Articles contained in this edition are current as of December 28, 2015.

Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology CPT codes. Descriptions and other data only are copyrighted 2015 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

Kentucky & Ohio

Annual Certification for CR3274

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

Kentucky & Ohio

CGS Administrators, LLC Announces MolDX Expansion to Jurisdiction 15

CGS is happy to announce that we are working with the MolDx contractor, Palmetto GBA concerning Molecular Diagnostic Testing (MDT). All laboratory service providers in the Jurisdiction 15 providing Molecular Diagnostic Testing (MDT) must register those MDT procedures/services with the MolDx contractor and submit coverage requests prior to being considered for reimbursement. Providers will have until December 28, 2015, to complete this process for current and any new tests billed before the claim is returned unable to process if the unique identifier is not present on the claim. At this time, Part A providers are not required but are encouraged to obtain an identifier and use the TA process, if needed, as this will expedite claims processing. Part A providers when billing MolDx tests, since the notepad is for the entire claim, please enter L, line number, and the short description /identifier,(L2-APC,fgs). This will allow us to distinguish which test is for which line.

As a CMS contractor, the MolDx contractor must determine reasonable and necessary services and apply fair reimbursement to services that are provided to Medicare beneficiaries.
In the AMA’s instructions for use of the CPT codebook, providers are instructed to select the name of the procedure/service that accurately identifies the service provided. Providers are not to select a CPT code that merely approximates the service provided. When no such specific code exists, providers are required to report the service using the appropriate unlisted procedure/service code.

For a wide range of laboratory and molecular diagnostic services, correct coding is complicated because the available code descriptions do not identify the specific test/service performed.

The vast numbers of new diagnostic and molecular assays entering the market magnify these issues. To address these vulnerabilities, the MolDx contractor has expanded to a laboratory and molecular diagnostic services program to meet the following objectives:

- Identify the specific services performed and billed to Medicare
- Collect and analyze claim submission data
- Develop correct coding/billing guidelines to report services
- Determine coverage for services
- Determine a fair reimbursement for services within current CMS guidelines

This program will affect diagnostic services reported with the following AMA® CPT codes:

<table>
<thead>
<tr>
<th>Code Category/Description</th>
<th>2013 MolDx Code Range</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>81161-81383; 81500-81599</td>
<td>New codes 1/1/13</td>
</tr>
<tr>
<td>Tier 2</td>
<td>81400-81479</td>
<td>New codes 1/1/13</td>
</tr>
<tr>
<td>HCPCS: Molecular pathology procedure; physician interpretation and report</td>
<td>G0452</td>
<td>New codes 1/1/13</td>
</tr>
<tr>
<td>Microdissection</td>
<td>88380-88381</td>
<td>No change from 2012-2013</td>
</tr>
<tr>
<td>NOC</td>
<td>81479</td>
<td>New codes 1/1/13</td>
</tr>
<tr>
<td>**NOC</td>
<td>84999, 85999, 86849, 87999, 88199, 88299, 88399, 89398</td>
<td>No change from 2012-2013</td>
</tr>
</tbody>
</table>

MoIDx defines a clear, evidence-based process to ensure clinical quality and manage molecular diagnostic services and the associated impact that they have on cost.

Four major challenges are addressed in this project:

- No standardized process to evaluate the safety and efficacy of each test/assay
- No standardized process to correlate clinical information with patient outcomes
- No standardized process to describe and assign a value for the assay service
- No unique identifier to track assay utilization

The project will require a registration process to address these challenges in the following manner:

- **Create/maintain a master catalog/test registry**
  Identification and cataloging of all known molecular diagnostic tests, assessment status, and the final CMS coverage determination and code assignments will be maintained in an electronic, readily accessible, Internet-based registry with secure information access levels for CMS, administrators, and the provider community. Click [http://www.palmettogba.com/](http://www.palmettogba.com/)
• **Provide objective, evidence-based assessments for each test**

In addition to evaluating analytical and clinical validity data, this project will provide a comprehensive assessment of clinical utility. Subject-matter experts will evaluate tests and develop coverage recommendations to CMS. For more information, please refer to the Test Assessment Process (http://www.palmettogba.com/palmetto/MolDX.nsf/docsCat/MolDx%20Website~MolDx~Browse%20By%20Topic~Technical%20Assessment?open&expand=1&navmenu=Browse%5eBy%5eTopic) section at the MolDx contractor website.

• **Provide test specific description recommendation**

Subject-matter experts will review new test literature and design unique descriptions or designate current appropriate descriptions to facilitate the CMS development of unique codes for appropriate utilization tracking and potential payment.

• **Provide reimbursement recommendation**

The MolDx contractor will review the overall test elements and make a value based determination for each test.

MolDx will be supported by the LCD Laboratory and Molecular Diagnostics Testing LCD Program, establishes a clear, evidence-based process to ensure clinical quality and to manage molecular diagnostic services and the associated healthcare cost impact. The MolDx contractor has contracted with McKesson Health Solutions to configure and maintain a Master Test Code Registry that will increase the efficiency and transparency of the evaluation and valuation of the affected procedures/assays.

**A/B MAC affected by this Project:** Jurisdiction 15

**Diagnostic services affected:** Molecular Diagnostic Testing (MDT) refers to any laboratory assay that quantifies a measurable characteristic of the patient care process at the molecular level. This includes gene tests (e.g. DNA or RNA, reported with codes listed in the above tables), infectious disease probes, tumor markers (any type), pharmacogenomic assays, selected predictive and/or risk assessment interpretative scores, and any other molecular test, with or without an existing CPT or HCPCS code that does not specify ONE test per ONE code. Multi-variant Molecular testing (MVMT) is considered a subset of Molecular Diagnostic Testing (MDT).

**Provider Requirements:** Register MDT procedures/services with MolDx contractor and submit coverage requests.

**Timelines:** Claims for MDT will NOT be considered for adjudication unless the test in question has been submitted to the test registry for review and a McKesson Z-Code Identifier has been assigned to the test. Please refer to Palmetto GBA MolDx J11 Program Timelines section for more information.

For more information, please refer to the MolDx contractor website (http://www.palmettogba.com/palmetto/MolDX.nsf/docsCat/MolDx%20Website~MolDx~Browse%20By%20Topic~General?open&expand=1&navmenu=Browse%5eBy%5eTopic).

**Kentucky & Ohio**

**CGS Administrators, LLC LCD Policy Updates**

The following LCDs have been released from draft into their final version. Please review them on the CGS website or click on the links provided. These policies will be effective February 1, 2016.
• L36460 Bone Mass Measurement
• L36487 MolDX: Chromosome 1p/19q deletion analysis
• L36494 Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint
• L36458 MolDX: Breast Cancer Index℠ Genetic Assay
• L36425 MolDX: Breast Cancer Assay: Prosigna

The following policy will be effective February 8, 2016.

• L36469 Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder

These policies will be effective February 15, 2016.

