HOME HEALTH PROVIDERS
Clarification on the Home Health Physician Recertification Estimate ........................................ 3

MM9223: Applying Therapy Caps to Maryland Hospitals ......................................................... 4

HOSPICE PROVIDERS

MM9201 (Revised): Implementation of the Hospice Payment Reforms .................................... 5

MM9255: Reporting of Anti-Cancer and Anti-Emetic Drugs ..................................................... 9

MM9301: Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for Fiscal Year (FY) 2016 ......................................................... 10

HOME HEALTH & HOSPICE PROVIDERS

CGS Website Updates .......................................................... 14

Medicare Credit Balance Quarterly Reminder .................................................. 15

MLN Connects™ Provider eNews ...................................................... 16

MM9179: Classification of Speech Generating Devices (SGD) and Accessories under the Payment Category for Inexpensive or Routinely Purchased Durable Medical Equipment .................................................. 16

MM9260: Healthcare Provider Taxonomy Codes (HPTCs) October 2015 Code Set Update ............ 17

MM9266: Quarterly Update in the Medicare Physician Fee Schedule Database (MPFSDB) – October CY 2015 Update ................................................................. 19


MM9277: Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update .............................................. 21

MM9279: October 2015 Code Set Update October Quarterly Update for 2015 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule ................................................................. 23

MM9285: Increase Tax Withholding to 100 Percent for Internal Revenue Service (IRS) Federal Payment Levy Program (FPLP) .......................................................... 25

MM9290: October 2015 Integrated Outpatient Code Editor (I/OCE) Specifications Version 16.3 ........ 26

News Flash Messages from the Centers for Medicare & Medicaid Services (CMS) .................. 28

Preparing the CMS-1450 Claim Form .................................................. 29

Provider Contact Center (PCC) Availability .................................................. 29

Quarterly Provider Update .................................................. 30

SE1520: National Site Visit Verification (NSV) Initiative ......................................................... 31

SE1521: Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims .................................................. 32

Stay Informed and Join the CGS ListServ Notification Service ............................................ 34

Upcoming Educational Events .................................................. 34

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For Home Health Providers

Clarification on the Home Health Physician Recertification Estimate

Change Request (CR) 9119 included manual updates clarifying requirements for physician certification and recertification of home health services. CGS has received clarification from the Centers for Medicare & Medicaid Services (CMS) regarding the way home health providers should document the requirement that the physician must include an estimate of how much longer the skilled services will be required.

The physician’s recertification estimate should be included with other required elements of the recertification and not on any separate form or order. As indicated in CR 9119, which updated the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, section 30.5.2, the physician must include an estimate of how much longer the skilled services will be required and must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1;
2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased. Where a patient’s sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the recertification, or as a signed addendum to the recertification;
3. A plan of care has been established and is periodically reviewed by a physician; and
4. The services are or were furnished while the patient is or was under the care of a physician.

For Home Health Providers

MM9223: Applying Therapy Caps to Maryland Hospitals

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

**MLN Matters® Number:** MM9223  
**Related CR Release Date:** August 6, 2015  
**Related CR Transmittal #:** R3309CP  
**Related Change Request (CR) #:** CR 9223  
**Effective Date:** January 4, 2016  
**Implementation Date:** January 1, 2016

**Provider Types Affected**

This MLN Matters® Article is intended for Maryland hospitals that provide therapy services and submit claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

**Provider Action Needed**

STOP – Impact to You

Change Request (CR) 9223 revises Original Medicare systems to ensure therapy services provided in Maryland hospitals are subject to the outpatient therapy per-beneficiary caps.

CAUTION – What You Need to Know

In earlier CRs, the therapy cap provisions were inadvertently not applied to Maryland hospitals when Section 3005 of the Middle Class Tax Relief and Job Creation of 2012 (MCTRJCA) applied them to other outpatient hospitals described in Section 1833(a)(8)(B) of the Social Security Act. CR 9223 corrects this oversight. It also includes corrections and clarifications to various sections of Chapter 5 of the “Medicare Claims Processing Manual.”

GO – What You Need to Do

Make sure that your billing staffs are aware of these system revisions related to therapy services provided in Maryland hospitals.

**Background**

Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) required Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital.

These provisions have been extended several times by additional legislation. They were implemented by Change Request (CR) 7785, effective October 1, 2012. (MM7785 can be viewed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7785.pdf on the CMS website.) To account for future extensions of the effective dates, in January 2013, CR 7881 created a mechanism that MACs use to update a screen of ‘legislation effective’ indicators in their claims processing systems (MM7881 can be viewed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7881.pdf on the CMS website).
In those earlier CRs, the therapy cap provisions were inadvertently not applied to Maryland hospitals when MCTRJCA applied them to other outpatient hospitals described at section 1833(a)(8)(B) of the Social Security Act. CR 9223 corrects that oversight.

Key Points

CR 9223 implements the following policies:

- Original Medicare pays outpatient therapy services furnished in Maryland hospitals at rates established under the Maryland All-Payer Model.
- The therapy caps and related provisions described at Section 1833(g) apply to hospitals paid under the Maryland All-Payer Model.
- Medicare will use the rates established under the All-Payer Model to count the therapy services of Maryland hospitals toward the therapy caps and threshold total of beneficiaries.

Additional Information


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

For Hospice Providers

MM9201 (Revised): Implementation of the Hospice Payment Reforms

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article on August 20, 2015. CMS then issued a revised article on August 27, 2015. The following reflects the revised article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

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

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

Change Request (CR) 9201 implements service intensity add-on payments for hospice social worker and nursing visits provided during the last 7 days of life when provided during routine home care. CR 9201 also will implement two routine home care rates, paying a higher rate in the first 60 days of a hospice election and a lower rate for days 61 and later. CR 9201 revises Sections 20.1.2, 30.1, and 30.2 of Chapter 11 in “Medicare Claims Processing Manual” (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html). The CR also creates a new section, 30.2.2, “Service Intensity Add-on (SIA) Payments” in that manual. The new and revised sections are attached to CR 9201.

GO – What You Need to Do

Make sure that your billing staffs are aware of these reforms and additions to hospice and routine home care payments.

