

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



REMINDER product from the Medicare Learning Network® (MLN)

- [“Medicare Coverage of Imaging Services”](#) Fact Sheet, ICN 907164, downloadable

MLN Matters® Number: MM8407

Related Change Request (CR) #: CR 8407

Related CR Release Date: November 6, 2013

Effective Date: January 1, 2014

Related CR Transmittal #: R2807CP

Implementation Date: January 6, 2014

## Therapy Cap Values for Calendar Year (CY) 2014

### Provider Types Affected

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

### What You Need to Know

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This article is based on Change Request (CR) 8407, which informs Medicare contractors about changes to the policy for outpatient therapy caps for CY 2014. **For physical therapy and speech-language pathology combined, the therapy cap for 2014 will be \$1,920. For occupational therapy, the cap for 2014 will be \$1,920. Make sure that your billing staffs are aware of these changes.**

### Background

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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. These limitations are commonly referred to as “therapy caps.” The therapy caps are updated each year based on the Medicare Economic Index. The Deficit Reduction Act of 2005 directed the Secretary to implement a process for exceptions to therapy caps for medically

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necessary services. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, section 603(a) of the American Taxpayer Relief Act of 2012 extended the therapy caps exception process through December 31, 2013.

## Additional Information

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The official instruction, CR 8407 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2807CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

**News Flash** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- [MLN Matters® Article #MM8433](#), "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season"
- [MLN Matters® Article #SE1336](#), "2013-2014 Influenza (Flu) Resources for Health Care Professionals"
- [HealthMap Vaccine Finder](#) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.

The CDC website for [Free Resources](#), including [prescription-style tear-pads](#) that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.

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MLN Matters® Number: SE1412

Related Change Request (CR) #: 8572

Related CR Release Date: December 27, 2013

Effective Date: January 1, 2014

Related CR Transmittal #: R2845CP

Implementation Date: January 6, 2014

## Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing

### Provider Types Affected

This MLN Matters® Special Edition Article is intended for Outpatient Prospective Payment System (OPPS) providers submitting claims to Medicare A/B Medicare Administrative Contractors (MACs) for outpatient clinical diagnostic laboratory services to Medicare beneficiaries.

### What You Need to Know

This article conveys updated requirements for Change Request (CR) 8572 which describes changes to the OPPS to be implemented in the January 2014 update. Make sure your billing staff is aware of these changes. This guidance updates the operational mechanism OPPS hospitals should use to bill Medicare on or after July 1, 2014, for outpatient clinical diagnostic laboratory tests (lab tests) furnished in CY 2014 that are eligible for separate payment under the Clinical Laboratory Fee Schedule (CLFS).

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## Background

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In the January 2014 update to the hospital OPPS (CR 8572 issued December 27, 2013), the Centers for Medicare & Medicaid Services (CMS) implemented a new policy under the CY 2014 OPPS final rule, providing packaged payment of outpatient lab tests (other than molecular pathology) under the OPPS rather than separate CLFS payment, effective for dates of service on or after January 1, 2014. In the Medicare claims system, packaged payment would apply to all lab tests (other than molecular pathology) billed by OPPS hospitals on a 013X Type of Bill (TOB) (Hospital Outpatient).

As per the OPPS final rule, CMS created very limited exceptions to the packaging policy and instructed hospitals to use the 014X TOB (Hospital Non-Patient) to obtain separate payment only in the following circumstances:

- (1) Non-patient (referred) specimen;
- (2) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or
- (3) A hospital conducts outpatient lab tests that are clinically **unrelated** to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.

In accordance with Medicare manual instructions, CMS assumed that a hospital functions as an independent laboratory in these circumstances. Therefore, hospitals could use the 014x bill used for "non-patients." In the absence of public comments indicating otherwise, CMS believed this was an appropriate use of the 014x TOB.

Since publication of the final rule and the January release of CR 8572, some hospitals expressed concern that submitting a 014x TOB in this manner may violate the Health Insurance Portability and Accountability Act. The National Uniform Billing Committee (NUBC) definition approved in 2005 for the 014x TOB for billing of laboratory services provided to "Non-Patients," means referred specimen, where the patient is not present at the hospital.

To alleviate this concern, for CY 2014 a new modifier will be used on the 013X TOB (instead of the 014X TOB) when non-referred lab tests are eligible for separate payment under the CLFS for exceptions (2) and (3) listed above. The 014x will only be used for non-patient (meaning referred) laboratory specimens (exception 1 above) and will not include this new modifier. The new modifier will be effective for claims received on or after July 1, 2014, and retroactive for dates of service on or after January 1, 2014. Please note that CMS views this new modifier as an immediate solution to hospitals' concern for CY 2014 and that we may evaluate better means to bill for laboratory services next year.

