Reaching Out to the Medicare Community
HOME HEALTH PROVIDERS

Prevent Denials Due to OASIS Assessment Not Matching

FOR HOSPICE PROVIDERS

Hospice Cap Changes
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HOME HEALTH & HOSPICE PROVIDERS

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- CGS website Updates
- MLN Connects News
- MM9893 (Revised): New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)
- MM10040: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update
- MM10041: Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)
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Upcoming Educational Events
Update to the Interest Paid on Clean Non-PIP Claims Not Paid Timely

New Medicare Cards Offer Greater Protection to More Than 57.7 Million Americans

Expanding Possibilities with myCGS
Are you missing out on a fast and secure system that provides Medicare information with a click of a mouse? Visit the myCGS website at http://www.cgsmedicare.com/hhh/mycgs/index.html to check out the many portal features and learn how to register if you are a new user. Save time and resources - take advantage of this Web-based resource today!
Prevent Denials Due to OASIS Assessment Not Matching

As implemented in Change Request 9585, final claims submitted with dates of service on or after April 1, 2017, will deny with reason code 37253 when the Outcome and Assessment Information Set (OASIS) assessment has not been submitted timely. The Home Health and Hospice Provider Contact Center (PCC) continue to receive calls regarding this requirement. In addition, reason code 37253 appeared in the July claim submission error data with 1,492 claims denied.

To avoid denials, prior to submission of the OASIS assessment and the final claim, ensure the following OASIS items are correct. These items are used to match the claim with the OASIS assessment.

- Home Health Agency (HHA) Certification Number (OASIS item M0010)
- Beneficiary Medicare Number (OASIS item M0063)
- Assessment Completion Date (OASIS item M0090)
- Reason for Assessment (OASIS Item M0100) equal to 01, 03, or 04

In addition, before submitting the final claim, it is important that you ensure the OASIS assessment has completed processing and was successfully accepted into the Quality Information and Evaluation System (QIES) National Database. Verify this by reviewing the OASIS Agency Final Validation Report or OASIS Submitter Final Validation Report for the submission which included the assessment. These reports will provide information that confirms the assessment’s receipt, the date of receipt, and any fatal or warning errors encountered.

For additional information, refer to the following resources:

For Hospice Providers

Hospice Cap Changes

The Centers for Medicare & Medicaid Services (CMS) published the fiscal year (FY) 2016 Hospice Wage Index and Payment Rate Update final rule on August 6, 2015. The final rule included a change to align the Inpatient and Aggregate Cap Accounting Year with the Federal Fiscal Year (9/30).

CMS is aligning the cap accounting year for both the inpatient cap and the hospice aggregate cap with the federal fiscal year for FYs 2017 and later. In addition to aligning the cap accounting year with the federal fiscal year, they will also align the timeframe for counting the number of beneficiaries with the federal fiscal year.

FY 2017 will be the transition year and the cap period will be 10/01/16 to 9/30/17. Then for FY’s 2018 and forward the cap period will be 10/01/yy to 9/30/yy. This will move the Self-Determined Hospice Caps due dates for, FY 2017 and forward, to between 12/31/yy to the end of February/1st week of March. (See Reminder for 2017 due date)

The table below summarizes FY 2016 to 2018 cap years, Beneficiary ID Periods and payments. Those hospices that use the streamlined method for counting beneficiaries please note that beginning with FY 2018 and forward the Beneficiary ID Period matches the cap year.

<table>
<thead>
<tr>
<th>Cap year</th>
<th>Beneficiaries</th>
<th>Payments</th>
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<tbody>
<tr>
<td>2017 (Transition Year)</td>
<td>9/28/16-9/30/17</td>
<td>11/1/16-9/30/17</td>
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<tr>
<td>2018 and later</td>
<td>10/1-9/30</td>
<td>10/1-9/30</td>
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Please contact Tom Bisbee at 1.615.660.5560 if you have any questions regarding above changes or Hospice Cap questions in general.

For Hospice Providers

Hospice Self-Determined Aggregate Cap Reminder

CMS published the fiscal year (FY) 2015 Hospice Wage Index and Payment Rate Update final rule on August 22, 2014. The final rule included a requirement for hospices to file a self–determined hospice aggregate cap. **Hospices are required to file the self-determined cap each year, between December 31 and February 28. The 2017 Self-Determined Cap’s are due no later than February 28, 2018.**

As a reminder, the Hospice Caps Web page at [http://www.cgsmedicare.com/hhh/financial/hospice_caps.html](http://www.cgsmedicare.com/hhh/financial/hospice_caps.html) was created on the CGS website to assist hospices with this process. This Web page includes a link to the “Provider Self-Determined Aggregate Cap Limitation” form, as well as instructions for completing the form.

Hospices are responsible for obtaining their own Provider Statistical and Reimbursement (PS&R) summary from the CMS website at [https://psr-ui.cms.cmsnet/psr-ui](https://psr-ui.cms.cmsnet/psr-ui). CGS will not provide this to hospices. An instruction for obtaining your PS&R reports is also available from the Hospice Caps Web page at [http://www.cgsmedicare.com/hhh/financial/hospice_caps.html](http://www.cgsmedicare.com/hhh/financial/hospice_caps.html). If a hospice is unable to obtain a copy of their PS&R reports, please contact Tom Bisbee at CGS, at 1.615.660.5560 for assistance.
Refer to the Hospice Caps Web page at http://www.cgsmedicare.com/hhh/financial/hospice_caps.html for more detailed information about this process and links to additional resources.

**For Hospice Providers**

**MM10094: Medicare Care Choices Model (MCCM) – Per Beneficiary per Month Payment (PBPM) - Implementation (Eligibility Updates and Clarification)**

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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html

**MLN Matters® Number:** MM10094  
**Change Request (CR) #:** CR 10094  
**Related CR Release Date:** May 18, 2017  
**Related CR Transmittal #:** R173DEMO  
**Effective Date:** January 1, 2016  
**Implementation Date:** October 2, 2017

**Provider Type Affected**

This MLN Matters Article is intended for providers working with Medicare Care Choices Model (MCCM) participating hospices and submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs for services provided to Medicare beneficiaries enrolled in MCCM.

**Provided Action Needed**

CR10094 updates the eligibility requirements and clarifies the current business rules for the MCCM. The MCCM is designed to evaluate whether eligible Medicare and dually eligible beneficiaries would elect to receive supportive care services typically provided by hospice if they could also continue to receive treatment for their terminal condition, and how this flexibility impacts quality of care and patient, family and caregiver satisfaction. Under the Model, participating hospices will provide designated services that are currently available under the Medicare hospice benefit for routine home care and respite levels of care, but cannot be separately billed under Medicare Parts A, B, and D. These services include nursing, social work, hospice aide, hospice homemaker, volunteer, chaplain, bereavement, nutritional support and respite care services. Please make certain your staff is aware of the changes under the MCCM.