• L36485 MolDX: HLA-DQB1*06:02 Testing for Narcolepsy
• L36456 MolDX: BRCA1 and BRCA2 Genetic Testing


Kentucky:

• Part A: https://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntrctr=239&ContrVer=1&CntnrctrSelected=239*1&name=CGS+Administrators%2c+LLC+(15101%2c+MAC+-+Part+A)&LCntrctr=239*1&DocType=Future&bc=AgACAAA-AAAAAAA%3d%3d&#ResultsAnchor

• Part B: https://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntrctr=228&ContrVer=2&CntnrctrSelected=228*2&name=CGS+Administrators%2c+LLC+(15102%2c+MAC+-+Part+B)&LCntrctr=228*2&DocType=Future&bc=AgACAAA-AAAAAAA%3d%3d&#ResultsAnchor

Ohio:

• Part A: https://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntrctr=240&ContrVer=1&CntnrctrSelected=240*1&name=CGS+Administrators%2c+LLC+(15201%2c+MAC+-+Part+A)&LCntrctr=240*1&DocType=Future&bc=AgACAAA-AAAAAAA%3d%3d&#ResultsAnchor

• Part B: https://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntrctr=238&ContrVer=2&CntnrctrSelected=238*2&name=CGS+Administrators%2c+LLC+(15202%2c+MAC+-+Part+B)&LCntrctr=238*2&DocType=Future&bc=AgACAAA-AAAAAAA%3d%3d&#ResultsAnchor
RE: VOLUNTARY REFUNDS - CALENDAR YEAR 2015
DECEMBER 2015

To: Medicare Providers

As you know, providers may at times receive incorrect payment (e.g., for services/items not covered, erroneously billed, etc.). When this happens, the overpayment is a debt due the Medicare program.

Medicare expects providers to exercise care when billing and accepting payment, and also expects that providers will promptly bring incorrect payments to the carrier’s attention. These submissions acknowledge your awareness of this expectation and confirm a measure of compliance. However, please be aware that the CMS Online Manual, Publication 100-08, Chapter 4, Section 4.16 states:

The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Thank you for your efforts to work in cooperation with CGS Administrators, LLC to ensure proper and appropriate delivery of Medicare benefits. If you have any questions, please contact our office at one of the following numbers.

Kentucky Part A Providers: 1.866.590.6703
Kentucky Part B Providers: 1.866.276.9558
Ohio Part A Providers: 1.866.590.6703
Ohio Part B Providers: 1.866.276.9558
Home Health Providers: 1.877.299.4500
Hospice Providers: 1.877.299.4500
DME Suppliers: 1.866.270.4909
MM9350: Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE

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

MLN Matters® Number: MM9350
Related CR Release Date: November 20, 2015
Related CR Transmittal #: R3411CP
Related Change Request (CR) #: CR 9350
Effective Date: April 1, 2016
Implementation Date: April 4, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9350 instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule publication. These system updates are based on the CORE Code Combination List to be published on or about February 1, 2016.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Patient Protection and Affordable Care Act of 2010.

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

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

CR9350 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2016. This update is based on the Claim Adjustment Reason Code (CARC)
and Remittance Advice Remark Code (RARC) updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2015.


Additional Information

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

Kentucky & Ohio
MM9357: New Influenza Virus Vaccine Code

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

MLN Matters® Number: MM9357  Related Change Request (CR) #: CR 9357
Related CR Release Date: November 9, 2016  Effective Date: August 1, 2015
Related CR Transmittal #: R3403CP  Implementation Date: April 4, 2016

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

Provider Action Needed
Change Request (CR) 9357 provides instructions for Medicare systems to be updated to include influenza virus vaccine code 90630 (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use) for claims with dates of service on or after August 1, 2015. Make sure your billing staffs are aware of this code change.

Background
CR9357 provides that (effective for claims with dates of service on or after August 1, 2015, processed on or after April 4, 2016) Medicare will pay for vaccine Current Procedural Terminology (CPT) code 90630 (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use).

Your MAC will add influenza virus vaccine CPT code 90630 to existing influenza virus vaccine edits and accept it for claims with dates of service on or after August 1, 2015.

Effective for dates of service on and after August 1, 2015, MACs will:

- Pay for vaccine code 90630 on institutional claims as follows:
  - Hospitals – Types of Bill (TOB) 12X and 13X, Skilled Nursing Facilities (SNFs) –TOB 22X and 23X, Home Health Agencies (HHAs) – TOB 34X, hospital-based Renal Dialysis Facilities (RDFs) – TOB 72X, and Critical Access Hospitals (CAHs) – TOB 85X, based on reasonable cost;
- Indian Health Service (IHS) Hospitals – TOB 12X, and 13X and IHS CAHs – TOB 85X, based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP); and
- Comprehensive Outpatient Rehabilitation Facility (CORF) – TOB 75X, and independent RDFs – TOB 72X, based on the lower of actual charge or 95 percent of the AWP.
- Pay for code 90630 on professional claims using the CMS Seasonal Influenza Vaccines Pricing webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html to determine the payment rate for influenza virus vaccine code 90630.

**Note:** In all of the above instances, annual Part B deductible and coinsurance do not apply.

In addition, until Medicare systems changes are implemented, MACs will hold institutional claims containing influenza virus vaccine CPT codes 90630 (with dates of service on or after August 1, 2015) that they receive before April 4, 2016. Once the system changes described in CR9357 are implemented, these institutional claims will be processed and paid.

**Additional Information**


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

---

**Kentucky & Ohio**

**MM9377: Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 22.1, Effective April 1, 2016**

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

**MLN Matters® Number:** MM9377
**Related Change Request (CR) #:** CR 9377
**Related CR Release Date:** November 20, 2015
**Related CR Transmittal #:** R3408CP
**Effective Date:** April 1, 2016
**Implementation Date:** April 4, 2016

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9377 informs MACs about the release of the latest package of National Correct Coding Initiative (NCCI) edits, Version 22.1, which will be effective April 1, 2016. Make sure that your billing staffs are aware of these changes.
Background
The Centers for Medicare & Medicaid Services (CMS) developed the National CCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The latest package of CCI edits, Version 22.1, effective April 1, 2016, will be available via the CMS Data Center (CDC). A test file will be available on or about January 31, 2016, and a final file will be available on or about February 14, 2016.

Version 22.1 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits.

CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file.

Additional Information

The CMS NCCI webpage has additional information at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website.

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

Kentucky & Ohio

MM9427: Claim Status Category and Claim Status Code Update

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

MLN Matters® Number: MM9427
Related CR Release Date: November 20, 2015
Effective Date: April 1, 2016
Implementation Date: April 4, 2016

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

Change Request (CR) 9427 informs MACs about the changes to Claim Status Category and Claim Status Codes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee (NCMC) in the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s).

Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The NCMC 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 NCMC has decided to allow the industry 6 months for implementation of newly added or changed codes.

The code sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes on the Internet. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the January 2016 committee meeting shall be posted on these sites on or about February 1, 2016. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes, by the implementation date of CR9427.

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 CR9427.

CMS and the MACs must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. These contractors must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses and when sending ASC X12 277 Healthcare Claim Acknowledgments. References in this CR to “277 responses” and “claim status responses” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

Additional Information


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

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

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

MLN Matters® Number: MM9266 Revised  Related Change Request (CR) #: CR 9266
Related CR Release Date: November 18, 2015  Effective Date: January 1, 2015
Related CR Transmittal #: R3407CP  Implementation Date: October 5, 2015

Note: This article was revised on November 25, 2015, to reflect the revised CR9266 issued on November 18. In the article, several codes were removed from the list of codes with bilateral surgery indicator changes. The CR release date, transmittal number, and the Web address for CR9266 are also revised.