Background

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

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

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

Routine Home Care (RHC) Per Diem Rates

In order to address these concerns, two different RHC per diem rates have been created for the RHC level of care, depending on the timing of the day within the patient’s episode of care. CMS considers a hospice “episode” of care to be a hospice election period or series of election periods. Days 1 through 60 will be paid at the RHC ‘High’ Rate while days 61+ will be paid at the RHC ‘Low’ Rate. These differing rates will serve to capture varying levels of resource intensity during the course of hospice care, as the beginning portion of the stay is generally more costly than the later segment.

Effective for hospice services with dates of service on or after January 1, 2016, a hospice day billed at the RHC level of care will be paid one of two RHC rates based upon the following:

1. The day is billed as an RHC level of care day.
2. If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC ‘High’ Rate.
3. If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC ‘Low’ Rate.

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

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

Service Intensity Add-On Payment (SIA)

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

1. The day is an RHC level of care day.
2. The day occurs during the last seven days of life (and the beneficiary is discharged dead).
3. Service is provided by a Registered Nurse (RN) or social worker that day for at least 15 minutes and up to 4 hours total.
4. The service is not provided by a social worker via telephone.

The SIA Payment amount shall equal:

- The number of hours (in 15 minute increments) of service provided by an RN or social worker during the last seven days of life for a minimum of 15 minutes and up to 4 hours total per day;
- Multiplied by the current hospice Continuous Home Care (CHC) hourly rate per 15 minutes x visit units (not greater than 16).
- Adjusted for geographic differences in wages.

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

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

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

Routine Home Care (RHC) Per Diem Rates

Example:

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

Since the break in hospice care from 01/30 to 02/16 was less than 60 days the patient day count continues on the second admission.
RHC provided during first election from 01/10/16 to 01/30/16 accounts for 21 days that the high RHC rate would apply. The 60 day count continues with second admission on 2/16/16 and the high RHC rate would apply for an additional 39 days. Day 61 begins the low RHC rate on 3/27/16.

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

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

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

Medicare systems would:

- Calculate the dates from 3/01 to 3/26 at the high RHC rate,
- Calculate the dates from 3/27 to 3/31 at the low RHC rate, and
- Sum these two amounts in the payment applied to this line item.

Service Intensity Add-On Payment (SIA)

Example:

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

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

* Visits reported prior to 12/03/XX are not included in the EOL 7 day SIA.

Day 1 of 7, 12/03/XX, no qualifying units reported for the EOL SIA.

Day 2 of 7, 12/04/XX, no qualifying units reported for the EOL SIA.

Day 3 of 7, 12/05/XX, qualifying units are 4. Day 3 of the EOL SIA payment is stored on the first applicable visit line for that date: 0561 G0155 12/05/XX UNITS 4

Day 4 of 7, 12/06/XX, qualifying units are 3. Day 4 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0154 12/06/XX UNITS 3

Day 5 of 7, 12/07/XX, no qualifying units reported for the EOL SIA.

Day 6 of 7, 12/08/XX, no qualifying units reported for the EOL SIA.
Day 7 of 7, 12/09/XX, qualifying units are 10. Day 7 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0154 12/09/XX UNITS 4.

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

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

Additional Information

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

**For Hospice Providers**

**MM9255: Reporting of Anti-Cancer and Anti-Emetic Drugs**

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

**MLN Matters® Number:** MM9255  
**Related CR Release Date:** August 6, 2015  
**Related CR Transmittal #:** R1528OTN  
**Related Change Request (CR) #:** CR 9255  
**Effective Date:** January 1, 2016  
**Implementation Date:** January 4, 2016

**Provider Types Affected**
This MLN Matters® Article is intended for hospices that submit claims to Home Health and Hospice Medicare Administrative Contractors (MACs) for hospice services provided to Medicare beneficiaries.

**Provider Action Needed**
This article is based on Change Request (CR) 9255, which revises Medicare systems to allow oral anti-cancer and anti-emetic drugs to be reported on hospice claims, as intended by CR 8358. See the “Background” and “Additional Information” sections of this article for further details, and make sure that your billing staffs are aware of these changes.

**Background**
CR 8358 required hospices to report prescription drugs for the palliation and management of the terminal illness and related conditions on their claims, beginning in April 1, 2014. You
Recently, MACs reported that a Common Working File (CWF) edit restricts the allowable types of bill (TOB) for certain anti-cancer and anti-emetic drugs. This edit does not include the hospice TOB. As a result, Medicare systems are returning hospice claims that report these drugs to the hospice in error. CR 9255 revises Medicare systems to allow the drugs on hospice claims, as originally intended by CR 8358.

Despite the fact that reporting drug services does not change the payment amount, the affected hospice claims are not being paid. Therefore, in order to allow payment for these claims and provide for more timely payments, hospices may:

- Remove the drug codes from their claims when returned in error; and
- Omit these codes from original claim submissions until the error is corrected on January 4, 2016.

When the problem is corrected, hospices may submit the unreported drug services via claims adjustments. Medicare does not require these adjustments, but encourages hospices to submit them in order to represent all their service costs in the claims data.

**Additional Information**


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

**For Hospice Providers**

**MM9301: Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for Fiscal Year (FY) 2016**

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

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

**Provider Types Affected**

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

**Provider Action Needed**

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

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

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

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

1. A higher RHC rate for days 1 through 60; and
2. A lower RHC rate for days 61 and beyond.

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

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

Effective January 1, 2016, hospices will receive a SIA payment on RHC days when direct patient care is provided by a Registered Nurse (RN) or social worker during the last seven days of the patient’s life. The SIA payment will be made in addition to the per diem rate for the RHC level of care. It will equal the Continuous Home Care (CHC) hourly rate multiplied by the hours of nursing/social work service (for at least 15 minutes and up to 4 hours total), that occurred on RHC days during the last seven days of life.

For more information regarding the SIA payment policy, please refer to MLN Matters® Article MM9201 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9201.pdf on the CMS website.