**Background**

Services under the MCCM will be available to enrolled beneficiaries around the clock, 365 days per year. The Centers for Medicare & Medicaid Services (CMS) pays a per beneficiary per month (PBPM) fee of $400 to participating hospices for beneficiaries enrolled in the Model for 15 or greater days in a calendar month, and $200 for beneficiaries enrolled in the Model for less than 15 days in a calendar month (except in the month of discharge, where the payment is $400 regardless of the number of days enrolled). Providers and suppliers continue to bill Medicare when furnishing reasonable and necessary services provided to beneficiaries who elect to participate in the Model, including treatment of the beneficiary’s terminal condition, which may include physical or occupational therapy, speech language pathology services, drugs for the management of pain or other symptoms from the terminal illness or related conditions, medical equipment and supplies any other service that is specified in the patient’s plan of care for which payment may otherwise be made under Medicare (for example, ambulance transports), short-term inpatient care for pain or symptom management that cannot be managed in the home environment, and physician services.
CMS originally planned to select at least 30 Medicare-certified hospices to participate in the Model and enroll up to 30,000 beneficiaries throughout a 3-year period. Due to robust interest, CMS invited over 140 Medicare-certified hospices to participate in the Model and expanded the duration of the Model to 5 years.

Delivery of Model services will be phased-in over 2 years, with participating hospices randomly assigned to either Cohort 1 or Cohort 2. Cohort 1, made up of approximately half of the participating hospices, began providing services under the Model on January 1, 2016. Cohort 2, which consists of the remaining participating hospices, will begin to provide services under the Model starting January 1, 2018. This model is expected to conclude on December 31, 2020. Application for this Model is closed and all selected hospices have been notified and assigned to a cohort.

Due to the multiple changes in the eligibility criteria contained in CR 9136, this CR 10094 contains instructions to the MACs related to those changes to the eligibility criteria for enrollment to MCCM. CR10094 assists the participating hospices in submission of the Notice of Election (NOE) and claims for PBPM fees through clarification of certain existing and modified business rules. CMS is making changes to the eligibility criteria for beneficiaries to participate in the MCCM to increase enrollment, add the auxiliary file information to the eligibility screen and remove the Expert Claims Processing System (ECPS) Events associated with this change request. All other business rules will remain in effect for CR9136, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R141DEMO.pdf.

Key Points

MCCM will consist of up to 141 participating hospices with up to 71 participating since the first year of the Model (2016) and up to 70 additional hospices entering the Model in Year 3 (2018). The number may decrease as hospices choose to withdraw or are otherwise terminated from the Model.

The target number of beneficiaries over the life of the Model is 150,000. A beneficiary would be considered eligible if he/she meets all of the following criteria:

- Medicare Part A and B has been primary for at least the last 12 continuous months prior to enrollment in the MCCM
- Has a diagnosis as indicated by certain ICD-10 codes for cancer, chronic obstructive pulmonary disease (COPD), human immunodeficiency virus (HIV), or chronic heart failure (CHF)
- Has had at least one hospitalization encounter (emergency room, observation stay, or inpatient stay) in the last 12 months prior to enrollment
- Has had at least three office visits with any Medicare-certified provider within the last 12 months prior to enrollment
- Meets hospice eligibility and admission criteria as stated in 42 CFR section 418.20, Eligibility requirements, and section 418.25[1], Admission to hospice care
- Has not elected the Medicare hospice benefit or Medicaid hospice benefit within the last 30 days prior to their participation in the MCCM

MCCM-specific NOEs will not turn off Part A, B, and D coverage so other providers may bill for related services to treat the terminal condition. Model services covered by the PBPM fee include:

- Counseling services to the beneficiary and family (bereavement, spiritual, dietary)
- Family support
- Psycho-social assessment
Those services that can be billed as a separate claim under Parts A, B, or D include:

- Physical or occupational therapy
- Speech language pathology services
- Drugs for the management of pain or other symptoms from the terminal illness or related conditions
- Medical equipment and supplies
- Physician services
- Short-term inpatient care for pain or symptom management which cannot be managed in the home environment including other services that are specified in the patient’s plan of care for which payment may otherwise be made under Medicare (for example, ambulance transports).

Other providers may continue to bill chronic care management (CCM) and care transitions codes.

If, during the course of participation in the Model, a beneficiary chooses to seek hospice care under the Medicare hospice benefit, the beneficiary would sign a hospice NOE, 42 CFR 418.24 and would not be eligible to continue participating in the Model. A beneficiary who leaves the Model for any reason would not be eligible to return to the Model at a later date.

Medicare will pay claims according to dates of service. Participating hospices will receive payment if they were on the list of approved participating hospices at the time services were rendered. Thus, if a quarterly update of participating providers is received and the provider is no longer on the list then he/she would receive the PBPM payment for dates of service prior to the quarterly 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.

Document History

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<td>May 18, 2017</td>
<td>Initial Article Released</td>
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SE17014: Required Workaround for Hospices Submitting Routine Home Care (RHC) and Service Intensity Add-On (SIA) Payments at the End of Life

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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html

MLN Matters® Number: SE17014  Change Request (CR) #: N/A
Related CR Release Date: May 24, 2017  Effective Date: August 21, 2017
Related CR Transmittal #: N/A  Implementation Date: August 21, 2017

Provider Type Affected
This MLN Matters Article is intended for Hospices that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Special Edition (SE) article 17014 corrects two errors with regard to hospice payments by Medicare that could result in overpayments. It also provides hospices with a workaround to deploy when submitting certain claims to ensure proper payment. Make sure your billing staffs are aware of the changes associated with these corrections in order to avoid possible overpayments.

Background
As of January 1, 2016, hospice payments were revised to apply a two-tiered payment rate for Routine Home Care (RHC) services and to make Service Intensity Add-on (SIA) payments at the end of life. Since then, Medicare discovered and corrected various payment errors associated with these policies.

In February 2017, two additional errors were discovered:

1.  If the prior days used are greater than 99, Medicare systems are calculating an incorrect payment. Medicare will correct its systems to eliminate this error on August 21, 2017.

2.  RHC visits are overpaid when there is a transfer within the benefit period because the days prior to the transfer are not being recognized. Medicare will correct its systems in a future release, but a workaround allows claims to be adjusted in the interim.

While Medicare would usually mass-adjust claims to correct similar payment errors, it is not feasible in this case. The claims cannot be identified from information in your MAC’s claims history. Payment errors depend on information only available in the Medicare’s Common Working File (CWF). Systematic correction would require adjusting nearly all hospice claims processed in 2016, so the claims process through CWF again. On many claims, this would not result in payment changes. This could have a disruptive effect on accounting at all hospices nationwide. The hospices themselves have the best available information about which claims need to be adjusted.

Required Action: Hospices should now submit adjustments to claims with outstanding SIA and RHC payment errors, except for those where the prior benefit days are greater than 99. Hospices can identify adjustments to be made by reviewing the CWF hospice benefit file to see if the benefit days used on prior election periods total more than 99 with
no 60-day gap in between periods. Hospices may adjust claims with greater than 99 prior days after August 21, 2017.