Provider Types Affected

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

What You Need to Know

Changes included in the October update to the 2015 MPFSDB are effective for dates of service on and after January 1 (unless otherwise stated). The key change is to the Malpractice Relative Value Units (RVU) of the following CPT/HCPCS codes: 33471, 33606, 33611, 33619, 33676, 33677, 33692, 33737, 33755, 33762, 33764, 33768, 33770, 33771, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33783, 33786, 33803, 33813, 33822, 33840, and 33851; and the Work RVUs for G0105 and G0121. The RVU changes for these codes are retroactive to January 1, 2015. In addition, effective January 1, 2015, codes 95866, 95866-TC, and 95866-26 have a revised bilateral surgery indicator = 3.

Also, effective October 1, 2015, CPT/HCPCS code Q9979 is assigned a procedure status indicator of E (Excluded from the PFS by regulation. These codes are for items and services that CMS has excluded from the PFS by regulation. No payment may be made under the PFS for these codes and generally, no RVUs are shown.).

Background

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

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

Additional Information

Kentucky & Ohio

MM9431: Calendar Year (CY) 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

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

MLN Matters® Number: MM9431  
Related CR Release Date: November 23, 2015  
Related CR Transmittal #: R3416CP  
Effective Date: January 1, 2016  
Implementation Date: January 4, 2016

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider Action Needed

Change Request (CR) 9431 provides the CY 2016 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background


Payment on a fee schedule basis is required by the Social Security Act (the Act) for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician’s office.

The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas for the items, based on information from the National Competitive Bidding Program (CBP). The Act provides authority...
for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP.

CMS issued a final rule on November 6, 2014 (79 FR 66223) on the methodologies for adjusting DMEPOS fee schedule amounts using information from competitive bidding programs. Program instructions on these changes are also available in Transmittal 3350, CR 9239 on September 11, 2015. The CBP product categories, HCPCS codes and Single Payment Amounts (SPAs) included in each Round of the CBP are available on the Competitive Bidding Implementation Contractor (CBIC) website (http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home).

There are three general methodologies used in adjusting the fee schedule amounts:

1. **Adjusted Fee Schedule Amounts for Areas within the Contiguous United States**
   Also, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA. The average of SPAs from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are also subject to a national ceiling (110% of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (i.e., those included in more than 10 CBAs).

2. **Adjusted Fee Schedule Amounts for Areas outside the Contiguous United States**
   Areas outside the contiguous United States (i.e., noncontiguous areas such as Alaska, Guam, Hawaii) receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

3. **Adjusted Fee Schedule Amounts for Items Included in 10 or Fewer Areas**
   DME items included in 10 or fewer CBAs receive adjusted fee schedule amounts so that they are equal to 110 percent of the straight average of the SPAs for the 10 or fewer CBAs. This methodology applies to all areas (i.e., non-contiguous and contiguous).

**Phasing In Fee Schedule Amounts**

The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the July quarterly update files will include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts.

Fee schedule amounts that are adjusted using SPAs will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where the SPAs from CBPs no longer in effect are used to adjust fee schedule amounts (§414.210(g)(4)), the SPAs will be
increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2016 for this update) and for each subsequent year (such as 2017 or 2018) claims with dates of service on or after July 1, 2016, the fee schedule amount on the DMEPOS file is based on 100 percent of the adjusted fee schedule amount.

Fee Schedule and Rural ZIP Code Files
The DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments taking effect January 1, 2016. In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file has been updated to include rural payment amounts for those HCPCS codes where the adjustment methodology is based on average regional SPAs. Also, on the PEN file the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology will remain unchanged. The DMEPOS and PEN fee schedules and the Rural ZIP code file Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties after October 29, 2015 at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched on the CMS website.

New Codes Added Effective January 1, 2016:
The HCPCS codes A4337, E1012, E0465, E0466, and L8607. are being added to the HCPCS effective January 1, 2016. Codes E1012, E0465, E0466, and L8607 will be added to the DMEPOS fee schedule file effective January 1, 2016.

Codes Deleted
The following codes will be deleted from the DMEPOS fee schedule files effective January 1, 2016: E0450, E0460, E0461, E0463, and E0464.

Shoe Modification Codes
Effective January 1, 2016, CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2016. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2016, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during CY 2014.

Update to CR8566—Wheelchair Accessory
Also as part of CR9431, CMS is adding HCPCS code E1012 (wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type). Code E1012 is eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair, effective January 1, 2016.

The 2015 Deflation Factors for Gap-Filling Purposes
For gap-filling pricing purposes, the 2015 deflation factors by payment category are: 0.459 for Oxygen, 0.462 for Capped Rental, 0.463 for Prosthetics and Orthotics, 0.588 for Surgical Dressings, 0.639 for Parental and Enteral Nutrition, 0.978 for Splints and Casts and 0.962 for Intraocular Lenses.
**Ventilators**

Fee schedules are being added for the following ventilator HCPCS codes:

- E0465 Home ventilator, any type, used with invasive interface (e.g., tracheostomy tube); and
- Code E0466 Home ventilator, any type, used with non-invasive interface (e.g., mask, chest shell).

Code E0465 is added to the HCPCS for billing Medicare claims previously submitted under E0450 and E0463. Code E0466 is added to the HCPCS for billing Medicare claims previously submitted under E0460, E0461 and E0464. The fee schedule amounts for codes E0465 and E0466 are established using the Medicare fee schedule amounts for HCPCS code E0450, based on updated average reasonable charges for ventilators from July 1, 1986, through June 30, 1987.

**Diabetic Testing Supplies (DTS)**

The fee schedule amounts for non-mail order DTS (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update. In accordance with the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order CBP under the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. The CBP for mail order diabetic supplies is effective July 1, 2013 to June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, CR 8325, dated May 17, 2013, and Transmittal 2661, CR 8204, dated February 22, 2013. (See related MLN Matters Articles MM8325 [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNN mattersArticles/Downloads/MM8325.pdf] and MM8204 [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8204.pdf]).

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data only for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts will be updated annually by the covered item update factor adjusted for multi-factor productivity. The mail order DTS fee schedule amounts are not used in determining the Medicare allowed payment amounts for mail order DTS. The single payment amount Public Use File (PUF) for the national mail order CBP is available at [http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts](http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts) on the Internet.

The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with The Act, the fee schedule amounts for mail order DTS furnished in the Northern Mariana Islands are adjusted to equal 100 percent of the single payment amounts established under the national mail order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the six-month phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which are based on 50 percent of the un-adjusted mail order fee schedule amounts and 50 percent of the adjusted mail order single payment amounts, will be provided on the DMEPOS fee schedule file in the Hawaii column of the mail order (KL) DTS (A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259) codes for dates of service January 1, 2016, through June 30, 2016. Beginning July 1, 2016, the fully adjusted mail order fees (the SPAs) will apply for mail order DTS furnished in the Northern Mariana Islands. The Northern Mariana Island DTS mail order payment amounts will
2016 Fee Schedule Update Factor of -0.4 Percent
For CY 2016, an update factor of 0.1 percent is applied to certain DMEPOS fee schedule amounts. For the majority of fee schedule amounts, in accordance with the statutory Sections 1834(a)(14) and 1866(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2016 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2015, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi[AG5] -Factor Productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 0.1 percent. Thus, the 0.1 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a net decrease of -0.4 percent for the update factor.