The FY 2016 hospice payment rates are effective for care and services furnished on or after October 1, 2015, through September 30, 2016. The hospice payment rates are discussed further in the “Medicare Claims Processing Manual,” Chapter 11 (Processing Hospice Claims), Section 30.2 (Payment Rates). The updated payment rates are shown in following tables and in the attachment to CR9301.
**Table 1: FY 2016 Hospice Payment Rate for RHC for October 1, 2015, through December 31, 2015**

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$186.84</td>
<td>$128.38</td>
<td>$58.46</td>
</tr>
<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$146.83</td>
<td>$100.89</td>
<td>$45.94</td>
</tr>
</tbody>
</table>

**Table 3: FY 2016 Hospice Payment Rates for CHC, Inpatient Respite Care IRC, and General Inpatient (GIP) Care**

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>652</td>
<td>Continuous Home Care Full Rate= 24 hours of care $=38.59 hourly rate</td>
<td>$926.19</td>
<td>$636.39</td>
<td>$289.80</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$164.15</td>
<td>$88.85</td>
<td>$75.30</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$705.93</td>
<td>$451.87</td>
<td>$254.06</td>
</tr>
</tbody>
</table>

**Hospice Cap**

The hospice aggregate cap amount for the 2015 cap year ending October 31, 2015, is $27,382.63. In computing the cap, CMS used the medical care expenditure category of the March 2015 Consumer Price Index for all Urban consumers, published by the Bureau of Labor Statistics ([http://www.bls.gov/cpi/home.htm](http://www.bls.gov/cpi/home.htm)), which was 244.020.

**Hospice Wage Index**

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

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

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

<table>
<thead>
<tr>
<th>CBSA Code</th>
<th>CBSA Name</th>
<th>CBSA Code</th>
<th>CBSA Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>10380</td>
<td>Aguadilla-Isabela, PR</td>
<td>35380</td>
<td>New Orleans-Metairie, LA</td>
</tr>
<tr>
<td>11100</td>
<td>Amarillo, TX</td>
<td>35614</td>
<td>New York-Jersey City-White Plains, NY-NJ</td>
</tr>
<tr>
<td>12060</td>
<td>Atlanta-Sandy Springs-Roswell, GA</td>
<td>36280</td>
<td>Ogden-Clearfield, UT</td>
</tr>
<tr>
<td>12260</td>
<td>Augusta-Richmond County, GA-SC</td>
<td>37460</td>
<td>Panama City, FL</td>
</tr>
<tr>
<td>13140</td>
<td>Beaumont-Port Arthur, TX</td>
<td>38660</td>
<td>Ponce, PR</td>
</tr>
<tr>
<td>13740</td>
<td>Billings, MT</td>
<td>39660</td>
<td>Rapid City, SD</td>
</tr>
<tr>
<td>13980</td>
<td>Blacksburg-Christiansburg-Radford, VA</td>
<td>40340</td>
<td>Rochester, MN</td>
</tr>
<tr>
<td>14010</td>
<td>Bloomington, IL</td>
<td>40380</td>
<td>Rochester, NY</td>
</tr>
<tr>
<td>14540</td>
<td>Bowling Green, KY</td>
<td>41540</td>
<td>Salisbury, MD-DE</td>
</tr>
<tr>
<td>15764</td>
<td>Cambridge-Newton-Framingham, MA</td>
<td>41980</td>
<td>San Juan-Carolina-Caguas, PR</td>
</tr>
<tr>
<td>16740</td>
<td>Charlotte-Concord-Gastonia, NC-SC</td>
<td>43340</td>
<td>Shreveport-Bossier City, LA</td>
</tr>
<tr>
<td>16820</td>
<td>Charleston, SC</td>
<td>43580</td>
<td>Sioux City, IA-NE-SD</td>
</tr>
<tr>
<td>17140</td>
<td>Cincinnati, OH-KY-IN</td>
<td>43900</td>
<td>Spartanburg, SC</td>
</tr>
<tr>
<td>18140</td>
<td>Columbus, OH</td>
<td>44060</td>
<td>Spokane-Spokane Valley, WA</td>
</tr>
<tr>
<td>18880</td>
<td>Crestview-Fort Walton Beach-Destin, FL</td>
<td>46220</td>
<td>Tuscaloosa, AL</td>
</tr>
<tr>
<td>19660</td>
<td>Deltona-Daytona Beach-Ormond Beach, FL</td>
<td>47260</td>
<td>Virginia Beach-Norfolk-Newport News, VA-NC</td>
</tr>
<tr>
<td>20524</td>
<td>Dutchess County-Putnam County, NY</td>
<td>47380</td>
<td>Waco, TX</td>
</tr>
<tr>
<td>21060</td>
<td>Elizabethtown-Fort Knox, KY</td>
<td>47894</td>
<td>Washington-Arlington-Alexandria, DC-VA-MD-WV</td>
</tr>
<tr>
<td>21340</td>
<td>El Paso, TX</td>
<td>48620</td>
<td>Wichita, KS</td>
</tr>
<tr>
<td>23104</td>
<td>Fort Worth-Arlington, TX</td>
<td>49180</td>
<td>Winston-Salem, NC</td>
</tr>
<tr>
<td>24340</td>
<td>Grand Rapids-Wyoming, MI</td>
<td>49340</td>
<td>Worcester, MA-CT</td>
</tr>
<tr>
<td>24860</td>
<td>Greenville-Anderson-Mauldin, SC</td>
<td>99901</td>
<td>Alabama</td>
</tr>
<tr>
<td>25060</td>
<td>Gulfport-Biloxi-Pascagoula, MS</td>
<td>99913</td>
<td>Idaho</td>
</tr>
<tr>
<td>25850</td>
<td>Huntington-Ashland, WV-KY-OH</td>
<td>99915</td>
<td>Indiana</td>
</tr>
<tr>
<td>26820</td>
<td>Idaho Falls, ID</td>
<td>99917</td>
<td>Kansas</td>
</tr>
<tr>
<td>26900</td>
<td>Indianapolis-Carmel-Anderson, IN</td>
<td>99918</td>
<td>Kentucky</td>
</tr>
<tr>
<td>29180</td>
<td>Lafayette, LA</td>
<td>99922</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>31140</td>
<td>Louisville/Jefferson County, KY-IN</td>
<td>99923</td>
<td>Michigan</td>
</tr>
<tr>
<td>31180</td>
<td>Lubbock, TX</td>
<td>99925</td>
<td>Mississippi</td>
</tr>
</tbody>
</table>
Table 7: List of CBSA codes that are invalid for Hospice for FY 2016 because of the wage index transition (these areas need to use 50xxx codes)