**Note:** Please contact your MAC if you need guidance on how to access the CWF hospice benefit file.

**CGS Example:**

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Hospices should apply a workaround when submitting adjustments to claims where there is a transfer in the benefit period. The hospice should enter the “Start Date 1” in the current benefit period as the admission date on their claim, rather than their own admission date. This will allow all the days in the period to be counted in the RHC payment calculation.

To facilitate processing the adjustments, hospices should add special coding to their adjustment claims. Append condition code D9 and submit a message in the Remarks section. The message should read, “Adjust due to RHC errors SE17014.”

**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.

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**For Home Health & Hospice Providers**

**Action Required:** Home Health & Hospice Providers FISS DDE User ID Annual Recertification

Each year, Medicare providers are required to recertify their Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) user access. The recertification period is now open For Home Health & Hospice Providers. Please review the information under the “What You Need to Do” heading. **Failure to recertify will result in the termination of FISS DDE/PPTN services.**

**What You Need to Do**

- **Complete** the Annual DDE PPTN Recertification Form, available at [https://www.cgsmedicare.com/forms/annual_dde_pptn_recert_formRE.pdf](https://www.cgsmedicare.com/forms/annual_dde_pptn_recert_formRE.pdf) **as soon as possible.**
  - Verify all User IDs, indicate if the User ID is active or inactive, and include an authorized signature, contact email, and phone number.
  
  **Note:** This form is not used to add new users, delete users, or to update current users. To add, delete, or update User ID information, you must complete an Online Inquiry Services form at [https://www.cgsmedicare.com/pdf/J15_EDI_OnlineInquiry2015re.pdf](https://www.cgsmedicare.com/pdf/J15_EDI_OnlineInquiry2015re.pdf).
FAX the Annual DDE PPTN Recertification Form as soon as possible to CGS at:
1.615.664.5947

If you have any questions concerning the recertification process, please contact the CGS J15 EDI department at 1.877.299.4500 and select Option 2.

For Home Health & 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 Comprehensive Error Rate Testing (CERT) Program Web page at https://www.cgsmedicare.com/hhh/education/materials/cert.html was updated to change the time period in which documentation requested must be sent to the CERT Documentation Contractor (CDC) from 75 days to 45 days.
- The Appeals Web page at https://www.cgsmedicare.com/hhh/appeals/index.html has been revised and is now titled Appeals/Redeterminations. In addition, icons were added to guide you to different CGS and CMS resources.
  - Levels of Appeals at https://www.cgsmedicare.com/hhh/appeals/level_of_appeals.html provides information about the time limit for filing requests for each level of appeal.
  - Timeliness Calculator at https://www.cgsmedicare.com/medicare_dynamic/J15/HHH_time_limit_calculator.asp will assist you in determining the date your appeal request must be received to meet timeliness.
  - Job Aids at https://www.cgsmedicare.com/hhh/appeals/job_aids.html provides helpful information related to Appeals.
  - Forms at https://www.cgsmedicare.com/hhh/forms/index.html#appeals takes you directly to a link to the CGS Jurisdiction 15 Redetermination Request Form.
  - When to File Appeal at https://www.cgsmedicare.com/hhh/appeals/when_to_file.html provides guidance on the type of claim denials that can be appeals.
  - When Not to File Appeal at https://www.cgsmedicare.com/hhh/appeals/when_not_to_file.html provides guidance on the type of claim denials that are not appealable.
  - Reopenings at https://www.cgsmedicare.com/hhh/appeals/Reopenings.html provides information about the types of reopenings that CGS performs.
  - A notice about the Centers for Medicare & Medicaid Services (CMS) Social Security Number Removal Initiative (SSNRI) was added as a scrolling image on the Home Page. In addition, a link to the CMS SSNRI Web page was added to the list of Hot Topics at https://www.cgsmedicare.com/hhh/index.html.
  - Home Health and Hospice Frequently Asked Questions (FAQs) Web page at https://www.cgsmedicare.com/hhh/education/faqs/index.html have been reviewed and updated accordingly.
  - The Provider Enrollment Web page at https://www.cgsmedicare.com/hhh/enrollment/index.html was updated to provide more information about submitting an enrollment application, enrollment fees, revalidations, and contact information.
The Provider Enrollment Packet Web page has been removed as it included outdated information.

The Enrollment link in the left side navigation menu has been changed to Provider Enrollment.

The Hospice Cap Web page at https://www.cgsmedicare.com/hhh/financial/hospice_caps.html was updated to include the 2017 changes to the timeframe for counting hospice beneficiaries and payments.

The Home Health Coverage Guidelines Web page at https://www.cgsmedicare.com/hhh/coverage/home_health_coverage_guidelines.html was updated to revise the link to the Outcome and Assessment Information Set (OASIS) link on the CMS website.

For Home Health & Hospice Providers

MLN Connects News

The MLN Connects is the official news from the Medicare Learning Network and contains a weeks worth of Medicare-related messages. 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, refer to https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819.


For Home Health & Hospice Providers

MM9893 (Revised): New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)

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

MLN Matters® Number: MM9893 Revised
Related CR Release Date: June 8, 2017
Related CR Transmittal #: R1857OTN
Change Request (CR) #: CR 9893
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

Note: This article was revised on June 9, 2017, due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same.
Provider Types Affected
This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know
This article is based on CR 9893. To comply with the Government Accountability Office (GAO) final report entitled Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333 - http://www.gao.gov/products/GAO-12-333), the Centers for Medicare & Medicaid Services (CMS) will establish two (2) new set-aside processes: a Liability Insurance Medicare Set-Aside Arrangement (LMSA), and a No-Fault Insurance Medicare Set-Aside Arrangement (NFMSA). An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual’s future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare.

Please be sure your billing staffs are aware of these changes.

Background
CMS will establish two (2) new set-aside processes: a Liability Medicare Set-Aside Arrangement (LMSA), and a No-Fault Medicare Set-Aside Arrangement (NFMSA).

CR 9893 addresses (1) the policies, procedures, and system updates required to create and utilize an LMSA and an NFMSA MSP record, similar to a Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) MSP record, and (2) instructs the MACs and shared systems when to deny payment for items or services that should be paid from an LMSA or an NFMSA fund.

Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment “has been made or can reasonably be expected to be made under a workers’ compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.” Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment “has been made” for such items or services through use of LMSA or NFMSA funds. However, Liability and No-Fault MSP claims that do not have a Medicare Set-Aside Arrangement (MSA) will continue to be processed under current MSP claims processing instructions.

Key Points of CR9893
Medicare will not pay for those services related to the diagnosis code (or related within the family of diagnosis codes) associated with the open LMSA or NFMSA MSP record when the claim’s date of service is on or after the MSP effective date and on or before the MSP termination date. Your MAC will deny such claims using Claim Adjustment Reason Code (CARC) 201 and Group Code “PR” will be used when denying claims based on the open LMSA or NFMSA MSP auxiliary record.

