7547 for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from CY 2014 rates. Make sure that your billing staffs are aware of these changes.

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Background

Payment files were issued to contractors based upon the CY 2015 MPFS Final Rule, displayed on October 31, 2014 (and published in the Federal Register on November 13, 2014). CR9081 amends those payment files in order to correct technical errors to the MPFS update files, including an updated conversion factor of $35.7547 for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from the CY 2014 rate.

In preparing the CY 2015 final rates, errors were made in work, practice expense and malpractice RVUs. In correcting these errors and making adjustments to reflect the policies in the CY 2015 final rule with comment period, relativity adjustments were required across the fee schedule, and the conversion factor was adjusted from that published in the final rule. The amended payment files reflect all these changes and a conversion factor of $35.7547 for services furnished on or after January 1, 2015, and on or before March 31, 2015.

Under current law, a new conversion factor will be required for services furnished on or after April 1, 2015. These files will be provided with the April quarterly update.

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.

Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit [MLN Matters® Article #MM8890](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and [MLN Matters® Article #SE1431](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

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

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Get Your Patients Off to a Healthy Start in 2015 with the Medicare Annual Wellness Visit — a yearly office visit that focuses on preventive health, and the Initial Preventive Physical Examination, commonly known as the "Welcome to Medicare" Preventive Visit — a one-time service for newly-enrolled beneficiaries. Read more.

MLN Matters® Number: MM9021 Related Change Request (CR) #: CR 9021
Related CR Release Date: January 9, 2015 Effective Date: January 1, 2015
Related CR Transmittal #: R3163CP Implementation Date: January 5, 2015

January 2015 Update of the Ambulatory Surgical Center (ASC) Payment System

Provider Types Affected

This MLN Matters® Article is intended for Ambulatory Surgical Centers (ASCs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9021 informs MACs about changes to and billing instructions for various payment policies implemented in the January 2015 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staff are aware of these changes.

Background

Included in this notification are Calendar Year (CY) 2015 payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and covered surgical and ancillary services (ASCFS file).

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Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare Physician Fee Schedule (MPFS). The payment files associated with this transmittal reflect the most recent changes to CY 2015 MPFS payment. Key updates are:

1. **New Device Pass-Through Category and Device Offset for Payment**

   Additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the outpatient prospective payment system (OPPS). Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by current or expired categories of devices. This policy was implemented in the 2008 revised ASC payment system.

   The Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS device pass-through category as of January 1, 2015 for the OPPS and the ASC payment systems. That HCPCS code is HCPCS code C2624 (Wireless pressure sensor) is assigned ASC PI=J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). Table 1 below shows more details.

   **Table 1 - New Device Pass-Through Code HCPCS**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long descriptor</th>
<th>ASC Payment Indicator (PI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2624</td>
<td>Wireless pressure sensor</td>
<td>Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components</td>
<td>J7</td>
</tr>
</tbody>
</table>

2. **New Service**

   The Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS surgical procedure code for ASC use effective January 1, 2015, as shown in table 2.

   **Table 2 – New Procedure Payable under the ASC Payment System Effective January 1, 2015**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9742</td>
<td>Laryngoscopy with injection</td>
<td>Laryngoscopy, flexible fiberoptic, with injection into vocal cord(s), therapeutic, including diagnostic laryngoscopy, if performed</td>
<td>G2</td>
</tr>
</tbody>
</table>

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3. Billing for Corneal Tissue


4. 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.”

The CY2015 National Correct Coding Initiative (NCCI) Policy Manual states (in Chapter VIII, Section D, Item 20 in the "Downloads" Section at [http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html](http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html)) that 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,” ([http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf)) Section 90.2, the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code J3490 (Unclassified drugs), regardless of the site of service of the surgery, and are packaged as surgical supplies in both the Hospital Outpatient Department (HOPD) and the ASC. Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399.

According to the “Medicare Claims Processing Manual,” Chapter 30, Section 40.3.6, ([http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf](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.

5. Drugs, Biologicals, and Radiopharmaceuticals

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

For CY 2015, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These are displayed in Table 3.