<table>
<thead>
<tr>
<th>CBSA Code</th>
<th>CBSA Name</th>
<th>CBSA Code</th>
<th>CBSA Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>31540</td>
<td>Madison, WI</td>
<td>99926</td>
<td>Missouri</td>
</tr>
<tr>
<td>32820</td>
<td>Memphis, TN-MS-AR</td>
<td>99934</td>
<td>North Carolina</td>
</tr>
<tr>
<td>33260</td>
<td>Midland, TX</td>
<td>99936</td>
<td>Ohio</td>
</tr>
<tr>
<td>33460</td>
<td>Minneapolis-St. Paul-Bloomington, MN-WI</td>
<td>99945</td>
<td>Texas</td>
</tr>
<tr>
<td>34820</td>
<td>Myrtle Beach-Conway-North Myrtle Beach, SC-NC</td>
<td>99946</td>
<td>Utah</td>
</tr>
<tr>
<td>34980</td>
<td>Nashville-Davidson—Murfreesboro—Franklin, TN</td>
<td>99949</td>
<td>Virginia</td>
</tr>
<tr>
<td>35084</td>
<td>Newark, NJ-PA</td>
<td>99951</td>
<td>West Virginia</td>
</tr>
</tbody>
</table>

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

For counties located in CBSAs and rural areas that still correspond to only one wage index value, the CBSA number will still be used.

Additional Information


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

For Home Health and Hospice Providers

CGS Website Updates

CGS has recently made updates to their website, giving providers additional resources to assist with billing Medicare-covered services appropriately.

Please review the following updates:

- The “DIAG CODES” field description on the home health “Claim Page 03 – Entering a RAP or Claim” Web page at http://www.cgsmedicare.com/hhh/education/materials/hhe_claim_page_3.html has been updated to add information about when ICD-9 vs. ICD-10 codes should be reported.
- The “Medical Review Signature and Attestation Guidelines” Web page at http://www.cgsmedicare.com/hhh/medreview/sig_guidelines.html as well as the
For Home Health and Hospice Providers

Medicare Credit Balance Quarterly Reminder

This article is a reminder to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by October 30, 2015, for the quarter ending September 30, 2015. A Medicare credit balance is an amount determined to be refundable to the Medicare program for an improper or excess payment made to a provider because of patient billing or claims processing errors.

Each provider must submit a quarterly Medicare Credit Balance Report (CMS-838) and certification for each individual PTAN, which is available at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS838.pdf. The report must be postmarked by the date indicated above. If the report is received with a postmark date later than the date indicated above, we are required to withhold 100 percent of all payments being sent to your facility. This withholding will remain in effect until the reporting requirements are met. If no credit balance exists for your facility during a quarter, a signed Medicare Credit Balance Report certification is still required. Please include your Medicare provider number on the certification form.

Refer to the Medicare Credit Balance Report (CMS-838) form for complete instructions. However, for additional assistance in completing the form, refer to the “Tips on Completing a Credit Balance Report (Form CMS-838)” Web page at https://www.cgsmedicare.com/hhh/financial/838_form_tips.html on the CGS website.

To ensure timely receipt and processing, send the CMS-838/Certification within 30 days of the quarter end date using one of the options below:

<table>
<thead>
<tr>
<th>Reports may be faxed to:</th>
<th>Fax: 1.615.664.5987</th>
<th>MCBR Receipts</th>
</tr>
</thead>
</table>

Please note that if you have or will be submitting an adjustment, please send the UB-04 along with the CMS-838 form.

If you are issuing a refund check for a credit balance:

Send the CMS-838 and a copy of the refund check using one of the options listed above.

Send the refund check with a copy of the CMS-838 or documentation that indicates the check is for a credit balance, the quarter end date, and provider number associated with the check to the following address:

CGS - J15 Home Health and Hospice
PO Box 957124
St. Louis, MO 63195-7124

If you have general questions related to the Credit Balance report, refer to the CGS Credit Balance Report (Form CMS-838) website at http://www.cgsmedicare.com/hhh/financial/CMS-588.html or call the Provider Contact Center at 1.877.299.4500 (Option 1). If you have questions about withholding, call 1.877.299.4500 and select Option 4.

For Home Health and Hospice Providers

MLN Connects™ Provider eNews

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


For Home Health and Hospice Providers

MM9179: Classification of Speech Generating Devices (SGD) and Accessories under the Payment Category for Inexpensive or Routinely Purchased Durable Medical Equipment

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

MLN Matters® Number: MM9179
Related CR Release Date: June 12, 2015
Related CR Transmittal #: R1511OTN
Related Change Request (CR) #: CR 9179
Effective Date: October 1, 2015
Implementation Date: October 5, 2015
Provider Types Affected
This MLN Matters® Article is intended for suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) submitting claims to Medicare Administrative Contractors (MACs) for speech generating devices (SGD) and accessories provided to Medicare beneficiaries.

What You Need to Know
This article is based on Change Request (CR) 9179, which provides instructions to MACs to change the DME payment category for SGDs and accessories essential for the effective use...
of the SGD from capped rental (CR) to inexpensive or routinely purchased (IN), effective for SGD and their accessories furnished between October 1, 2015, through September 30, 2018.

Effective for claims with dates of service on or after October 1, 2015, if the beneficiary opts to purchase the SGD, MACs will deduct the cumulative allowed amount for any and all previously paid claims for the item from the allowed amount for the purchase of the item so that payment for purchase of the item does not exceed the fee schedule amount for purchase of the equipment.