In addition to CARC 201 and Group Code PR, when denying a claim based upon the existence of an open LMSA or NFMSA MSP record, your MAC will include the following Remittance Advice Remark Codes (RARCs) as appropriate to the situation:

- **N723**—Patient must use Liability Set Aside (LSA) funds to pay for the medical service or item.
- **N724**—Patient must use No-Fault Set-Aside (NFSA) funds to pay for the medical service or item.
Where appropriate, MACs may override and make payment for claim lines or claims on which:

- Auto/no-fault insurance set-asides diagnosis codes do not apply, or
- Liability insurance set-asides diagnosis codes do not apply, or are not related, or
- When the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in CR9009.

On institutional claims, if the MAC is attempting to allow payment on the claim, the MAC will include an “N” on the ‘001’ Total revenue charge line of the claim.

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.

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<td>The article was revised due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed.</td>
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<td>May 10, 2017</td>
<td>The article was revised due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed.</td>
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<tr>
<td>February 17, 2017</td>
<td>Initial article released</td>
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For Home Health & Hospice Providers

**MM10040: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update**

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

**MLN Matters® Number:** MM10040
**Change Request (CR) #:** CR 10040
**Related CR Release Date:** May 26, 2017
**Effective Date:** October 1, 2017
**Related CR Transmittal #:** R3780CP
**Implementation Date:** October 2, 2017

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 100040 updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists and also instruct ViPS Medicare System (VMS)
and Fiscal Intermediary Shared System (FISS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

**Background**

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

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

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

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR10040, the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR 9878).

**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.

**Document History**

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<tr>
<td>May 26, 2017</td>
<td>Initial article released</td>
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</table>
MM10041: Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)

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

MLN Matters® Number: MM10041
Related CR Release Date: May 26, 2017
Related CR Transmittal #: R3781CP
Change Request (CR) #: CR 10041
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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

Provider Action Needed
This article is based on Change Request (CR) 10041 which instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates reflect the Committee on Operating Rules for Information Exchange (CORE) Code Combination List for June 2017. Make sure that your billing staff is aware of these changes.

In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

Background
The Department of Health and Human Services (DHHS) adopted the Phase III CAQH CORE, EFT and ERA Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act (ACA) of 2010.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the ACA, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The ACA defines operating rules and specifies the role of operating rules in relation to the standards.
Change Request (CR) 10041 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about June 10, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2017. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.


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

Additional Information


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

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</table>

For Home Health & Hospice Providers

MM10043: Claim Status Category and Claim Status Codes Update

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

MLN Matters® Number: MM10043
Related CR Release Date: May 26, 2017
Related CR Transmittal #: R3782CP
Change Request (CR) #: CR 10043
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

Provider Type Affected

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

Change Request (CR) 10043 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. This Recurring Update Notification (RUN) can be found in Chapter 31, Section 20.7.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.


Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the June 2017 committee meeting will be posted on these sites on or about July 1, 2017. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 10043.

The Centers for Medicare & Medicaid Services (CMS) will issue RUNs regarding the need for future updates to these codes. When instructed, Medicare contractors must update their claims systems to ensure that the current version of these codes is used in their claim status responses. Contractor and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of this CR 10043.

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.

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For Home Health & Hospice Providers


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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html

MLN Matters® Number: MM10107
Related CR Release Date: May 18, 2017
Related CR Transmittal #: R3776CP
Change Request (CR) #: CR 10107
Effective Date: July 1, 2017
Implementation Date: July 3, 2017

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

What You Need to Know
The HCPCS code set is updated on a quarterly basis. Change Request (CR) 10107 informs MACs of updating specific drug/biological HCPCS codes. Beginning on July 1, 2017, the HCPCS file will include the following new codes:

- Q9984:
  - Short Description: Kyleena
  - Long Description: Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg
  - Type of Service (TOS) Code 9
- Q9985
  - Short Description: Inj, hydroxyprogesterone, NOS
  - Long Description: Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
  - TOS Code 1, P
- Q9986
  - Short Description: Inj, Makena
  - Long Description: Injection, hydroxyprogesterone caproate (Makena), 10 mg
  - TOS Code 1, P
- Q9988
  - Short Description: Platelets, pathogen reduced
  - Long Description: Platelets, pathogen reduced, each unit
  - TOS Code 9
- Q9989
  - Short Description: Ustekinumab IV Inj, 1 mg
  - Long Description: Ustekinumab, for Intravenous Injection, 1 mg
  - TOS Code 1, P

Also, beginning on July 1, 2017, HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) is no longer payable for Medicare.

Make sure your billing staffs are aware of these changes.

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.

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For Home Health & Hospice Providers

**MM10115: July 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.2**

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: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html)

**MLN Matters® Number:** MM10115  
**Change Request (CR) #:** CR 10115  
**Related CR Release Date:** May 18, 2017  
**Effective Date:** July 1, 2017  
**Related CR Transmittal #:** R3777CP  
**Implementation Date:** July 3, 2017

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 10115 informs providers that the I/OCE is being updated July 1, 2017. The I/OCE routes all institutional outpatient claims (which includes non-Outpatient Prospective Payment System (OPPS) hospital claims) through a single integrated OCE. Make sure that your billing staffs are aware of these changes.

**Background**

CR10115 provides the Integrated OCE instructions and specifications for the Integrated OCE that will be used 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 Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. The I/OCE specifications will be posted to the CMS website at [http://www.cms.gov/OutpatientCodeEdit/](http://www.cms.gov/OutpatientCodeEdit/).

The following table summarizes the modifications of the I/OCE for the July 2017 v18.2 release. Note that some I/OCE modifications 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 Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Modify the logic for Community Mental Health Center (CMHC) claims (bill type 76x) eligible for outlier payment limitations related to condition code MY; if present with or without condition code 66, new payment method flag 9 is assigned to OPPS payable lines (see special processing logic and Appendix E of Attachment to CR10115).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Assign a payment APC of ‘00000’ for drug HCPCS codes with SI = G or K (see special processing logic and note in Appendix E).</td>
</tr>
</tbody>
</table>
### Effective Date | Edits Affected | Modification
---|---|---
7/1/2017 | 95 | Reactivate edit 95 as a line item informational only edit returned when weekly Partial Hospitalization Program (PHP) services do not meet the 20-hour per week service requirement (see special processing logic, tables 4, 5 and 7; note in Appendix C-a flowchart). A new value of 3 returned in the line item denial or rejection flag field is returned indicating the rejection has no impact on payment for the line(s) returning edit 95. Edit description is modified to: Weekly partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care (LIR). Edit criteria is modified to: A PHP claim contains weekly PH services that total less than 20 hours per 7-day span.