2016 Update Labor Payment Rates for HCPCS Codes K0739, L4205 and L7520 January 1, 2016 through December 31, 2016
The 2016 labor payment amounts are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2016, through December 31, 2016. Those amounts are as follows:

<table>
<thead>
<tr>
<th>STATE</th>
<th>K0739</th>
<th>L4205</th>
<th>L7520</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>$28.01</td>
<td>$31.91</td>
<td>$37.54</td>
</tr>
<tr>
<td>AL</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>AR</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>AZ</td>
<td>$18.39</td>
<td>$22.13</td>
<td>$37.01</td>
</tr>
<tr>
<td>CA</td>
<td>$22.81</td>
<td>$36.38</td>
<td>$42.39</td>
</tr>
<tr>
<td>CO</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>CT</td>
<td>$24.83</td>
<td>$22.65</td>
<td>$30.08</td>
</tr>
<tr>
<td>DC</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>DE</td>
<td>$27.38</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>FL</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>GA</td>
<td>$18.39</td>
<td>$31.91</td>
<td>$37.54</td>
</tr>
<tr>
<td>HI</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$36.01</td>
</tr>
<tr>
<td>IA</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>ID</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>IL</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>IN</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>KS</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$37.54</td>
</tr>
<tr>
<td>KY</td>
<td>$14.87</td>
<td>$28.37</td>
<td>$38.47</td>
</tr>
<tr>
<td>LA</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>MA</td>
<td>$24.83</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>MD</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>ME</td>
<td>$24.83</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>MI</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>MN</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>MO</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>MS</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>MT</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$37.54</td>
</tr>
<tr>
<td>NC</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>ND</td>
<td>$18.53</td>
<td>$31.84</td>
<td>$37.54</td>
</tr>
<tr>
<td>NE</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$41.94</td>
</tr>
<tr>
<td>NH</td>
<td>$15.97</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>NJ</td>
<td>$20.06</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>NM</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>NV</td>
<td>$23.69</td>
<td>$22.13</td>
<td>$41.00</td>
</tr>
<tr>
<td>NY</td>
<td>$27.38</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>OH</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>OK</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>OR</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$43.25</td>
</tr>
<tr>
<td>PA</td>
<td>$15.97</td>
<td>$22.79</td>
<td>$30.08</td>
</tr>
<tr>
<td>PR</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>RI</td>
<td>$17.72</td>
<td>$22.81</td>
<td>$30.08</td>
</tr>
<tr>
<td>SC</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>SD</td>
<td>$16.62</td>
<td>$22.13</td>
<td>$40.22</td>
</tr>
<tr>
<td>TN</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>TX</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>UT</td>
<td>$14.91</td>
<td>$22.13</td>
<td>$46.84</td>
</tr>
<tr>
<td>VA</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>VI</td>
<td>$14.87</td>
<td>$22.16</td>
<td>$30.08</td>
</tr>
<tr>
<td>WA</td>
<td>$23.69</td>
<td>$32.47</td>
<td>$38.57</td>
</tr>
<tr>
<td>WI</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>WV</td>
<td>$14.87</td>
<td>$22.13</td>
<td>$30.08</td>
</tr>
<tr>
<td>WY</td>
<td>$20.73</td>
<td>$29.53</td>
<td>$41.94</td>
</tr>
</tbody>
</table>

2016 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment
CMS is implementing the 2016 national monthly fee schedule payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2016, through June 2016. The updated national 2016 monthly payment amount of $180.10 for the stationary oxygen equipment codes will not appear on the 2016 DMEPOS fee schedule. Instead, for dates of service January 1, 2016, through June 30, 2016, the 2016 fee schedule rate of $180.10 blends with the stationary oxygen regional SPAs based on 50 percent of the un-adjusted stationary oxygen fee schedule amounts and 50 percent of the adjusted oxygen regional SPAs.

Beginning July 1, 2016, the stationary oxygen equipment fee schedule amounts on the quarterly update to the CY 2016 DMEPOS fee schedule file will reflect 100 percent of the adjusted oxygen regional SPAs.

no longer appear in the Hawaii column and the DTS mail order (KL) fee schedules for all states and territories will be removed from the DMEPOS fee schedule file as of July 1, 2016.
When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2016 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2016 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, Change Request (CR) 6792, dated February 5, 2010, and Transmittal 717, CR6990, dated June 8, 2010. (See related MLN Matters Articles MM6792 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6792.pdf) and MM6990 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6990.pdf)). To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier’s or manufacturer’s warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the “MS” modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR §414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2016 maintenance and servicing fee is adjusted by the -0.4 percent MFP-adjusted covered item update factor to yield a CY 2016 maintenance and servicing fee of $69.48 for oxygen concentrators and transfilling equipment.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.
MM9448: Therapy Cap Values for Calendar Year (CY) 2016

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

MLN Matters® Number: MM9448
Related Change Request (CR) #: CR 9448
Related CR Release Date: November 25, 2015
Related CR Transmittal #: R3417CP
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

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

Provider Action Needed
Change Request (CR) 9448, from which this article was developed, describes the amounts and the policy for outpatient therapy caps for CY 2016. For physical therapy and speech-language pathology combined, the 2016 therapy cap will be $1,960. For occupational therapy, the cap for 2016 will be $1,960. Please make sure your billing staffs are aware of these updates.

Background
The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as “therapy caps.” The therapy caps are updated each year based on the Medicare Economic Index. An exceptions process to the therapy caps for reasonable and medically necessary services was required by section 5107 of the Deficit Reduction Act of 2005. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy cap exceptions process through December 31, 2017.

Additional Information

For more information on the therapy caps and other issues related to outpatient therapy services, please see the Therapy Services webpage at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.
**MM9410: Update to Medicare Deductible, Coinsurance and Premium Rates for 2016**

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

**MLN Matters® Number:** MM9410  
**Related CR Release Date:** November 25, 2015  
**Related CR Transmittal #:** R96GI  
**Effective Date:** January 1, 2016  
**Implementation Date:** January 4, 2016

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2016 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

**Background**

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

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

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. In addition, some beneficiaries may pay higher Part B premiums, based on their income.
2016 PART A - HOSPITAL INSURANCE (HI)
- **Deductible:** $1,288.00
- **Coinsurance:**
  - $322.00 a day for 61st-90th day
  - $644.00 a day for 91st-150th day (lifetime reserve days)
  - $161.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- **Base Premium (BP):** $411.00 a month
- **BP with 10% surcharge:** $452.10 a month
- **BP with 45% reduction:** $226.00 a month (for those who have 30-39 quarters of coverage)
- **BP with 45% reduction and 10% surcharge:** $248.60 a month

2016 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)
- **Standard Premium:** $121.80 a month
- **Deductible:** $166.00 a year
- **Pro Rata Data Amount:**
  - $118.86 1st month
  - $47.14 2nd month
- **Coinsurance:** 20 percent

Additional Information

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

**Kentucky & Ohio**

**MM9374: Remittance Advice Remark and Claim Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update**

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

**MLN Matters® Number:** MM9374  
**Related Change Request (CR) #:** CR 9374  
**Related CR Release Date:** November 25, 2015  
**Effective Date:** April 1, 2016  
**Related CR Transmittal #:** R3418CP  
**Implementation Date:** April 4, 2016

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

Change Request (CR) 9374 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software. Make sure your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use it.

Background

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

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

CR9374 is 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, but the deactivated code in derivative messages is allowed. MACs make necessary program changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per CR9374 or as posted on the WPC website when:

- Medicare is not primary;
- The COB claim is received after the deactivation effective date; and
- The date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC website.

MACs make necessary programming changes so that deactivated reason and remark codes are allowed even after the deactivation implementation date in a Reversal and Correction situation, when a value of 22 in CLP02 identifies the claim to be a corrected claim, and in Medicare Secondary Payer (MSP) claims, when forwarded to Medicare by primary payers before the deactivation date and Medicare adjudication is done after the deactivation date.

SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the WPC website, found at http://wpc-edi.com/Reference/ on the Internet. If any new or modified code has an effective date past the implementation date specified in CR9374, MACs must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times per year and may not match the CMS systems release schedule. For this recurring CR, MACs and SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR9278, with a related MLN Matters® article available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9278.pdf on the CMS website.)

In accordance with HIPAA Legislation Published in the Federal Register (45 CFR Part 162), covered entities are required to comply with established standards and code set regulations. Furthermore, the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) further defines the requirements for the 835 transaction by specifying Phase III Operating Rules, the 835 transaction (Health Care
Claim Payment/Advice) and standard paper remittance advice which require the use of CARCs and RARCs.

Additional Information


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

Kentucky & Ohio

MM9239: Implementation of Adjusted Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule Amounts Using Information from the National Competitive Bidding Program (CBP)

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

MLN Matters® Number: MM9239
Related CR Release Date: September 11, 2015
Related CR Transmittal #: R3350CP
Related Change Request (CR) #: CR 9239
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You
The adjusted fee schedule amounts for the applicable Healthcare Common Procedure Coding System (HCPCS) codes will be used to pay claims with dates of service on or after January 1, 2016, and will be included in the DMEPOS fee schedule files beginning January 1, 2016.

CAUTION – What You Need to Know
Section1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the Competitive Bidding Program (CBP). Section 1842(s)(3)(B) of the Social Security Act (the Act) provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. Change Request (CR) 9239 implements the adjusted DMEPOS fees schedule from the CBP.

GO – What You Need to Do
Make sure that your billing staffs are aware of the adjusted DMEPOS fee schedule amounts from the CBP.
Background

Medicare payment for most DMEPOS is based on either fee schedules or single payment amounts (SPAs) established under the CBP in certain specified geographic areas, as mandated by 1847(a) and (b) the Act.

Competitive bidding was phased in with the Round 1 Rebid contracts beginning January 1, 2011, in 9 competitive bid areas (CBAs). Contracts for the Round 1 Rebid expired on December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is required by law to recompete contracts for the DMEPOS CBP at least once every 3 years. The same 9 CBAs were rebid under the Round 1 Recompete with the contracts and process claims with date of service beginning January 1, 2014. Competitive bidding was phased in with the Round 2 contracts beginning July 1, 2013, in 100 additional CBAs. Beginning with the Round 2 Recompete scheduled to take effect on July 1, 2016, CBAs covering more than one state will be subdivided into CBAs that do not cross state lines, resulting in an increase in the total number of CBAs.


Section 1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the CBP. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. The methodologies for using information from the CBP to adjust the fee schedule amounts for DME and enteral nutrition are set forth in regulations at 42 Code of Federal Regulations (CFR) 414.210(g). There are three general methodologies:

- Adjustment of fee schedule amounts for areas within the contiguous United States, with a special rule for rural areas;
- Adjustment of fee schedule amounts for areas outside the contiguous United States; and
- Adjustment of fee schedule amounts for certain items for all areas in cases where the items have been included in competitive bidding programs in 10 or fewer CBAs.

Fee Schedule Amounts for Areas within the Contiguous United States

This methodology for adjusting the fee schedule amounts uses the average of SPAs from CBPs located in eight different regions of the contiguous United States to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are also subject to a national ceiling (110% of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (that is, those included in more than 10 CBAs).

There is also a special rule for areas within the contiguous United States that are designated as rural areas. The fee schedule amounts for these areas will be adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural area to be a geographical area represented by a postal ZIP Code where at least 50 percent of the total geographical area of the ZIP Code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

As a result of these adjustments, the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts.

Fee Schedule Amounts for Areas outside the Contiguous United States

Areas outside the contiguous United States (noncontiguous areas such as Alaska, Guam, Hawaii) are subject to a different methodology that adjusts the fee schedule amounts so that...
they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

Fee Schedule Amounts for Items Included in 10 or Fewer CBAs
DME items included in 10 or fewer CBAs are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs. This methodology applied to all areas (non-contiguous and contiguous).

Phasing In and Updating Fee Schedule Amounts
The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016 through June 30, 2016, so that the fee schedule amount is based on a blend of 50 percent of the current fee schedule amounts (the fee schedule amounts that would have gone into effect on January 1, 2016, if they had not been adjusted based on information from the CBP) and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the fee schedule is based on 100 percent of the adjusted fee schedule amount.

In most cases, the adjusted fee schedule amounts will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where SPAs from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment is made (for example, 2016) and for each subsequent year (for example, 2017, 2018).

The DME MAC and Part B MAC DMEPOS fee schedule file shall be adjusted to include the rural fee and rural fee indicator and these changes will be reflected in the file format and data requirements specified in Chapter 23 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf), Section 60.1 of the “Medicare Claims Processing Manual.” Similarly, the Fiscal Intermediary (FI) DMEPOS fee schedule file format, outlined in Chapter 23 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf), Section 50.2 of the “Medicare Claims Processing Manual,” will be updated to include the rural fee and rural fee indicator. Beginning January 1, 2016, the DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodology as well as codes that are not subject to the adjustments. The DMEPOS fee schedule file will continue to be updated and available for download on a quarterly basis as necessary.

The parenteral and enteral nutrition (PEN) fee schedule file will accommodate adjusted fees for the enteral HCPCS codes that are state specific. The PEN file layout is outlined in Chapter 23, Section 70.1 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf) of the “Medicare Claims Processing Manual.”

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.
MM9231 Revised: New and Revised Place of Service Codes (POS) for Outpatient Hospitals

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

MLN Matters® Number: MM9231 Revised
Related CR Release Date: August 6, 2015
Related CR Transmittal #: R3315CP

Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Note: This article was revised on December 9, 2015, to clarify the effective date of POS 19. POS 19 will be accepted for any claims processed on or after January 1, 2016. That is, POS code 19 is valid for any claim, regardless of the date of service, when it is processed on or after January 1, 2016. The title of the table on page 2 was also changed for clarification. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9231, from which this article is taken, updates the “Medicare Claims Processing Manual” by:

- Revising the current Place of Service (POS) code set by adding new POS code 19 for “Off Campus-Outpatient Hospital” and revising POS code 22 from “Outpatient Hospital” to “On Campus-Outpatient Hospital;” and
- Making minor corrections to POS codes 17 (Walk-in Retail Health Clinic) and 26 (Military Treatment Facility).

You should ensure that your billing staffs are aware of these POS code changes.

Background

As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with HIPAA’s standards and their implementation guides. The currently adopted professional implementation guide for the Accredited Standards Committee (ASC) X12N 837 standard requires that each electronic claim transaction include a POS code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains.

The POS code set provides care-setting information necessary to appropriately pay Medicare and Medicaid claims. At times, Medicaid has had a greater need for code specificity than Medicare, and many of the past years’ new codes that have been developed to meet Medicaid’s needs.

While Medicare does not always need this greater specificity in order to appropriately pay claims; it nevertheless adjudicates claims with the new codes to ease coordination of benefits, and to give Medicaid and other payers the setting information that they require. Therefore, as a payer, Medicare must be able to recognize any valid code from the POS code set that appears on the HIPAA standard claim transaction.
Therefore, in response to the discussion in the CY 2015 Physician Fee Schedule (PFS) final rule with comment period published on November 13, 2014 (79 FR 67572); in order to differentiate between on-campus and off-campus provider-based hospital departments, CMS is creating a new POS code (POS 19) and revising the current POS code description for outpatient hospital (POS 22).