**Background**

Change Request 9179 provides instructions regarding the recent amendment of Section 1834(a)(2)(A) of the Act ([http://www.ssa.gov/OP_Home/ssact/title18/1834.htm](http://www.ssa.gov/OP_Home/ssact/title18/1834.htm)), that changes the payment category for SGDs and accessories essential for the effective use of the SGD furnished between October 1, 2015, and September 30, 2018, from capped rental to inexpensive or routinely purchased.

As a result of the amendment, SGDs (and their accessories) furnished between October 1, 2015, and September 30, 2018, are now classified as inexpensive or routinely purchased items and subject to the payment rules outlined in Section 1834(a)(2) of the Act. Items in this payment category are paid on a purchased new (NU), purchased used (UE) or rental (RR) basis. Total payments for items in this category (sum of allowed charges for all claims for rental or purchase) may not exceed the fee schedule amount for purchase of NU.

**Note:** The NU, UE or RR fee schedule amounts for the SGD and accessory codes will be provided on the October 2015 DMEPOS fee schedule update.

**Additional Information**


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

**For Home Health and Hospice Providers**

**MM9260: Healthcare Provider Taxonomy Codes (HPTCs) October 2015 Code Set Update**

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

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

**Provider Types Affected**

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

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

Background

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

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

You should note that:

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

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

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

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

Additional Information


If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at [1.877.299.4500](tel:1.877.299.4500) and choose Option 1.
MM9266: Quarterly Update in the Medicare Physician Fee Schedule Database (MPFSDB) – October CY 2015 Update

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

MLN Matters® Number: MM9266
Related CR Release Date: August 6, 2015
Related CR Transmittal #: R3317CP
Related Change Request (CR) #: CR 9266
Effective Date: October 5, 2015
Implementation Date: January 1, 2015

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

What You Need to Know
Changes included in the October update to the 2015 MPFSDB are effective for dates of service on and after January 1 (unless otherwise stated). The key change is to the Malpractice Relative Value Units (RVU) of the following CPT/HCPCS codes: 33471, 33606, 33611, 33619, 33676, 33677, 33692, 33737, 33755, 33762, 33764, 33768, 33770, 33771, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33783, 33786, 33803, 33813, 33822, 33840, and 33851. The RVU changes for these codes are retroactive to January 1, 2015. Also, effective October 1, 2015, CPT/HCPCS code Q9979 is assigned a procedure status indicator of E (Excluded from the PFS by regulation. These codes are for items and services that CMS has excluded from the PFS by regulation. No payment may be made under the PFS for these codes and generally, no RVUs are shown.).

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

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

Additional Information

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

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

MLN Matters® Number: MM9273
Related CR Release Date: August 6, 2015
Related CR Transmittal #: R3304CP
Related Change Request (CR) #: CR 9273
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

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

Provider Action Needed
Change Request (CR) 9273 informs the MACs that, effective for claims with dates of service on or after October 1, 2015, new Healthcare Common Procedure Coding System (HCPCS) code Q9979 (INJECTION, ALEMTUZUMAB, 1 MG) will be payable for Medicare. Make sure that your billing staff are aware of these changes.

Background
The Healthcare Common Procedure Coding System (HCPCS) code set is updated on a quarterly basis. Change Request (CR) 9273 instructs that, effective for claims with dates of service on or after October 1, 2015, HCPCS code Q9979 will be established for alemtuzumab (Lemtrada) and will be payable for Medicare. See the following table for details regarding this temporary HCPCS code:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Long Description</th>
<th>Type of Service (TOS) Code</th>
<th>Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9979</td>
<td>Injection, Alemtuzumab</td>
<td>Injection, Alemtuzumab, 1 mg</td>
<td>1, P</td>
<td>E</td>
</tr>
</tbody>
</table>

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.
MM9278: Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

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

MLN Matters® Number: MM9278
Related Change Request (CR) #: CR 9278
Related CR Release Date: August 6, 2015
Related CR Transmittal #: R3298CP
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

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

Provider Action Needed
STOP – Impact to You
If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (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.

CAUTION – What You Need to Know
Change Request (CR) 9278 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists and also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software used by some providers.

GO – What You Need to Do
Make sure that your billing staffs are aware of these updates.

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 Claim Adjustment Reason Codes (CARCs) and appropriate Remittance Advice Remark Codes (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 impact Medicare are usually requested by staff of the Centers for Medicare & Medicaid Services (CMS), in conjunction with a policy change. MACs 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. If any new or modified code has an effective date past the implementation date specified in CR 9278, MACs must implement on the effective date found at the WPC website.

The discrepancy between the dates may arise because the Washington Publishing Company (WPC) website gets updated only three times per year and may not match the CMS release schedule. CR 9278 lists only the changes that have been approved since the last code update by CR 9125, issued on April 13, 2015, and does not provide a complete list of codes for these two code sets.

The WPC website has four listings available for both CARC and RARC. Those listings are available at http://www.wpc-edi.com/Reference on the WPC website.

### Changes in RARC List Since CR 9125

#### New Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N753</td>
<td>Missing/Incomplete/Invalid Attachment Control Number.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>N754</td>
<td>Missing/Incomplete/Invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>N755</td>
<td>Missing/Incomplete/Invalid ICD Indicator on the 1500 Claim Form.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>N756</td>
<td>Missing/Incomplete/Invalid point of drop-off address.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>N757</td>
<td>Adjusted based on the Federal Indian Fees schedule (MLR).</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>N758</td>
<td>Adjusted based on the prior authorization decision.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>N759</td>
<td>Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.</td>
<td>07/01/2015</td>
</tr>
</tbody>
</table>

#### Modified Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>M47</td>
<td>Missing/Incomplete/Invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>MA74</td>
<td>ALERT: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>N432</td>
<td>ALERT: Adjustment based on a Recovery Audit.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>N22</td>
<td>ALERT: This procedure code was added/changed because it more accurately describes the services rendered.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>M39</td>
<td>ALERT: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>M109</td>
<td>ALERT: This claim/service was chosen for complex review.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>M38</td>
<td>ALERT: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>N381</td>
<td>ALERT: Consult our contractual agreement for restrictions/billing/payment information related to these charges.</td>
<td>07/01/2015</td>
</tr>
<tr>
<td>MA91</td>
<td>ALERT: This determination is the result of the appeal you filed.</td>
<td>07/01/2015</td>
</tr>
</tbody>
</table>

#### Deactivated Codes - RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N102</td>
<td>This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.</td>
<td>07/01/2016</td>
</tr>
</tbody>
</table>

* N735- This RARC is not included in the list of deactivated codes because CMS did not add this code during the previous release when it was included on the WPC website. The RARC was previously added to the WPC website erroneously.
Changes in CARC List Since CR 9125

<table>
<thead>
<tr>
<th>New Code – CARC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>270</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modified Code – CARC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>45</td>
</tr>
</tbody>
</table>

There have been no deactivated CARC codes since CR 9125.