1/1/2016 |  | Add modifiers XE, XP, XS, and XU to the critical care ancillary services logic to process under the current exceptions for modifier 59 (see special processing logic).
5/1/2017 | 68 | Implement National Coverage Determination (NCD) mid-quarter effective editing for procedure codes 0004U and 0005U.
10/7/2016 | 67 | Implement FDA mid-quarter effective editing for procedure code 90651.
1/1/2017 |  | Add new payment method flag 9 (see table 7 and Appendix E).
7/1/2017 |  | Add new line item denial or rejection flag value of 3 (see table 7).
1/1/2016 |  | Update the multiple imaging composite Ambulatory Payment Classification (APC) family lists to remove the following codes with Status Indicator (SI) = Q1: 76604, 76775, 76870; add note for code 75635 as an exception to the composite logic in Appendix K.
7/1/2017 |  | Update the following lists for the release (see quarterly data files):
• Coinsurance/Deductible N/A list
•Device-procedure list (edit 92)
•Terminated procedures for device credit
•Comprehensive APC ranking
•Male-only procedure list (edit 8)
7/1/2017 |  | Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
7/1/2017 | 20, 40 | Implement version 23.2 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers).

### 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.

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<td>May 18, 2017</td>
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</table>
MM10122: July 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html

MLN Matters® Number: MM10122  
Change Request (CR) #: CR 10122  
Related CR Release Date: May 30, 2017  
Effective Date: July 1, 2017  
Related CR Transmittal #: R3783CP  
Implementation Date: July 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers that submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH&H) MACs, for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed
This article is based on Change Request (CR) 10122 which describes changes to the OPPS to be implemented in the July 2017 update. Make sure your billing staffs are aware of these changes.

Background

Key changes to and billing instructions for various payment policies implemented in the July 2017 Outpatient Prospective Payment System (OPPS) updates are as follows:

Category III CPT Codes Effective July 1, 2017
The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2017 update, the CMS is implementing 10 Category III CPT codes that the AMA released in January 2017 for implementation on July 1, 2017. The Status Indicators (SI) and APC assignments for these codes are shown below in Table 1. Payment rates for these services are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>July 2017 OPPS SI</th>
<th>July 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0469T</td>
<td>Retinal polarization scan, ocular screening with on-site automated results, bilateral</td>
<td>E1</td>
<td>N/A</td>
</tr>
<tr>
<td>0470T</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>0471T</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**Table 1 — Category III CPT Codes Effective July 1, 2017**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>July 2017 OPPS SI</th>
<th>July 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0472T</td>
<td>Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional</td>
<td>Q1</td>
<td>5743</td>
</tr>
<tr>
<td>0473T</td>
<td>Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional</td>
<td>Q1</td>
<td>5742</td>
</tr>
<tr>
<td>0474T*</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space</td>
<td>J1</td>
<td>5492</td>
</tr>
<tr>
<td>0475T</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>0476T</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage</td>
<td>Q1</td>
<td>5734</td>
</tr>
<tr>
<td>0477T</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result</td>
<td>Q1</td>
<td>5734</td>
</tr>
<tr>
<td>0478T</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional</td>
<td>M</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* For the device offset amount associated with this CPT code, refer to the discussion on device offset.

**Proprietary Laboratory Analyses (PLA) CPT Codes Effective May 1, 2017**

The AMA CPT Editorial Panel established two additional PLA CPT codes, specifically, CPT codes 0004U and 0005U effective May 1, 2017. The long descriptors for the codes are listed below in Table 2. Because the codes were effective May 1, 2017, they were not included in the April 2017 OPPS Update and are instead being including in the July Update with an effective date of May 1, 2017.

Under the hospital OPPS, CPT code 0004U is assigned to status indicator “A” and CPT code 0005U to status indicator “Q4” (Conditionally packaged laboratory tests). For more information on OPPS SI “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2017 OPPS/ASC final rule for the latest definitions to the OPPS status indicators for CY 2017.

CPT codes 0004U and 0005U have been added to the July 2017 I/OCE with an effective date of May 1, 2017. These codes, along with their short descriptors and status indicators, are in the July 2017 Addendum B at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html).

**Table 2 — Proprietary Laboratory Analyses (PLA) CPT Codes Effective May 1, 2017**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0004U</td>
<td>Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESSBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate</td>
<td>A</td>
</tr>
<tr>
<td>0005U</td>
<td>Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score</td>
<td>Q4</td>
</tr>
</tbody>
</table>

**New Separately Payable Procedure Codes**

Effective July 1, 2017, three new HCPCS codes, C9745, C9746, and C9747 have been created as described in the Table 3.
Table 3 ─ New Separately Payable Procedure Codes Effective July 1, 2017

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9745</td>
<td>Nasal endo balloon dil</td>
<td>Nasal endoscopy, surgical; balloon dilation of eustachian tube</td>
<td>J1</td>
<td>5165</td>
<td>J8</td>
</tr>
<tr>
<td>C9746</td>
<td>Trans imp balloon cont</td>
<td>Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed</td>
<td>J1</td>
<td>5377</td>
<td>J8</td>
</tr>
<tr>
<td>C9747</td>
<td>Ablation, HIFU, prostate</td>
<td>Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU)</td>
<td>J1</td>
<td>5376</td>
<td>J8</td>
</tr>
</tbody>
</table>

New Procedures Requiring the Insertion of a Device

As described in the CY 2017 OPPS/ASC final rule with comment period, effective January 1, 2017, all new procedures requiring the insertion of an implantable medical device will generally be assigned a default device offset percentage of 41 percent and assigned device intensive status, until claims data become available. In certain rare instances, CMS may temporarily assign a higher offset percentage if warranted by additional information.

In accordance with this policy, the following new code(s) requiring the insertion of a device (listed Table 4) will be assigned device intensive status.

Table 4 ─ New Device Intensive Procedures Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Effective Date</th>
<th>July 2017 OPPS SI</th>
<th>July 2017 OPPS APC</th>
<th>CY 2017 OPPS Payment Rate</th>
<th>CY 2017 Device Offset</th>
</tr>
</thead>
<tbody>
<tr>
<td>0474T</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space</td>
<td>7-01-2017</td>
<td>J1</td>
<td>5492</td>
<td>$3,418.76</td>
<td>$1,401.69</td>
</tr>
<tr>
<td>C9745</td>
<td>Nasal endoscopy, surgical; balloon dilation of eustachian tube</td>
<td>7-01-2017</td>
<td>J1</td>
<td>5165</td>
<td>$4,130.94</td>
<td>$1,693.69</td>
</tr>
<tr>
<td>C9746</td>
<td>Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed</td>
<td>7-01-2017</td>
<td>J1</td>
<td>5377</td>
<td>$14,363.61</td>
<td>$5,889.08</td>
</tr>
</tbody>
</table>

New HCPCS Code for Pathogen Testing for Blood Platelets

For the July 2017 update, the HCPCS Workgroup inactivated HCPCS P9072 for Medicare reporting and replaced the code with two new HCPCS codes effective July 1, 2017. Specifically, to report either of the services described by HCPCS P9072 based on the code descriptor in effect for January 1, 2017 – June 30, 2017, providers must instead report either HCPCS code Q9988 (Platelets, pathogen reduced, each unit) or Q9987 (Pathogen(s) test for platelets) effective July 1, 2017. CMS notes that HCPCS code Q9987 should be reported to describe the test used for the detection of bacterial contamination in platelets as well as any other test that may be used to detect pathogen contamination. The coding changes associated with these codes are available at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html effective July 2017. The payment rates for HCPCS codes Q9987 and Q9988 are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. Also, see Table 5 below.