CR 9231, from which this article is taken, provides this POS code update, effective January 1, 2016. Specifically, CR 9231 updates the current POS code set by adding new POS code 19 for “Off Campus-Outpatient Hospital” and revising POS code 22 from “Outpatient Hospital” to “On Campus-Outpatient Hospital” as described in the following table.

New and Revised POS Codes for Claims Processed on or after January 1, 2016 (Regardless of Service Date)

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>POS 19 Off Campus-Outpatient Hospital</td>
<td>Descriptor: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.</td>
</tr>
<tr>
<td>POS 22 On Campus-Outpatient Hospital</td>
<td>Descriptor: A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.</td>
</tr>
</tbody>
</table>

CR9231 also:

- Implements the systems and local contractor level changes needed for Medicare to adjudicate claims with the new and revised codes (your B MAC or DME MAC will develop policies as needed to edit and adjudicate claims that contain these new/revised codes according to Medicare national policy); and
- Makes minor corrections to POS codes 17 (Walk-in Retail Health Clinic) and 26 (Military Treatment Facility) by adding those two codes back into the POS list in the “Medicare Claims Processing Manual.” Those two codes were removed inadvertently from a prior version of that manual.

Additional Information Related to POS Codes 19 and 22

- Payments for services provided to outpatients who are later admitted as inpatients within 3 days (or, in the case of non-IPPS hospitals, 1 day) are bundled when the patient is seen in a wholly owned or wholly operated physician practice. The 3-day payment window applies to diagnostic and nondiagnostic services that are clinically related to the reason for the patient’s inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same. The 3-day payment rule will also apply to services billed with POS code 19.
- Claims for covered services rendered in an Off Campus-Outpatient Hospital setting (or in an On Campus-Outpatient Hospital setting, if payable by Medicare) will be paid at the facility rate. The payment policies that currently apply to POS 22 will continue to apply to this POS, and will now also apply to POS 19 unless otherwise stated.
- Reporting outpatient hospital POS code 19 or 22 is a minimum requirement to trigger the facility payment amount under the PFS when services are provided to a registered outpatient. Therefore, you should use POS code 19 or POS code 22 when you furnish services to a hospital outpatient regardless of where the face-to-face encounter occurs.
- Your MACs will allow POS 19 to be billed for G0447 (Face-to-face behavioral counseling for obesity, 15 minutes) and G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes) in the same way as those services are billed with POS code 22.

Additional Information

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

**Document History**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 9, 2015</td>
<td>Revised to clarify the effective date of POS 19. POS 19 will be accepted for any claims processed on or after January 1, 2016. That is, POS code 19 is valid for any claim regardless of the date of service when it is processed on or after January 1, 2016. The title of the table on page 2 was also changed for clarification.</td>
</tr>
</tbody>
</table>

**Kentucky & Ohio**

**MM9252 Revised: ICD-10 Conversion/Coding Infrastructure Revisions to National Coverage Determinations (NCDs)—3rd Maintenance CR**

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

**MLN Matters® Number:** MM9252 Revised  
**Related CR Release Date:** December 3, 2015  
**Related CR Transmittal #:** R1580OTN  
**Related Change Request (CR) #:** CR 9252  
**Effective Date:** October 1, 2015

**Implementation Date:** January 4, 2016, Exceptions: FISS will implement the following NCDs: April 4, 2016: 260.1, 80.11, 270.6, 160.18, 110.10, 110.21, 250.5, 100.1, 160.24

**Note:** This article was revised on December 3, 2015, to reflect an updated CR that: 1) Removed invalid TOB 52X from NCD250.5; 2) Removed invalid TOB 25X from NCD80.11 and added TOB 85X; and 3) Included complete history in NCD160.18. In the article, the CR release date, transmittal number, and the Web address for accessing CR9252 are revised. All other information remains the same.

**Provider Types Affected**

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

**What you Need to Know**

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

**Background**

CR9252 creates and updates NCD editing, both hard-coded shared system edits as well as local MAC edits that contain ICD-10 diagnosis/procedure codes, plus all associated coding infrastructure such as HCPCS/CPT codes, reason/remark codes, frequency edits, Place of Service (POS)/Type of Bill (TOB)/provider specialties, and so forth. The requirements described in CR9252 reflect the operational changes that are necessary to implement the conversion of the Medicare local and shared system diagnosis and procedure codes specific to the 26 Medicare NCD spreadsheets, which are available at [https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9252.zip](https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9252.zip) on the Centers for Medicare & Medicaid (CMS) website.

NCD policies may contain specific covered, non-covered and/or discretionary diagnosis and procedure coding. These 26 spreadsheets are designated as such and are based on current NCD policies and their corresponding edits.

You should be aware that nationally covered and non-covered diagnosis code lists are finite and cannot be revised without a subsequent CR. Discretionary code lists are to be regarded as CMS’ compilation of discretionary codes based on current analysis/interpretation. MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions.

Some coding details are as follows:

1. Your MAC will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages, where appropriate:
   - Remittance Advice Remark Code (RARC) N386 (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered), along with
   - Claim Adjustment Reason Code (CARC) 50 (These are noncovered services because this is not deemed a “medical necessity” by the payer),
   - CARC 96 (Non-covered charge(s). At least one Remark Code must be provided [may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT]), and/or
   - CARC 119 (Benefit maximum for this time period or occurrence has been reached).
2. When denying claims associated with the NCDs in the 26 spreadsheets, except where otherwise indicated, your MACs will use:
   - Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 (Advance Beneficiary Notice), or with occurrence code 32 and a GA modifier (The provider or supplier has provided an Advance Beneficiary Notice (ABN) to the patient), indicating a signed ABN is on file).
   - Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier (The provider or supplier expects a medical necessity denial; however, did not provide an Advance Beneficiary Notice (ABN) to the patient), indicating no signed ABN is on file)
   - For modifier GZ, your MAC will use CARC 50.
Additional Information

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

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 3, 2015</td>
<td>Article was revised to reflect new CR that: 1) Removed invalid TOB 52X from NCD250.5, 2) Removed invalid TOB 25X from NCD80.11 and added TOB 85X and, 3) Included complete history in NCD160.18.</td>
</tr>
<tr>
<td>October 6, 2015</td>
<td>Article was revised to reflect new CR issued on October 5, 2015. In the article, the CR release date, transmittal number, and the Web address for accessing CR9252 are revised.</td>
</tr>
</tbody>
</table>

**Kentucky & Ohio**

**MM9476: Summary of Policies in the Calendar Year (CY) 2016 Medicare Physician Fee Schedule (MPFS) Final Rule and Telehealth Originating Site Facility Fee Payment Amount**

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

**MLN Matters® Number:** MM9476

**Change Request (CR) #:** CR 9476

**Related CR Release Date:** December 18, 2015

**Effective Date:** January 1, 2016

**Related CR Transmittal #:** R3423CP

**Implementation Date:** January 4, 2016

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 9476 which provides a summary of the policies in the Calendar Year (CY) 2016 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. Make sure that your billing staff is aware of these updates for 2016.