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

Additional Information


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

For Home Health and Hospice Providers

**MM9279: October 2015 Code Set Update**

October Quarterly Update for 2015 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

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

MLN Matters® Number: MM9279
Related CR Release Date: August 14, 2015
Related CR Transmittal #: R3323CP
Related Change Request (CR) #: CR 9279
Implementation Date: October 5, 2015
Effective Date: January 1, 2015 (for implementation of fee schedule amounts for codes in effect on January 1, 2015; October 1, 2015 for all other changes).

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice MACs and Durable Medical Equipment (DME MACs), for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider Action Needed

Change Request (CR) 9279 alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2015. Make sure your billing staffs are aware of the changes.
Background
The DMEPOS fee schedule are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in Pub.100-04, “Medicare Claims Processing Manual,” Chapter 23, Section 60, found here http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

The recurring update notification provides instructions regarding the October quarterly update for the 2015 DMEPOS fee schedule. Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 for Parenteral and Enteral Nutrition (PEN), splints and casts, and Intraocular Lenses (IOLs) inserted in a physician's office.

As part of the October 2015 update, fee schedules are established for the following two Healthcare Common Procedure Coding System (HCPCS) codes added to the HCPCS file effective January 1, 2005:
- E0639 - Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories, and
- E0640 - Patient lift, fixed system includes all components/accessories.

The fee schedule amounts for both codes were established using fees for comparable items in accordance with the instructions found in the "Medicare Claims Processing Manual," Chapter 23, Section 60.3 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf on the CMS website. An average of the existing hydraulic or mechanical patient lift code E0630 and the electric patient code E0635 were used to establish the fee schedules for the hydraulic or electric patient lifts described under E0639 and E0640. The fee schedules for E0639 and E0640 are effective for dates of service on or after January 1, 2015. This update also revises the type of service code for HCPCS codes E0639 and E0640 from “9” to type of service code “R.”

CR 9279 also provides revised fee schedules for speech generating device (SGD) HCPCS codes E2500, E2502, E2504, E2506, E2508, E2510 and E2351 per the recent amendments to Section 1834(a)(2)(A) of the Social Security Act. The Steve Gleason Act of 2015 was signed by the President on July 30, 2015 and changes the DME payment category for SGDs and accessories essential for the effective use of the SGD furnished between October 1, 2015 and September 30, 2018, from capped rental (CR) to inexpensive or routinely purchased (IN). Instructions relating to the implementation of the SGD amendments to Section 1834(a)(2)(A) were issued in Change Request 9179, dated June 12, 2015. The NU, UE, and RR fee schedule amounts for codes E2500, E2502, E2504, E2506, E2508, E2510 and E2351 are being added to the fee schedule file as part of this update.


Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.
MM9285: Increase Tax Withholding to 100 Percent for Internal Revenue Service (IRS) Federal Payment Levy Program (FPLP)

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

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

**Provider Types Affected**

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

**What You Need to Know**

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

**Background**

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

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

Consistent with this authority, CMS introduced CR 6125 in October of 2008, which reduced federal payments subjected to the levy by the required 15 percent, or the exact amount of the tax owed if it is less than 15 percent of the payment. You can review the MLN Matters® Article MM6125, corresponding to CR 6125, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6125.pdf on the CMS website.

In December 2014, the Internal Revenue Code Section 6331(h) was amended by the Tax Increase Prevention Act of 2014 Section 209(a) (see http://www.gpo.gov/fdsys/pkg/BILLS-113hr5771enr/html/BILLS-113hr5771enr.htm), which mandated an increase to the tax levy to 30 percent. In order to do this, CMS introduced CR 9154. You can review the MLN Matters® Article MM9154 corresponding to CR 9154, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm9154.pdf on the CMS website.
In April 2015, the Internal Revenue Code Section 6331(h) was amended by the Medicare Access and CHIP Reauthorization Act of 2015, Section 413(a), which increases the tax levy withholding to 100 percent.

Additional Information

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

For Home Health and Hospice Providers

MM9290: October 2015 Integrated Outpatient Code Editor (I/OCE) Specifications Version 16.3

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

MLN Matters® Number: MM9290
Related CR Release Date: August 14, 2015
Related CR Transmittal #: R3328CP
Related Change Request (CR) #: CR 9290
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

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

Provider Action Needed
STOP – Impact to You
Be aware that the Integrated/Outpatient Code Editor (I/OCE) is being updated for October 1, 2015. Change Request (CR) 9290 details those changes.

CAUTION – What You Need to Know
CR 9290 provides the instructions and specifications for the I/OCE to be used under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System (PPS) or to a hospice patient for the treatment of a non-terminal illness. This notification applies to Chapter 4, Section 40.1 of the “Medicare Claims Processing Manual,” which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

GO – What You Need to Do
Make sure that your billing staffs are aware of the updated I/OCE for October 1, 2015.
Background
CR 9290 provides the I/OCE instructions and specifications for the Integrated OCE that will be utilized under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health PPS or to a hospice patient for the treatment of a non-terminal illness. The I/OCE specifications will be posted online and can be found at http://www.cms.gov/OutpatientCodeEdit/ on the CMS website.