Table 5 ─ Blood Platelet Coding Changes Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>July 2017 OPPS SI</th>
<th>July 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9072</td>
<td>Plate path red/rapid bac tes</td>
<td>Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit</td>
<td>E1</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table 5 – Blood Platelet Coding Changes Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>July 2017 OPPS SI</th>
<th>July 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9987</td>
<td>Pathogen test for platelets</td>
<td>Pathogen(s) test for platelets</td>
<td>S</td>
<td>1493</td>
</tr>
<tr>
<td>Q9988</td>
<td>Platelets, pathogen reduced</td>
<td>Platelets, pathogen reduced, each unit</td>
<td>R</td>
<td>9536</td>
</tr>
</tbody>
</table>

Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2017

For CY 2017, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2017, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective July 1, 2017 are available at [http://www.cms.gov/HospitalOutpatientPPS/](http://www.cms.gov/HospitalOutpatientPPS/).

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

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html) on the first date of the quarter. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

c. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2017

Two drugs and biologicals have been granted OPPS pass-through status effective July 1, 2017. These items, along with their descriptors and APC assignments, are in Table 6 below.

Table 6 – Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9489</td>
<td>Injection, nusinersen, 0.1 mg</td>
<td>9489</td>
<td>G</td>
</tr>
<tr>
<td>C9490</td>
<td>Injection, bezlotoxumab, 10 mg</td>
<td>9490</td>
<td>G</td>
</tr>
</tbody>
</table>

d. New Drug HCPCS Codes Effective July 1, 2017

Effective July 1, 2017, three new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 7.

Table 7 – New Drug HCPCS Codes Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9984</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg</td>
<td>E1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9985</td>
<td>Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9986</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
<td>K</td>
<td>9074</td>
</tr>
</tbody>
</table>
e. Changes to Status Indicator for CPT Code 90682

The influenza vaccine associated with CPT code 90682 (Influenza virus vaccine, quadrivalent (riv4), derived from recombinant DNA, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use) is approved for use in the 2017-2018 flu season. (This is per CR9876; see related MLN Matters Article MM9876 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN MattersArticles/Downloads/MM9876.pdf.) CPT code 90682 was added to the January 2017 I/OCE with an effective date of January 1, 2017 and assigned status indicator “L” (Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance). Because this code is not payable until the start of the 2017 flu season, the status indicator will be retroactively corrected from SI=L to SI=E1 (Not paid by Medicare when submitted on outpatient claims [any outpatient bill type]) effective January 1, 2017, through June 30, 2017. Effective July 1, 2017, CPT code 90682 is assigned SI=L. Table 8, below, describes the status indicator change and effective date.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90682</td>
<td>(Influenza virus vaccine, quadrivalent (riv4), derived from recombinant DNA, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use)</td>
<td>E1</td>
<td>January 1, 2017 – June 30, 2017</td>
</tr>
<tr>
<td>90682</td>
<td>(Influenza virus vaccine, quadrivalent (riv4), derived from recombinant DNA, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use)</td>
<td>L</td>
<td>July 1, 2017</td>
</tr>
</tbody>
</table>

f. Revised Status Indicator for HCPCS Code J1725

For the July 2017 update, the HCPCS Workgroup inactivated HCPCS code J1725 for Medicare reporting and replaced it with HCPCS code Q9986. Therefore, effective July 1, 2017, the status indicator for HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E1 (Not paid by Medicare when submitted on outpatient claims [any outpatient bill type]). Table 9, below, describes the status indicator change and effective date for HCPCS code J1725. The payment rates for HCPCS codes Q9986 are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1725</td>
<td>Injection, hydroxyprogesterone caproate, 1 mg</td>
<td>K</td>
<td>01/01/2012</td>
<td>06/30/2017</td>
</tr>
<tr>
<td>J1725</td>
<td>Injection, hydroxyprogesterone caproate, 1 mg</td>
<td>E1</td>
<td>07/01/2017</td>
<td></td>
</tr>
</tbody>
</table>

g. Other Changes to CY 2017 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Effective July 1, 2017, HCPCS code Q9989 (Ustekinumab, for Intravenous Injection, 1 mg) will replace HCPCS code C9487 (Ustekinumab, for Intravenous Injection, 1 mg). The status indicator will remain G, “Pass-Through Drugs and Biologicals”. Table 10 describes the HCPCS code change and effective date.
Table 10 ─ Other Changes to CY 2017 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9487</td>
<td>G</td>
<td>9487</td>
<td>04/01/2017</td>
<td>06/30/2017</td>
</tr>
<tr>
<td>Q9989</td>
<td>G</td>
<td>9487</td>
<td>07/01/2017</td>
<td></td>
</tr>
</tbody>
</table>

Application of Co-insurance and Deductible for HCPCS Code G0404

For CY 2017 HCPCS code G0404 (Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the Initial Preventive Physical Examination (IPPE)) was inadvertently assigned a waiver of coinsurance and deductible. Beginning July 1, 2017, CMS will apply coinsurance and deductible to HCPCS code G0404. This change will be retroactive back to January 1, 2017.

Changes to OPPS Pricer Logic

a. Effective January 1, 2017, for outliers for Community Mental Health Centers (CMHCs) (bill type 76x), updated logic to cap CMHC claims’ outlier payments at 8% of payments based on the current claim’s OPPS Pricer calculations.

b. Effective January 1, 2017, added Payment Method Flag (PMF) ‘9’ to valid list to bypass the outlier cap logic.

c. Effective for CY’s 2016 and 2017, changed the location of the device credit selection logic to ensure that providers with a special payment indicator of ‘1’ or ‘2’ in the Outpatient Provider Specific File receive the device credit.

d. Effective July 1, 2017, added line item Denial/Rejection (D/R) Flag ‘3’ to valid list for FISS informational use.

Coverage Determinations

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

Additional Information


If you have 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.

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 30, 2017</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>
New Medicare Cards Offer Greater Protection to More Than 57.7 Million Americans

The following is a news release issued by the Centers for Medicare & Medicaid Services (CMS). Refer to the CMS Newsroom Web page at https://www.cms.gov/Newsroom/Newsroom-Center.html for this and other news.

New cards will no longer contain Social Security numbers, to combat fraud and illegal use

The Centers for Medicare & Medicaid Services (CMS) is readying a fraud prevention initiative that removes Social Security numbers from Medicare cards to help combat identity theft, and safeguard taxpayer dollars. The new cards will use a unique, randomly-assigned number called a Medicare Beneficiary Identifier (MBI), to replace the Social Security-based Health Insurance Claim Number (HICN) currently used on the Medicare card. CMS will begin mailing new cards in April 2018 and will meet the congressional deadline for replacing all Medicare cards by April 2019. Today, CMS kicks-off a multi-faceted outreach campaign to help providers get ready for the new MBI.