Table 3 – New CY 2015 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th>CY 2015 HCPCS Code</th>
<th>CY 2015 Long Descriptor</th>
<th>CY 2015 Payment Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9027</td>
<td>Injection, pembrolizumab, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9136</td>
<td>Injection, factor viii, fc fusion protein, (recombinant), per i.u.</td>
<td>K2</td>
</tr>
<tr>
<td>C9349</td>
<td>FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter</td>
<td>K2</td>
</tr>
<tr>
<td>C9442</td>
<td>Injection, belinostat, 10 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9443</td>
<td>Injection, dalbavancin, 10 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9444</td>
<td>Injection, oritavancin, 10 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9446</td>
<td>Injection, tedizolid phosphate, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9447</td>
<td>Injection, phenylephrine and ketorolac, 4 ml vial</td>
<td>K2</td>
</tr>
<tr>
<td>J7180</td>
<td>Factor XIII anti-hem factor</td>
<td>K2</td>
</tr>
<tr>
<td>J7327</td>
<td>Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose</td>
<td>K2</td>
</tr>
</tbody>
</table>

b) Other CY 2015 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals.

Table 4 notes those separately payable drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS codes, their long descriptors, or both. Each product’s CY...
2014 HCPCS code and CY 2014 long descriptors are noted in the two left-hand columns. The CY 2015 HCPCS code and long descriptors are noted in the adjacent right-hand columns.

### Table 4 – Other CY 2015 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>J7195</td>
<td>Factor ix (antihemophilic factor, recombinant) per i.u.</td>
<td>J7195</td>
<td>Injection, Factor ix (antihemophilic factor, recombinant) per i.u., not otherwise specified</td>
</tr>
<tr>
<td>C9021</td>
<td>Injection, obinutuzumab, 10 mg</td>
<td>J9301</td>
<td>Injection, obinutuzumab, 10 mg</td>
</tr>
<tr>
<td>C9022</td>
<td>Injection, elosulfase alfa, 1mg</td>
<td>J1322</td>
<td>Injection, elosulfase alfa, 1mg</td>
</tr>
<tr>
<td>C9023</td>
<td>Injection, testosterone undecanoate, 1mg</td>
<td>J3145</td>
<td>Injection, testosterone undecanoate, 1mg</td>
</tr>
<tr>
<td>C9133</td>
<td>Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.</td>
<td>J7200</td>
<td>Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.</td>
</tr>
<tr>
<td>C9134</td>
<td>Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.</td>
<td>J7181</td>
<td>Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.</td>
</tr>
<tr>
<td>C9135</td>
<td>Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.</td>
<td>J7201</td>
<td>Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.</td>
</tr>
<tr>
<td>J7335</td>
<td>Capsaicin 8% patch, per 10 square centimeters</td>
<td>J7336</td>
<td>Capsaicin 8% patch, per square centimeter</td>
</tr>
<tr>
<td>Q9970</td>
<td>Injection, ferric carboxymaltose, 1mg</td>
<td>J1439</td>
<td>Injection, ferric carboxymaltose, 1mg</td>
</tr>
</tbody>
</table>

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2015

For CY 2015, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP plus six 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.

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Effective January 1, 2015, payment rates for many drugs and biologicals have changed from the values published in the CY 2015 Outpatient Payment Prospective System (OPPS)/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2014. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2015 ASC Drug file.

CMS is not publishing the updated payment rates in this CR implementing the January 2015 update of the ASC Payment System. The updated payment rates effective January 1, 2015, can be found in the January 2015 ASC Addendum BB at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html) on the CMS website.

d. Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for OPPS pass-through status are packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. The skin substitute products are divided into two groups:

1) High cost skin substitute products, and
2) Low cost skin substitute products for packaging purposes.

Table 5 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1).

High cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by CPT codes 15271-15278. Low cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278. All OPPS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT codes 15271-15278.

Table 5 – Skin Substitute Product Assignment to High Cost/Low Cost Status for CY 2015