**Background**

The Social Security Act (Section 1848(b)(1); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) requires the Centers for Medicare & Medicaid Services (CMS) to establish by regulation a fee schedule of payment amounts for physicians’ services for the subsequent year. CMS issued a final rule with comment period on October 30, 2015, (see http://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf), that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2016.
The final rule also addresses public comments on Medicare payment policies proposed earlier this year. The proposed rule “Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016” was published in the Federal Register on July 15, 2015 (see http://www.gpo.gov/fdsys/pkg/FR-2015-07-15/pdf/2015-16875.pdf).

The final rule also addresses interim final values established in the CY 2015 MPFS final rule with comment period. The final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2016 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until December 29, 2015.

CR9476 provides a summary of the payment polices under the Medicare Physician Fee Schedule (PFS) and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2016 and they are as follows:

**Sustainable Growth Rate (SGR)**

The Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10, enacted on April 16, 2015) (MACRA; see http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf) repealed the Medicare SGR update formula for payments under the MPFS.

**Access to Telehealth Services**

CMS is adding the following services to the list of services that can be furnished to Medicare beneficiaries under the telehealth benefit: Prolonged service inpatient CPT codes 99356 and 99357 and ESRD-related services 90963 through 90966. The prolonged service codes can only be billed in conjunction with subsequent hospital and subsequent nursing facility codes. Limits of one subsequent hospital visit every three days, and one subsequent nursing facility visit every 30 days, would continue to apply when the services are furnished as telehealth services.

For the ESRD-related services, the required clinical examination of the catheter access site must be furnished face-to-face “hands on” (without the use of an interactive telecommunications system) by a physician, Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), or Physician Assistant (PA). For the complete list of telehealth services, visit [http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html](http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html) on the CMS website.

Certified Registered Nurse Anesthetists (CRNAs) initially were omitted from the list of distant site practitioners for telehealth services in the regulation because CMS did not believe these practitioners would furnish any of the service on the list of Medicare telehealth services. However, CRNAs in some states are licensed to furnish certain services on the telehealth list, including evaluation and management services. Therefore, CMS revised the regulation at 42 CFR 410.78(b)(2) (Telehealth services) (http://www.ecfr.gov/cgi-bin/text-idx?SID=6e06827438f8f30fa7fbc12acf20732b&m=true&node=pt42.2.410&rgn=div5%23se42.2.410_178) to include a CRNA, as described under 42 CFR 410.69 (http://www.ecfr.gov/cgi-bin/text-idx?SID=6e06827438f8f30fa7fbc12acf20732b&m=true&node=pt42.2.410&rgn=div5%23se42.2.410_169), to the list of distant site practitioners who can furnish Medicare telehealth services.

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

The Social Security Act (Section 1834(m)(2)(B); see [https://www.ssa.gov/OP_Home/ssact/title18/1834.htm](https://www.ssa.gov/OP_Home/ssact/title18/1834.htm)) establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in the Social Security Act (Section 1842(i)(3); see [https://www.ssa.gov/OP_Home/ssact/title18/1842.htm](https://www.ssa.gov/OP_Home/ssact/title18/1842.htm)).

The MEI increase for 2016 is 1.1 percent. Therefore, for CY 2016, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the
actual charge, or $25.10. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Incomplete Colonoscopies
The method for calculating the payment for incomplete colonoscopies has been revised for 2016. New payment rates will apply when modifier 53 (discontinued procedure) is appended to codes 44388, 45378, G0105, and G0121. (For more information, see the MLN Matters article (MM9317) corresponding to CR9317 at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9317.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9317.pdf) on the CMS website.)

Advance Care Planning, and With an Annual Wellness Visit (AWV)
Advance Care Planning (ACP) services are separately payable under the MPFS in 2016 (deductible and coinsurance apply). When voluntary ACP services are furnished as part of an Annual Wellness Visit (AWV), the deductible and coinsurance would not be applied for ACP.

Portable X-ray Transportation Fee
The “Medicare Claims Processing Manual,” Chapter13, Section 90.3 was revised to remove the word “Medicare” before “patient” in Section 90.3. Also, guidance for the billing of the transportation fee of portable X-ray suppliers has been clarified. When more than one patient is X-rayed at the same location, the single transportation payment under the Physician Fee Schedule is to be prorated among all patients (Medicare Parts A and B, and non-Medicare) receiving portable X-ray services during that trip, regardless of their insurance status. For more information, see the MLN Matters article (MM9354) corresponding to CR9354 for more information at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9354.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9354.pdf) on the CMS website.

“Incident to” Policy
CMS finalized the changes to 42 CFR 410.26(a)(1) ([http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr410_main_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr410_main_02.tpl)) without modification, and the change to the regulation at 42 CFR 410.26(b)(5) with a clarifying modification. Specifically, CMS is amending the definition of the term, “auxiliary personnel” at § 410.26(a)(1) that are permitted to provide “incident to” services to exclude individuals who have been excluded from the Medicare program or have had their Medicare enrollment revoked. Additionally, CMS is amending § 410.26(b)(5) by revising the final sentence to make clear that the physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) that is treating the patient more broadly, and adding a sentence to specify that only the physician (or other practitioner) that supervises the auxiliary personnel that provide incident to services may bill Medicare Part B for those incident to services.

Establishing Values for New, Revised, and Misvalued Codes
The list of codes with changes for CY 2016 included under this definition of “adjustments to Relative Value Units (RVUs) for misvalued codes” is available under the “downloads” section at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html) on the CMS website.

Target for Relative Value Adjustments for Misvalued Services
The Protecting Access to Medicare Act of 2014 (PAMA; Section 220(d); see [http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf](http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf)) added a new subparagraph to the Social Security Act (Section 1848(c)(2)(O)) to establish an annual target for reductions in MPFS expenditures resulting from adjustments to relative values of misvalued codes. Under the Social Security Act (Section 1848(c)(2)(O)(ii)), if the estimated net reduction in expenditures for a year as a result of adjustments to the relative values for misvalued codes is equal to or greater than the target for that year, reduced expenditures attributable to such adjustments will be redistributed in a budget-neutral manner within the MPFS in accordance with the existing
budget neutrality requirement under the Social Security Act (Section 1848(c)(2)(B)(ii)(II)). The provision also specifies that the amount by which such reduced expenditures exceeds the target for a given year will be treated as a net reduction in expenditures for the succeeding year, for purposes of determining whether the target has been met for that subsequent year. Section 1848(c)(2)(O)(iv) defines a target recapture amount as the difference between the target for the year and the estimated net reduction in expenditures under the MPFS resulting from adjustments to RVUs for misvalued codes. Section 1848(c)(2)(O)(iii) specifies that, if the estimated net reduction in MPFS expenditures for the year is less than the target for the year, an amount equal to the target recapture amount will not be taken into account when applying the budget neutrality requirements specified in the Social Security Act (Section 1848(c)(2)(B)(ii)(II)).

The PAMA (Section 220(d)) applies to Calendar Years (CYs) 2017 through 2020 and sets the target under the Social Security Act (Section 1848(c)(2)(O)(v)) at 0.5 percent of the estimated amount of expenditures under the PFS for each of those 4 years.

The Achieving a Better Life Experience Act of 2014 (ABLE; Section 202) (Division B of Pub. L. 113-295, enacted December 19, 2014) amended the Social Security Act (Section 1848(c)(2)(O)) to accelerate the application of the MPFS expenditure reduction target to CYs 2016, 2017, and 2018, and to set a 1 percent target for CY 2016 and 0.5 percent for CYs 2017 and 2018. As a result of these provisions, if the estimated net reduction for a given year is less than the target for that year, payments under the MPFS will be reduced.