Additionally to alleviate concerns on what hospitals can do in the interim period until the new modifier is implemented on July 1, 2014, CMS, **at the request of the NUBC**, will continue to allow providers to utilize the 014x TOB during this interim period when a hospital seeks separate payment under any of the three exceptions listed above, as per the CY 2014 OPPS final rule. This will allow time for

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providers to make necessary system adjustments without having to hold claims until the July implementation.

It will continue to be the hospital's responsibility to determine when laboratory tests qualify to receive separate payment. Starting with claims received July 1, 2014, and after, when a hospital appends the new modifier to a laboratory service, the provider is attesting that exception (2) or (3) listed above is met. The requirement for all OPSS services to be submitted on a single 13x claim (other than recurring services) continues to apply. In addition, laboratory tests for molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged in the OPSS and do not require the new modifier.

**Note:** Under the CY 2014 OPSS final rule, it is optional for OPSS hospitals to seek separate payment under the CLFS for a given outpatient lab test. To minimize administrative burden, OPSS hospitals are not required to distinguish related and unrelated outpatient lab tests, and may bill "unrelated" outpatient labs on the 013X TOB prior to July 1, 2014, or on the 013X TOB without the new modifier on or after July 1, 2014, to receive packaged payment under the OPSS. Hospitals are not required to reprocess any previously submitted claims.

The table below summarizes the billing discussed above.

Condition	Claims with Dates of Service on or after January 1, 2014, and received Prior to July 1, 2014	Claims with Dates of Service on or after January 1, 2014 Received on or after July 1, 2014
(1) Non-patient (referred) specimen;	TOB 14x	TOB 14x without the new modifier
(2) A hospital collects specimen and furnishes only the outpatient labs on a given date of service;	*TOB 14x	TOB 13x and the new modifier, effective January 1, 2014
(3) A hospital conducts outpatient lab tests that are clinically <b>unrelated</b> to other hospital outpatient services furnished the same day	*TOB 14x	TOB 13x and the new modifier, effective January 1, 2014

\*The 014X TOB does not provide differential CLFS payment rates for SCHs with qualified laboratories and other OPSS hospitals. See section below for further details.

### Sole Community Hospitals (SCHs)

SCHs are paid under the OPSS. Therefore, the new OPSS packaging policies apply to SCHs as to other OPSS hospitals for laboratory and other services furnished on or after January 1, 2014. However, SCHs with qualified laboratories continue to be eligible for the 62 percent CLFS payment amount described in the "Medicare Claims Processing Manual" (Pub. 100-04 Chapter 16, Section 40.3) when they furnish outpatient lab tests that are separately payable under exceptions (2) or (3) listed above. The 014X TOB does not provide differential CLFS payment rates for SCHs with qualified laboratories and other OPSS hospitals. Qualified SCHs must submit a 013X TOB with the new

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modifier appended to separately payable outpatient lab services in order to obtain the 62 percent CLFS payment amount provided in current manual instructions. CMS recognizes that these providers may wish to cancel or adjust claims that are submitted without the new modifier prior to July 1, 2014, and submit a new 013x claim with the appended modifier after July 1, 2014, in order to receive corrected reimbursement or for other reasons when the new modifier is implemented in July.

CMS will be reviewing claims data for CY 2014 for potential inappropriate unbundling of laboratory services under the new OPSS packaging policy. As stated in the OPSS final rule, CMS does not expect changes in practice patterns under the new policy. Hospitals may not establish new scheduling patterns in order to provide laboratory services on separate dates of service from other hospital services for the purpose of receiving separate payment under the CLFS.

**Billing Scenarios for the New Modifier (on or after July 1, 2014):**

- 1) A patient goes to hospital and the hospital only collects the specimen and furnishes only laboratory services on that date of service. No other services are rendered on this date of service. It is generally appropriate to append the new modifier to the laboratory services (see example 2).
- 2) A beneficiary has a pre-surgery exam in a provider-based clinic for an outpatient cataract surgery that is scheduled in two weeks with the ophthalmologist. On the same day, while at the hospital the beneficiary goes to the hospital lab to have blood drawn for long-term psychiatric medication monitoring, by order of a community psychiatrist. In this situation, the hospital can use the new modifier to bill Medicare for separate payment under the CLFS of the lab test to monitor the patient's psychiatric medication level. However, any lab tests run by the hospital lab that day upon the order of the ophthalmologist or another physician in the ophthalmologist's group practice in preparation for the cataract surgery cannot be billed for separate payment.
- 3) The beneficiary in example 2 goes to the hospital lab to have blood drawn for long-term psychiatric medication monitoring, by order of a community psychiatrist, and has no other hospital services that day. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS of the lab test to monitor the patient's psychiatric medication level.
- 4) The beneficiary in example 2 has the pre-surgery exam in the ophthalmologist's free-standing physician office. The ophthalmologist refers the beneficiary to the hospital lab located across the street for diagnostic lab tests in preparation for the upcoming outpatient surgery. The beneficiary has to immediately return to work and chooses to have the lab work done at the hospital 2 days later. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS.
- 5) The beneficiary in example 3 goes to the hospital lab the same day to have the pre-surgical labs drawn. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS.