<table>
<thead>
<tr>
<th>CY 2015 HCPCS Code</th>
<th>CY 2015 Short Descriptor</th>
<th>ASC PI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9349</td>
<td>Fortaderm, fortaderm antimic</td>
<td>N1</td>
<td>High</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CY 2015 HCPCS Code</th>
<th>CY 2015 Short Descriptor</th>
<th>ASC PI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9358</td>
<td>SurgiMend, fetal</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>C9360</td>
<td>SurgiMend, neonatal</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>C9363</td>
<td>Integra Meshed Bil Wound Mat</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4100</td>
<td>Skin substitute, NOS</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4101</td>
<td>Apligraf</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4102</td>
<td>Oasis wound matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4103</td>
<td>Oasis burn matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4104</td>
<td>Integra BMWD</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4105</td>
<td>Integra DRT</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4106</td>
<td>Dermagraft</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4107</td>
<td>Graftjacket</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4108</td>
<td>Integra Matrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4110</td>
<td>Primatrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4111</td>
<td>Gammagraft</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4112</td>
<td>Cymetra injectable</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4113</td>
<td>GraftJacket Xpress</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4114</td>
<td>Integra Flowable Wound Matrix</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4115</td>
<td>AlloMatrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4116</td>
<td>Alloderm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4117</td>
<td>Hyalomatrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4118</td>
<td>Matristem Micromatrix</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4119</td>
<td>Matristem Wound Matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4120</td>
<td>Matristem Burn Matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4121</td>
<td>Theraskin</td>
<td>K2</td>
<td>High</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell</td>
<td>K2</td>
<td>High</td>
</tr>
<tr>
<td>Q4123</td>
<td>AlloMatrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>CY 2015 HCPCS Code</td>
<td>CY 2015 Short Descriptor</td>
<td>ASC PI</td>
<td>Low/High Cost Skin Substitute</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------------------</td>
<td>--------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Q4124</td>
<td>Oasis Tri-layer Wound Matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4125</td>
<td>Arthroflex</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4126</td>
<td>Memoderm/derma/tranz/integup</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4127</td>
<td>Talymed</td>
<td>K2</td>
<td>High</td>
</tr>
<tr>
<td>Q4128</td>
<td>Flexhd/Allopatchhd/matrixhd</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4129</td>
<td>Unite Biomatrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4131</td>
<td>Epifix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4132</td>
<td>Grafix core</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4133</td>
<td>Grafix prime</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4134</td>
<td>HMMatrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4135</td>
<td>Mediskin</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4136</td>
<td>EZderm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4137</td>
<td>Amnioexcel or Biodexcel, 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4138</td>
<td>BioDfence DryFlex, 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4139</td>
<td>Ammiomatrix or Biodmatrix, 1cc</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4140</td>
<td>Biodfence 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4141</td>
<td>Alloskin ac, 1 cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4142</td>
<td>Xcm biologic tiss matrix 1cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4143</td>
<td>Repriza, 1cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4145</td>
<td>Epifix, 1mg</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4146</td>
<td>Tensix, 1cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect ecm px fx 1 sq cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4148</td>
<td>Neox 1k, 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4149</td>
<td>Excellagen, 0.1 cc</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4150</td>
<td>Allowrap DS or Dry 1 sq cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4151</td>
<td>AmnioBand, Guardian 1 sq cm</td>
<td>N1</td>
<td>Low</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CY 2015 HCPCS Code</th>
<th>CY 2015 Short Descriptor</th>
<th>ASC PI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4152*</td>
<td>Dermapure 1 square cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4153</td>
<td>Dermavest 1 square cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4154</td>
<td>Biovance 1 square cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4155</td>
<td>NeoxFlo or ClarixFlo 1 mg</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4156</td>
<td>Neox 100 1 square cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4157</td>
<td>Revitalon 1 square cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4158</td>
<td>MariGen 1 square cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4159</td>
<td>Affinity 1 square cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4160</td>
<td>NuShield 1 square cm</td>
<td>N1</td>
<td>High</td>
</tr>
</tbody>
</table>

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

6. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology may 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://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html](http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html) on the CMS website.

Suppliers, who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections, may request their MAC's adjustment of the previously processed claims.

7. CY2015 ASC Wage index

As discussed and finalized in the CY 2015 OPPS/ASC final rule with comment (79 FR 66937), in CY2015, CMS is using the new Core Based Statistical Area (CBSA) delineations issued by the Office of Management and Budget (OMB) in OMB Bulletin 13-01, dated February 28, 2013, for the IPPS hospital wage index. Therefore, because the ASC wage indexes are the pre-floor and pre-reclassified IPPS hospital wage indexes, the CY 2015 ASC wage indexes reflect the new OMB delineations.

In CY2015, where the CY 2015 ASC wage index value with the CY 2015 CBSAs is lower than the CY 2014 CBSA values, CMS calculates, or blends, the CY 2015 ASC wage index.
adjusted payment rates such that it will equal 50 percent of the ASC wage index based on the CY 2014 CBSA value and 50 percent of the ASC wage index based on the new CY 2015 CBSA value. The blending of these specific wage index values will mitigate any short-term instability to ASC payments. CY2015 CBSAs with wage index values that are higher than the CY2014 are not transitioned or blended and reflect the full higher wage index value. For additional information on this ASC wage index policy, please refer to page 66937 in the CY 2015 OPPS/ASC Final Rule (CMS-1613-FC), which is accessible at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html) on the CMS website.