“We’re taking this step to protect our seniors from fraudulent use of Social Security numbers which can lead to identity theft and illegal use of Medicare benefits,” said CMS Administrator Seema Verma. “We want to be sure that Medicare beneficiaries and healthcare providers know about these changes well in advance and have the information they need to make a seamless transition.”

Providers and beneficiaries will both be able to use secure look up tools that will support quick access to MBIs when they need them. There will also be a 21-month transition period where providers will be able to use either the MBI or the HICN further easing the transition.

CMS testified on Tuesday, May 23rd before the U.S. House Committee on Ways & Means Subcommittee on Social Security and U.S. House Committee on Oversight & Government Reform Subcommittee on Information Technology, addressing CMS’s comprehensive plan for the removal of Social Security numbers and transition to MBIs.

Personal identity theft affects a large and growing number of seniors. People age 65 or older are increasingly the victims of this type of crime. Incidents among seniors increased to 2.6 million from 2.1 million between 2012 and 2014, according to the most current statistics from the Department of Justice. Identity theft can take not only an emotional toll on those who experience it, but also a financial one: two-thirds of all identity theft victims reported a direct financial loss. It can also disrupt lives, damage credit ratings and result in inaccuracies in medical records and costly false claims.

Work on this important initiative began many years ago, and was accelerated following passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). CMS will assign all Medicare beneficiaries a new, unique MBI number which will contain a combination of numbers and uppercase letters. Beneficiaries will be instructed to safely and securely destroy their current Medicare cards and keep the new MBI confidential. Issuance of the new MBI will not change the benefits a Medicare beneficiary receives.

CMS is committed to a successful transition to the MBI for people with Medicare and for the health care provider community. CMS has a website dedicated to the Social Security Removal Initiative (SSNRI) at https://www.cms.gov/medicare/ssnri/index.html where providers can find the latest information and sign-up for newsletters. CMS is also planning regular calls as a way to share updates and answer provider questions before and after new cards are mailed beginning in April 2018.

For more information, please visit: https://www.cms.gov/medicare/ssnri/index.html
For Home Health & Hospice Providers

Provider Contact Center (PCC) Training

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 Training/Closures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday, August 10</td>
<td>8:00 a.m. – 10:00 a.m. Central Time</td>
</tr>
<tr>
<td>Thursday, August 24</td>
<td>8:00 a.m. – 10:00 a.m. Central 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 https://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 https://www.cgsmedicare.com/hhh/index.html and click the “myCGS” button on the left side of the webpage.

For your reference, access the “Home Health & Hospice 2017 Holiday/Training Closure Schedule” at https://www.cgsmedicare.com/hhh/help/pdf/2017_hhh_calendar_FINAL.pdf for a complete list of PCC closures.

For Home Health & Hospice Providers

Requested Documentation Not Received/Received Timely

When a claim is selected for medical review, a medical review additional development request (MR ADR) is generated requesting medical record documentation be submitted to ensure appropriate payment. Documentation must be received by CGS within 45 calendar days. If the documentation is not received by day 46, the claim is denied with reason code 56900 (documentation not received or not received timely). Reason code 56900 continues to be one of the top medical review denial codes for Home Health & Hospice Providers.

To help reduce 56900 claim denials, please share the following information with your appropriate staff.

Checking for MR ADRs: CGS encourages providers to use the Fiscal Intermediary Standard System (FISS) to check for MR ADRs at least once per week. To check for MR ADRs, use Option 12 (Claim Inquiry), key your NPI number and the status/location ‘S B6001’ and press Enter. Claims selected for MR ADR will appear with reason code 39700.

FISS Pages 07 and 08: Access the FISS Pages 07 and 08 to determine what is being requested and the date it must be received by CGS. Pages 07 and 08 only apply to claims.
in the status/location ‘S B6001’. FISS Page 07 displays the due date, which is the 45th day.