The modifications of the I/OCE for the October 2015 release (V16.3) are summarized in the table below. Some I/OCE modifications in this update may be retroactively added to prior releases. If so, the retroactive date appears in the “Effective Date” column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2015</td>
<td>87</td>
<td>Modify the program logic to not ignore skin substitute product code(s) present with line item action flag 2 in order to process edit 87.</td>
</tr>
<tr>
<td>10/1/2015</td>
<td>87</td>
<td>Update to the skin substitute product list (move HCPCS Q4151 from List A to List B – Appendix P, list E of CR 9290).</td>
</tr>
<tr>
<td>10/1/2015</td>
<td>88, 89</td>
<td>Modify the program logic to not assign edits 88 and 89 for Federally Qualified Health Center (FQHC) PPS claims when only FQHC non-covered services are present with edit 91 (page 11; Appendix M processing steps and flowchart).</td>
</tr>
<tr>
<td>10/1/2015</td>
<td>2, 3, 86</td>
<td>Update the diagnosis/age and diagnosis/sex conflict, and manifestation edits based on the official ICD-10-CM diagnosis code editing content for the MCE.</td>
</tr>
<tr>
<td>10/1/2015</td>
<td></td>
<td>Modify the diagnosis code content to replace all preliminary ICD-10-CM content with the official ICD-10-CM code content effective for 10/1/2015; restrict the use of ICD-9-CM code content for historical claims with From Dates through 9/30/2015.</td>
</tr>
<tr>
<td>10/1/2015</td>
<td></td>
<td>Updates to FQHC non-covered procedures and flu/PPV vaccine lists (see quarterly data file changes).</td>
</tr>
<tr>
<td>10/1/2015</td>
<td></td>
<td>Make Healthcare Common Procedure Coding System (HCPCS)/ Ambulatory Payment Classification (APC)/Status Indicator (SI) changes as specified by CMS (data change files).</td>
</tr>
<tr>
<td>10/1/2015</td>
<td>20, 40</td>
<td>Implement version 21.3 of the NCCI (as modified for applicable institutional providers).</td>
</tr>
<tr>
<td>10/1/2015</td>
<td></td>
<td>Update page 3 and Table 1 (OCE Control Block) to indicate ICD-10-CM diagnosis codes as the primary diagnosis code set with ICD-9-CM diagnosis codes remaining for historical claims.</td>
</tr>
</tbody>
</table>

Note: Readers should also read through the entire CR 9290 document and note the highlighted sections, which also indicate changes from the prior release of the software. A full summary of data changes in I/OCE V16.3, including diagnosis, HCPCS, Current Procedural Terminology (CPT) and APC codes, is attached to the CR.

Additional Information

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

News Flash Messages from the Centers for Medicare & Medicaid Services (CMS)

• New products from the Medicare Learning Network®

• Revised products from the Medicare Learning Network®

• Providers and Suppliers — Browse the MLN Connects® Call Program Collection of Resources - The CMS MLN Connects® National Provider Call Program has hosted many educational conference calls for the health care community on a variety of topics, including ICD-10, PQRS, Chronic Care Management, Open Payments (the Sunshine Act), 2-Midnight Rule, Medicare Shared Savings Program, ESRD QIP, and Dementia Care in Nursing Homes — just to name a few. Check out our Calls and Events Web page at https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html for links to slide presentations, audio recordings, written transcripts, and a list of upcoming calls, or view one of our videos on the Medicare Learning Network® Playlist at https://www.youtube.com/playlist?list=PLaV7m2zFKphxHxb4AIWNjbsIUUKCGIi on the CMS YouTube Channel. Become more informed about the Medicare program by reading, listening, or viewing these information-packed programs at your convenience. Visit http://www.cms.govnpc for more information on the MLN Connects® National Provider Call Program.

• MLN Matters® Articles Index: Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/ on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search for a keyword(s) and you will find articles that contain those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.
Preparing the CMS-1450 Claim Form

CGS uses an optical character recognition (OCR) system to enter claim information from the CMS-1450 claim form into our processing system. Using OCR automates the process and reduces the chance of human keying errors. To ensure the OCR is able to capture all claims data correctly, it is important that the following be considered:

- An original UB-04 CMS-1450 claim form is required
- Computerized or typed claims are preferred over handwritten claims
  - Laser printers are recommended
  - Remove the pin-feed perforated edges before mailing claims
- Print claims using BLACK ink (ink should be dark and legible)
- Courier or Arial in 10, 11 or 12 point font is preferred
- Use capital letters when possible
- Data should be inside the boxes of the claim form
- Avoid using liquid correction fluid or tape on claims
- Do not use highlighter pens
- Do not include stickers and/or notations in the margin of the claim form
- Do not attach mailing labels to the claim
- Narrative descriptions with procedure and/or diagnosis codes may cause scanning errors

When sending documentation:

- Do not staple or tape attachments to the claim
  - Paper clips and rubber bands are acceptable
- Documentation for multiple patients should be clearly separated
- The use of a highlighter is not recommended
- Verify that all attachments include information pertinent to the patient
  - The patient’s name, and Health Insurance Claim (HIC) number should be identified on all pages of attachments
- Attachments should be 8 ½ x 11 in size

For Home Health and Hospice Providers

Provider Contact Center (PCC) Availability

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for
Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). The list below indicates when the home health and hospice PCC at 1.877.299.4500 (option 1) will be closed for training.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, October 12, 2015</td>
<td>(Columbus Day) 8:00 a.m. – 4:30 p.m. Eastern Time</td>
</tr>
</tbody>
</table>

The Interactive Voice Response (IVR) (1.877.220.6289) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at http://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf on the CGS website. In addition, CGS’ Internet portal, myCGS, is available to access eligibility information through the Internet. For additional information, go to http://www.cgsmedicare.com/hhh/index.html and click the “myCGS” button on the left side of the webpage.


**For Home Health and Hospice Providers**

**Quarterly Provider Update**

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

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

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

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

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

SE1520: National Site Visit Verification (NSV) Initiative

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

MLN Matters® Number: SE1520 Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Provider Types Affected
This MLN Matters® Special Edition Article is intended for all providers and suppliers, that enroll in the Medicare program and submit fee-for-service (FFS) claims to Medicare Administrative Contractors (MACs), including home health and hospice MACs, for services provided to Medicare beneficiaries.