8. Coverage Determinations

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

**Additional Information**


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

- “Medicare Shared Savings Program and Rural Providers”, Fact Sheet, ICN 907408, downloadable

MLN Matters® Number: MM8667 Revised
Related Change Request (CR) #: CR 8667
Related CR Release Date: May 16, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R1384OTN
Implementation Date: October 6, 2014

Posting the Limiting Charge after Applying the Electronic Health Record (EHR) and Physician Quality Reporting System (PQRS) Negative Adjustments

Note: This article was revised on January 15, 2015, to correct a typo on page 4. The reference should have stated “2% EHR negative adjustment $1.90 (95 x .02).” It incorrectly stated “2% PQRS.” All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Medicare eligible professionals (EPs) submitting professional claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8667, whose purpose is to place the Electronic Health Record (EHR) and Physician Quality Reporting System (PQRS) Negative Adjustment Limiting Charge amounts on MAC websites and hard copy disclosure reports. EPs under the Medicare EHR Incentive Program include: Doctor of medicine or osteopathy, Doctor of oral surgery or dental medicine, Doctor of podiatry, Doctor of optometry, and Chiropractor. Be sure your billing staffs are aware of these changes.

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Background

**Electronic Health Record (EHR)**

Beginning January 1, 2015, Section 1848(a)(7) of the Social Security Act as amended by Section 4101(b) of the HITECH Act, requires that EPs that are not meaningful EHR users are subject to the EHR negative adjustment.

Specifically, Section 1848(a)(7) of the Act states that: “If the eligible professional is not a meaningful EHR user (as determined under Subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).”

**Physician Quality Reporting System (PQRS)**

Beginning on January 1, 2015, Section 1848(a)(8) of the Social Security Act, as added by Section 3002(b) of the Affordable Care Act, requires that EPs who do not satisfactorily report data on quality measures for covered professional services for the quality reporting period of the year are subject to the PQRS negative adjustment.

Specifically, Section 1848(a)(8) of the Act states that: “If the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under Subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).”

The negative payment adjustment applies to all EPs, regardless of whether the EP elects to be “participating” or “non-participating” for purposes of Medicare payments.

Non-participating (Non-Par) EPs in the Medicare program may choose either to accept or not accept assignment on Medicare claims on a claim-by-claim basis. If EPs choose not to accept assignment, they may not charge the beneficiary more than the Medicare limiting charge for unassigned claims for Medicare services. The limiting charge is 115 percent of the MPFS amount. The beneficiary is not responsible for billed amounts in excess of the limiting charge for a covered service.

Non-participating EPs that do not accept assignment on a claim may choose to collect the entire limiting charge amount up front from the beneficiary at the time of service.

Submission of a non-par, non-assigned Medicare Physician Fee Schedule (MPFS) service with a charge in excess of the Medicare limiting charge amount constitutes a violation of the limiting charge. A physician or supplier who violates the limiting charge is subject to a civil

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monetary penalty of not more than $10,000, an assessment of not more than 3 times the amount claimed for each item or service, and possible exclusion from the Medicare program. Therefore, it is crucial that EPs are provided with the correct limiting charge they may bill for a MPFS service.

Your MAC will list and display the limiting charge amount after applying the EHR and PQRS negative adjustment on their website. Specifically, they will add the following to their website:

- EHR Limiting Charge;
- PQRS Limiting Charge;
- EHR/2014 eRx Limiting Charge;
- EHR + PQRS Limiting Charge; and
- EHR/2014 eRx + PQRS Limiting Charge.

**Examples**

**Non-Par Non-Assigned Claim No EHR/PQRS Adjustment:**

Original Fee Schedule Amount: $100

5% non-PAR status: $5 (100 x .05)

Adjustment Total $5.00

MPFS Allowed Amount $100-$5.00= $95.00

Limiting Charge Allowed= $95.00 x 115%= $109.25

**Non-Par Non-Assigned Claim with EHR Adjustment:**

Original Fee Schedule Amount: $100

5% non-PAR status: $5 (100 x .05)

1% EHR negative adjustment $.95 (95 x.01)

Adjustment Total $5.95

MPFS Allowed Amount $100-$5.95= $94.05

Limiting Charge Allowed= $94.05 x 115%= $108.16

**Non-Par Non-Assigned Claim with PQRS Adjustment:**

Original Fee Schedule Amount: $100

5% non-PAR status: $5 (100 x .05)

1.5% PQRS negative adjustment $1.43 (95 x.015)

Adjustment Total $ 6.43

MPFS Allowed Amount $100-$6.43= $93.57

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Limiting Charge Allowed= $93.57 x 115% = $107.61