Page 08 provides details of the information being requested. The requested documentation must be received by CGS on/before 45 calendar days. Attach a copy of FISS Page 07 as the top page of your documentation to ensure it is matched to the appropriate claim.

```
REPORT: 001  MEDICARE PART A 15004  FVDR NO: XXXXXXXXXXX
DATE: MM/DD/CCY  ADDITIONAL DEVELOPMENT REQUEST BILL TYPE: XXX
CASE ID: 15004XXXXXXXXXXXXXXXXXXXXX
A GOOD AGENCY
123 MAIN STREET

ANYTOWN  IA  50000  1111

WE HAVE RECEIVED THIS CLAIM RECORD AND FOUND THAT ADDITIONAL DEVELOPMENT WILL BE NECESSARY BEFORE PROCESSING CAN BE FINALIZED. TO ASSIST YOU IN PROVIDING THE REQUIRED INFORMATION, WE HAVE ASSIGNED REASON CODES TO THE AFFECTED CLAIM RECORD (SEE BELOW) FOR YOUR REVIEW. PLEASE REFER TO THE ACcompanyING LIST FOR EXPLANATION OF THE ASSIGNED CODES. SOLICITED LETTERS CAN BE ANY ADR LETTERS AT CONTRACTORS’ DISCRETION, AND NOT SOLELY FOR CGS J15 MAC
J15 - HHN CORRESPONDENCE
P O BOX 20014
NASHVILLE  TN  37207

PATIENT CTRL NBR:   DUE DATE: MM/DD/CCY
MEDICAL REC NO:    DOB: XXXXXXXXXXXXXXXXXXX
MEDICARE ID: XXXXXXXXXXXX  PATIENT NAME: IMA PATIENT
FROM DATE: MM/DD/CCY  THRU DATE: MM/DD/CCY
CPR/MED ANALYST:  TOTAL CHARGES:  5000.00
MISRS PP3-EXIT PP3-SCROLL BKWD PP3-SCROLL FW RD PP3-RENT PP3-UPDT

Submitting Your Documentation: Documentation may be submitted to CGS either by myCGS (CGS Web Portal), US Mail, Electronic Submission of Medical Documentation (esMD), Fax, or on CD/DVD.

- **myCGS** is a free Web portal that allows you to submit your MR ADR documentation directly to CGS. This submission method will help ensure the documentation is received by CGS timely. Once the documentation is submitted you will receive a secure message confirming receipt. A second message will confirm that it was accepted. For additional information, refer to the myCGS User Manual, Chapter 7: ‘Forms’ Tab at [https://www.cgsmedicare.com/pdf/mycgs/chapter7_hhh.pdf](https://www.cgsmedicare.com/pdf/mycgs/chapter7_hhh.pdf) on the CGS website.

- **US Mail** – Mail paper documentation or a CD/DVD to the address that displays on FISS Page 07.

- **esMD** is an option for submitting medical record documentation to CGS. You must obtain access to a CONNECT-compatible gateway. For additional information, refer to the Electronic Submission of Medical Documentation Web Page at [https://www.cgsmedicare.com/hhh/medreview/esmd.html](https://www.cgsmedicare.com/hhh/medreview/esmd.html) on the CGS website.

- **Fax** to 1.615.660.5981

**Resources**

To learn more about MR ADRs, refer to the Medical Review Additional Development Request (ADR) Process Web page at [https://cgsmedicare.com/hhh/medreview/adr_process.html](https://cgsmedicare.com/hhh/medreview/adr_process.html) on the CGS website. Additional resources include:

- Medicare Program Integrity Manual, Pub. 100-08, Ch. 3 Section 3.2.3.2 - [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf)


SE1605 (Revised): Provider Enrollment Revalidation – Cycle 2

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

MLN Matters® Number: SE1605 Revised
Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was revised on June 15, 2017, to change the effective date of deactivations due to non-billings from 5 days from the date of the deactivation letter to 10 days. (See page 6.) All other information is unchanged.

Provider Types Affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), Medicare Carriers, Fiscal Intermediaries, and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed

STOP – Impact to You
Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements that are captured within this article.

CAUTION – What You Need to Know

Special Note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

GO – What You Need to Do

1. Check http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation;

2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:

   - Submit a revalidation application through Internet-based PECOS located at https://pecos.cms.hhs.gov/pecos/login.do, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
- Complete the appropriate CMS-855 application available at [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html);

- If applicable, pay your fee by going to [https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do); and

- Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

**Background**

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

**What’s ahead for your next Medicare enrollment revalidation?**

**Established Due Dates for Revalidation**

CMS has established due dates by which the provider/supplier’s revalidation application must reach the MAC in order for them to remain in compliance with Medicare’s provider enrollment requirements. The due dates will generally be on the last day of a month (for example, June 30, July 31 or August 31). Submit your revalidation application to your MAC within 6 months of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

- The list will be available at [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) and will include all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a “TBD” (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) on the CMS website.

**IMPORTANT:** The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.

- Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).

- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier’s due date.

Revalidation notices sent via email will indicate “URGENT: Medicare Provider Enrollment Revalidation Request” in the subject line to differentiate from other emails. If all of the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

**NOTE:** Providers/suppliers who are within 2 months of their listed due dates on [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.
To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

Large Group Coordination

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming 6 month period. A spreadsheet detailing the applicable provider’s Name, National Provider Identifier (NPI) and Specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on http://go.cms.gov/MedicareRevalidation to determine their provider/supplier’s revalidation due dates.

Unsolicited Revalidation Submissions

All unsolicited revalidation applications submitted more than 6 months in advance of the provider/supplier’s due date will be returned.

- What is an unsolicited revalidation?
  - If you are not due for revalidation in the current 6 month period, your due date will be listed as “TBD” (To Be Determined). This means that you do not yet have a due date for revalidation. **Please do not submit a revalidation application if there is NOT a listed due date.**
  - Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
  - If your intention is to submit a change to your provider enrollment record, you must submit a ‘change of information’ application using the appropriate CMS-855 form.

Submitting Your Revalidation Application

**IMPORTANT: Each provider/supplier is required to revalidate their entire Medicare enrollment record.**

A provider/supplier’s enrollment record includes information such as the provider’s individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided). This means the provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and Provider Transaction Access Numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

**The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.**

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do. PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, **YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper...**
PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html on the CMS website.

**Getting Access to PECOS:**

To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as “I&A”. The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.

To learn more about establishing an I&A account or to verify your ability to submit applications using PECOS, please refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.

If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the revalidation notice. You may also find a list of MAC’s at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf.

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1.866.484.8049 or at EUSSupport@cgi.com.

**Deactivations Due to Non-Response to Revalidation or Development Requests**

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. *Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.*

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

**NOTE:** The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will not be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider’s liability.

**Revalidation Timeline and Example**

Providers/suppliers may use the following table/chart as a guide for the sequence of events through the revalidation progression.

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revalidation list posted</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2017</td>
</tr>
</tbody>
</table>
### Deactivations Due to Non-Billing

Providers/suppliers that have not billed Medicare for the previous 12 consecutive months will have their Medicare billing privileges deactivated in accordance with 42 CFR §424.540. The effective date of deactivation will be 10 days from the date of the corresponding deactivation letter issued by the MACs notifying the providers/suppliers of the deactivation action.

 Providers/suppliers who Medicare billing privileges are deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

### Application Fees

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $560.00 for Calendar Year (CY) 2017. CMS has defined “institutional provider” to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2017 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to [https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do) and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with your uploaded documents on PECOS or mail it to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

### SUMMARY:

- CMS will post the revalidation due dates for the upcoming revalidation cycle on [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier’s billing privileges.

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<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue large group notifications</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2017</td>
</tr>
<tr>
<td>MAC sends email/letter notification</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2017</td>
</tr>
<tr>
<td>MAC sends letter for undeliverable emails</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2017</td>
</tr>
<tr>
<td>Revalidation due date</td>
<td>September 30, 2017</td>
<td></td>
</tr>
<tr>
<td>Apply payment hold/issue reminder letter</td>
<td>Within 25 days after due date</td>
<td>October 25, 2017</td>
</tr>
<tr>
<td>(group members)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deactivate</td>
<td>60 – 75 days after due date</td>
<td>November 29 – December 14, 2017</td>
</tr>
</tbody>
</table>
If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.

If the provider/supplier has not billed Medicare for the previous 12 consecutive months, the MAC will deactivate their Medicare billing privileges.

If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.

If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional Information
To find out whether a provider/supplier has been mailed a revalidation notice go to http://go.cms.gov/MedicareRevalidation on the CMS website.


For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf on the CMS website.

For more information about the application fee payment process, refer to MLN Matters Article SE1130, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf on the CMS website.

The MLN fact sheet titled “The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations” is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment webpage at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html.

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.

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 15, 2017</td>
<td>The article was revised, to change the effective date of deactivations due to non-billings from 5 days from the date of the deactivation letter to 10 days.</td>
</tr>
<tr>
<td>March 15, 2017</td>
<td>The updated article revised the table on page 6 and added additional information after that table.</td>
</tr>
<tr>
<td>February 22, 2016</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>
For Home Health & 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 https://www.cgsmedicare.com/hhh/education/Education.html. CGS suggests that you bookmark this page and visit it often for the latest educational opportunities.

For Home Health & Hospice Providers

Update to the Interest Paid on Clean Non-PIP Claims Not Paid Timely

According to the Medicare Claims Processing Manual, (Pub 100-04, Ch. 1., §80.2.2), interest is paid on clean claims, not paid under the periodic interim payment (PIP) method, if payment is not made within 30 days after the date of receipt. The interest rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. Effective, July 1, 2017, the interest amount is 2.375%.

Note: Interest is not paid on home health prospective payment system (HH PPS) request for anticipated payment (RAP) billing transactions.

For additional information about when interest is paid on a claim, and how to calculate the interest, refer to the Medicare Claims Processing Manual, (Pub 100-04, Ch. 1., §80.2.2) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf on the Centers for Medicare & Medicaid Services (CMS) website. Current and past interest rate amounts can be viewed at http://fms.treas.gov/prompt/rates.html on the Treasury Department website.