In the CY 2016 PFS proposed rule, CMS proposed a methodology to implement this statutory provision in a manner consistent with the broader statutory construct of the MPFS. CMS finalized the policy to calculate the net reduction using the simpler method as proposed. CMS estimates the CY 2016 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.23 percent. Since this does not meet the 1 percent target established by the Achieving a Better Life Experience Act of 2014 (ABLE), payments under the MPFS must be reduced by the difference between the target for the year and the estimated net reduction in expenditures (the “Target Recapture Amount”). As a result, CMS estimates that the CY 2016 Target Recapture Amount will produce a reduction to the CF of -0.77 percent.

Additional Information


Kentucky & Ohio

**MM9465: Calendar Year (CY) 2016 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment**

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

<table>
<thead>
<tr>
<th>MLN Matters® Number: MM9465</th>
<th>Change Request (CR) #: CR 9465</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Release Date: December 11, 2015</td>
<td>Effective Date: January 1, 2016</td>
</tr>
<tr>
<td>Related CR Transmittal #: R3420CP</td>
<td>Implementation Date: January 4, 2016</td>
</tr>
</tbody>
</table>
Provider Types Affected
This MLN Matters® article is intended for clinical diagnostic laboratories that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9465 provides instructions for the CY 2016 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Make sure your billing staffs are aware of these updates.

Background
In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), the annual update to the local clinical laboratory fees for CY 2016 is 0.10 percent. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2016 is 0.10 percent (See 42 CFR 405.509(b)(1)) [http://www.ecfr.gov/cgi-bin/text-idx?SID=7e5da647e7036ba2840fe7730a18d9e&mc=true&node=se42.2.405_1509&rgn=div8]. Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the National Limitation Amount (NLA). The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key Points of CR 9465

National Minimum Payment Amounts
For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Further, payment may not exceed the actual charge. The CY 2016 national minimum payment amount is $14.39 (14.38 times 0.10 percent update for CY 2016). The affected codes for the national minimum payment amount are 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, 88176, 88177, 88178, G0123, G0143, G0144, G0145, G0147, G0148, and P3000.

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

Access to Data File
Internet access to the CY 2016 clinical laboratory fee schedule data file is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html on the Centers for Medicare & Medicaid (CMS) website. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board may use the Internet to retrieve the CY 2016 clinical laboratory fee schedule; available in multiple formats: Excel, text, and comma delimited.

Public Comments and Final Payment Determinations
On July 16, 2015, CMS hosted a public meeting to solicit input on the payment relationship between CY 2015 codes and new CY 2016 CPT codes. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html on the CMS website. Additional written comments from the public were accepted until October 26, 2015. CMS has posted a summary of the public comments and the rationale for the final payment determinations at http://www.cms.gov/
Pricing Information

The CY 2016 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2016, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2016 clinical laboratory fee schedule also includes codes that have a “OW” modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or Disease Oriented Panel Codes

Similar to prior years, the CY 2016 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping Information

New code G0477 is priced at the same rate as 0.75 times code G0434.
New code G0478 is priced at the same rate as code G0434.
New code G0479 is priced at the same rate as 4.00 times code G0434.
New code G0480 is priced at the same rate as 3.25 times code 82542.
New code G0481 is priced at the same rate as 5.00 times code 82542.
New code G0482 is priced at the same rate as 6.75 times code 82542.
New code G0483 is priced at the same rate as 8.75 times code 82542.
New code 87651QW is priced at the same rate as code 87651.
New code 87806QW is priced at the same rate as code 87806.
New code 87502QW is priced at the same rate as code 87502.
New code 86780QW is priced at the same rate as code 86780.
New code 87650QW is priced at the same rate as code 87650.
New code 87389QW is priced at the same rate as code 87389.
New code 86850 is priced at the same rate as code 86902.
New code 80081 is priced at the same rate as the sum of codes 85025, 87340, 87389, 86762, 86592, 86850, 86900, and 86901.
New code 80055 is priced at the same rate as the sum of codes 85025, 87340, 86762, 86592, 86850, 86900, and 86901.
New code G0472 is priced at the same rate as code 86803.
New code G0472QW is priced at the same rate as code 86803.
New code 81162 is priced at the same rate as the sum of 0.90 times code 81211, and 0.90 times code 81213.
New code 81170 is priced at the same rate as code 81235.
New code 81218 is priced at the same rate as code 81235.
New code 81219 is priced at the same rate as code 81245.
New code 81272 is priced at the same rate as code 81235.
New code 81273 is priced at the same rate as code 81270.
New code 81276 is priced at the same rate as code 81275.
New code 81311 is priced at the same rate as 1.50 times code 81275.
New code 81314 is priced at the same rate as code 81235.
New code 81528 is priced at the same rate as the sum of codes 81315, 81275, and 82274.
New code 81535 is priced at the same rate as the sum of 2.00 times code 88239 and code 87900.
New code 81536 is priced at the same rate as code 87900.
New codes to be gap filled are: 81412, 81432, 81433, 81434, 81437, 81438, 81442, 81490, 81493, 81525, 81538, 81540, 81545, 81595, 0009M, and 0010M.
The following existing codes are to be deleted: G0431, G0434, G0434QW, G0464, G6030, G6031, G6032, G6034, G6035, G6036, G6037, G6038, G6039, G6040, G6041, G6042, G6043, G6044, G6045, G6046, G6047, G6048, G6049, G6050, G6051, G6052, G6053, G6054, G6055, G6056, G6057, G6058, 82486, 82487, 82488, 82489, 82491, 82492, 82541, 82543, 82544, and 83788.

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

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2016 is 0.1 percent.

Manual instructions for determining the reasonable charge payment are available in the “Medicare Claims Processing Manual,” Chapter 23 (Fee Schedule Administration and Coding Requirements, [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf)), Sections 80 through 80.8. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

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

**Blood Product Codes**


Also, payment for the following codes should be applied to the blood deductible as instructed in the “Medicare General Information, Eligibility and Entitlement Manual,” Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations, [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf)), Sections 20.5 through 20.5.4: P9010, P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9056, P9057, and P9058.
NOTE: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047, should be obtained from the Medicare Part B drug pricing files.

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

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

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

Additional Information

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

Kentucky & Ohio

News Flash Items

- Each Office Visit is an Opportunity to Recommend Influenza Vaccination.
  Protect your patients, your staff, and yourself. Medicare Part B covers one influenza vaccination and its administration each influenza season for Medicare beneficiaries. If medically necessary, Medicare may cover additional seasonal influenza vaccinations.
  - Preventive Services Educational Tool: https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf
  - CDC Influenza website: http://www.cdc.gov/FLU/
- Raising Awareness of Diabetes in November American Diabetes Month®, Diabetic Eye Disease Month, and World Diabetes Day promote diabetes awareness and the impact of diabetes on public health. Take this opportunity to recommend appropriate Medicare preventive services for detection and treatment, including Diabetes Screening, Diabetes Self-Management Training, Medical Nutrition Therapy, and Glaucoma Screening.


- **REVISED product from the Medicare Learning Network® (MLN)**

  - “837P and Form CMS-1500” ([http://learner.mlnlms.com/Catalog/TrainingCatalog.aspx?at=T](http://learner.mlnlms.com/Catalog/TrainingCatalog.aspx?at=T)) Web-Based Training (WBT) has been revised and is now available.


- **RELEASED product from the Medicare Learning Network® (MLN)**