**Non-Par Non-Assigned Claim with EHR + e-prescribing:**

Original Fee Schedule Amount: $100
5% non-PAR status: $5 (100 x .05)
2% EHR negative adjustment $1.90 (95 x .02)
Adjustment Total $6.90
MPFS Allowed Amount $100-$6.90= $93.10
Limiting Charge Allowed= $93.10 x 115% = $107.07

**Non-Par Non-Assigned Claim with EHR without 2014 e-Prescribing Adjustment + PQRS:**

Original Fee Schedule Amount: $100
5% non-PAR status: $5 (100 x .05)
1% EHR negative adjustment $.95 (95 x .01)
EHR Adjustment Total $5.95
MPFS Allowed Amount $100-$5.95= $94.05
1.5% PQRS negative adjustment $1.41 ($94.05 x .015)
PQRS Adjustment Total $94.05-$1.41=$92.64
MPFS Allowed Amount $92.64
Limiting Charge Allowed= $92.64 x 115% = $106.54

**Non-Par Non-Assigned Claim with EHR with 2014 e-Prescribing Adjustment + PQRS:**

Original Fee Schedule Amount: $100
5% non-PAR status: $5 (100 x .05)
2% EHR negative adjustment $1.90 (95 x .02)
EHR Adjustment Total $6.90
MPFS Allowed Amount $100-$6.90= $93.10
1.5% PQRS negative adjustment $1.40 (93.10 x .015)
PQRS Adjustment Total $93.10-$1.40=$91.70
MPFS Allowed Amount $91.70
Limiting Charge Allowed= $91.70 x 115% = $105.46

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Additional Information


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REVISED product from the Medicare Learning Network® (MLN)

- “Medicaid Program Integrity: Preventing Provider Medical Identity Theft” Fact Sheet, ICN 908265, Downloadable

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

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

Note: This article was revised on January 18, 2015, to provide a link to a related MLN Matters® Article MM9081 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9081.pdf on the CMS website. This article announced an emergency update to payment files issued to contractors based on the CY 2015 MPFS Final Rule. The update amends those payment files, including an updated conversion factor of $35.7547 for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from CY 2014 rates. All other information is unchanged.

Provider Types Affected

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

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Provider Action Needed

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

Background

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

The final rule also addresses public comments on Medicare payment policies that were described in the proposed rule earlier this year: "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare & Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule" was published in the Federal Register on July 11, 2014. (See http://www.gpo.gov/fdsys/pkg/FR-2014-07-11/pdf/2014-15948.pdf on the Internet).

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

Sustainable Growth Rate (SGR)

The Protecting Access to Medicare Act of 2014 (see http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf on the Internet) provides for a zero percent update from the CY 2014 rates for services furnished between January 1, 2015, and March 31, 2015. Adjusting by .06 percent to achieve required budget neutrality, the conversion factor for this period is $35.8013.

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

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Screening and Diagnostic Digital Mammography

To ensure that the higher resources needed for 3D mammography are recognized, Medicare will pay for 3D mammography using add-on codes that will be reported in addition to the 2D mammography codes when 3D mammography is furnished. See MLN Matters® Article MM8874 for more information.

Primary Care and Chronic Care Management

Medicare continues to emphasize primary care by making payment for chronic care management (CCM) services -- non-face-to-face services to Medicare beneficiaries who have two or more chronic conditions -- beginning January 1, 2015. CCM services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management. CCM can be billed once per month per qualified beneficiary, provided the minimum level of services is furnished.

CMS is finalizing its proposal to allow greater flexibility in the supervision of clinical staff providing CCM services. The proposed application of the “incident to” supervision rules was widely supported by the commenters.

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

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

Application of Beneficiary Cost Sharing To Anesthesia Related To Screening Colonoscopies

The Medicare statute waives the Part B deductible and coinsurance applicable to screening colonoscopy. In the CY 2015 final rule, CMS revised the definition of a “screening colonoscopy” to include separately provided anesthesia as part of the screening service so that the coinsurance and deductible do not apply to anesthesia for a screening colonoscopy, reducing beneficiaries’ cost-sharing obligations under Part B. For more information, review MLN Matters® Article MM8874 on the CMS website.

Enhanced Transparency in Setting PFS Rates

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

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codes goes through notice and comment rulemaking prior to being adopted. After a transition in CY 2016, the process will be fully implemented in CY 2017.

**Potentially Misvalued Services**

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

The following are major misvalued code decisions for 2015:

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

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

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

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

**Global Surgery**

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

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

**Access to Telehealth Services**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Additional Information**


If you have any questions, please contact 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) on the CMS website.

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