What You Need to Know
This article provides the latest information about the Centers for Medicare & Medicaid Services (CMS) National Site Visit Verification (NSV) initiative. The NSV initiative is part of CMS’ National Fraud Prevention Program (NFPP) and assists CMS in its efforts to prevent fraud and abuse in the Medicare program starting with the enrollment process.

Key Information
National Fraud Prevention Program (NFPP)
The NFPP is an integral part of the CMS Fraud Prevention Initiative. The NFPP enables CMS to proactively identify and respond to suspicious behavior, thus making the Agency more effective at fighting health care fraud than ever before. The NFPP focuses on two key program integrity gateways: provider enrollment and claims payment. By integrating these steps into one program, CMS can better ensure that it enrolls only qualified providers and pays only valid claims. CMS’ comprehensive program integrity strategy is designed to stop fraudsters at every step of the process by:

• Identifying and preventing bad actors from enrolling in Medicare;
• Identifying and removing bad actors that are already in the program; and
• Identifying and preventing payment of fraudulent claims by responding with quick administrative action (e.g. enrollment revocations or payment suspensions).

National Site Visit Contractor: Ensuring Program Integrity at the Provider Enrollment Stage
In 2011, CMS implemented a site visit verification program using a National Site Visit Contractor (NSVC). The site visit verification program is a screening mechanism to prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. The NSVC will conduct unannounced site visits for Medicare Part A/B providers and suppliers. Site visits for Durable Medical Equipment (DMEPOS) suppliers and providers will continue to be conducted by the National Supplier Clearinghouse. The NSVC may conduct either an observational site visit or a detailed review to verify enrollment related information and collect specific information based on pre-defined checklists and procedures determined by CMS.
During an observational visit, the inspector engages in minimal contact with the provider or supplier and does not inhibit the daily activities that occur at the facility. The inspector may take photographs of the facility as part of the site visit. During a detailed review, the inspector will enter the facility, speak with staff, take photographs, and collect information to confirm the provider or supplier’s compliance with CMS standards.

MSM Security Services, LLC was awarded the national site visit contract December 20, 2011. MSM and its subcontractors, Computer Evidence Specialists, LLC (CES) and Health Integrity, LLC (HI) are authorized by CMS to conduct the provider and supplier site visits.

Inspectors performing the site visits will be employees of MSM, CES, or HI and shall possess a photo ID and a letter of authorization issued and signed by CMS that the provider or supplier may review.

If the provider and/or its staff want to verify that a site visit has been ordered by CMS, please contact the respective jurisdiction's Medicare Administrative Contactor (MAC). MAC contact information can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf located on the CMS website.

If the provider and/or its staff wish to verify that an inspector is credentialed to complete a site visit verification, please call MSM Security Services, Monday through Friday from 7:00 a.m. to 8:00 p.m. ET at 1.855.220.1071. After 8 p.m., you may leave a message and the call will be returned the next business day.

Additional Information
To learn more about the CMS Fraud Prevention Initiative, visit the “Fraud Prevention Toolkit” Web page at http://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp on the CMS website.

For Home Health and Hospice Providers

SE1521: Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims

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

MLN Matters® Number: SE1521 Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

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

What You Need to Know
This Special Edition article is being published by the Centers for Medicare & Medicaid Services (CMS) to inform providers of the clarification CMS has given to the MACs
and Qualified Independent Contractors (QICs) regarding the scope of review for redeterminations (Technical Direction Letter-150407). This updated instruction applies to redetermination requests received by a MAC or QIC on or after August 1, 2015, and will not be applied retroactively.

**Background**

CMS recently provided direction to MACs and QICs regarding the applicable scope of review for redeterminations and reconsiderations for certain claims. Generally, MACs and QICs have discretion while conducting appeals to develop new issues and review all aspects of coverage and payment related to a claim or line item. As a result, in some cases where the original denial reason is cured, this expanded review of additional evidence or issues results in an unfavorable appeal decision for a different reason.

For redeterminations and reconsiderations of claims denied following a post-payment review or audit, CMS has instructed MACs and QICs to limit their review to the reason(s) the claim or line item at issue was initially denied. Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a Zone Program Integrity Contractor (ZPIC), Recovery Auditor, MAC, or Comprehensive Error Rate Testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment. If an appeal involves a claim or line item denied on a pre-payment basis, MACs and QICs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

Please note that contractors will continue to follow existing procedures regarding claim adjustments resulting from favorable appeal decisions. These adjustments will process through CMS systems and may suspend due to system edits. Claim adjustments that do not process to payment because of additional system imposed payment limitations, conditions or restrictions (for example, frequency limits or Correct Coding Initiative edits) will result in new denials with full appeal rights. In addition, if a MAC or QIC conducts an appeal of a claim or line item that was denied on post-payment review because a provider, supplier, or beneficiary failed to submit requested documentation, the contractor will review all applicable coverage and payment requirements for the item or service at issue, including whether the item or service was medically reasonable and necessary. As a result, claims initially denied for insufficient documentation may be denied on appeal if additional documentation is submitted and it does not support medical necessity.

This clarification and instruction applies to redetermination and reconsideration requests received by a MAC or QIC on or after August 1, 2015. It will not be applied retroactively. Appellants will not be entitled to request a reopening of a previously issued redetermination or reconsideration for the purpose of applying this clarification on the scope of review. CMS encourages providers and suppliers to include any audit or review results letters with their appeal request. This will help alert contractors to appeals where this instruction applies.

**Additional Information**


You can also find out more about 1) conducting a redeterminations in 42 CFR 405.948, at [http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1948](http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1948); and 2) conducting a reconsideration in 42 CFR 405.968 at [http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1968](http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1968) on the Internet.
Stay Informed and Join the CGS ListServ Notification Service

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

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

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

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

For Home Health and Hospice Providers

Upcoming Educational Events

The CGS Provider Outreach and Education department offers educational events through webinars and teleconferences throughout the year. Registration for live events is required. For upcoming events, please refer to the Calendar of Events Home Health & Hospice Education Web page at http://www.cgsmedicare.com/hhh/education/Education.html. CGS suggests that you bookmark this page and visit it often for the latest educational opportunities.