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As a reminder, for claims received on or after July 1, 2014, OPPS providers are instructed to submit “specimen only” services on the 014x TOB. OPPS providers are instructed not to use the new modifier on 014x TOB.

### Additional Information

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To read the article related to CR 8572, go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8572.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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**Free Resources** can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under “Programs”, select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

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REVISED products from the MLN

- [“Medicare Learning Network® \(MLN\) Suite of Products & Resources for Compliance Officers”](#), Educational Tool, ICN 908525, Downloadable only

MLN Matters® Number: MM8863

Related Change Request (CR) #: CR 8863

Related CR Release Date: August 15, 2014

Effective Date: January 1, 2015

Related CR Transmittal #: R1422OTN

Implementation Date: January 5, 2015

## Specific Modifiers for Distinct Procedural Services

### Provider Types Affected

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

### Provider Action Needed



#### STOP – Impact to You

New coding requirements related to Healthcare Common Procedure Coding System (HCPCS) modifier -59 could impact your reimbursement.



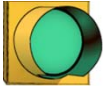
#### CAUTION – What You Need to Know

Change Request (CR) 8863 notifies MACs and providers that the Centers for Medicare & Medicaid Services (CMS) is establishing four new HCPCS modifiers to define subsets of the -59 modifier, a modifier used to define a “Distinct Procedural Service.”

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## GO – What You Need to Do

Make sure your billing staffs are aware of the coding modifier changes.

## Background

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The Medicare National Correct Coding Initiative (NCCI) has Procedure to Procedure (PTP) edits to prevent unbundling of services, and the consequent overpayment to physicians and outpatient facilities. The underlying principle is that the second code defines a subset of the work of the first code. Reporting the codes separately is inappropriate. Separate reporting would trigger a separate payment and would constitute double billing.

CR8863 discusses changes to HCPCS modifier -59, a modifier which is used to define a “Distinct Procedural Service.” Modifier -59 indicates that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled.

The -59 modifier is the most widely used HCPCS modifier. Modifier -59 can be broadly applied. Some providers incorrectly consider it to be the “modifier to use to bypass (NCCI).” This modifier is associated with considerable abuse and high levels of manual audit activity; leading to reviews, appeals and even civil fraud and abuse cases.

The primary issue associated with the -59 modifier is that it is defined for use in a wide variety of circumstances, such as to identify:

- Different encounters;
- Different anatomic sites; and
- Distinct services.

The -59 modifier is

- Infrequently (and usually correctly) used to identify a separate encounter;
- Less commonly (and less correctly) used to define a separate anatomic site; and
- More commonly (and frequently incorrectly) used to define a distinct service.

The -59 modifier often overrides the edit in the exact circumstance for which CMS created it in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.

CR8863 provides that CMS is establishing the following four new HCPCS modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 modifier:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,

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- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

CMS will continue to recognize the -59 modifier, but notes that Current Procedural Terminology (CPT) instructions state that the -59 modifier should not be used when a more descriptive modifier is available. While CMS will continue to recognize the -59 modifier in many instances, it may selectively require a more specific - X{EPSU} modifier for billing certain codes at high risk for incorrect billing. For example, a particular NCCI PTP code pair may be identified as payable only with the -XE separate encounter modifier but not the -59 or other -X{EPSU} modifiers. The -X{EPSU} modifiers are more selective versions of the -59 modifier so it would be incorrect to include both modifiers on the same line.

The combination of alternative specific modifiers with a general less specific modifier creates additional discrimination in both reporting and editing. As a default, at this time CMS will initially accept either a -59 modifier or a more selective - X{EPSU} modifier as correct coding, although the rapid migration of providers to the more selective modifiers is encouraged.

However, please note that these modifiers are valid even before national edits are in place. MACs are not prohibited from requiring the use of selective modifiers in lieu of the general -59 modifier, when necessitated by local program integrity and compliance needs.

## Additional Information

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The official instruction, CR 8863 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R14220TN.pdf> 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-Net-work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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NEW product from the Medicare Learning Network® (MLN)

- **"ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets"**  
Educational Tool (ICN 900943), downloadable

MLN Matters® Number: MM8792

Related Change Request (CR) #: CR 8792

Related CR Release Date: July 25, 2014

Effective Date: October 27, 2014

Related CR Transmittal #: R106DEMO

Implementation Date: October 27, 2014

**Affordable Care Act Bundled Payments for Care Improvement (BPCI) Initiative: Provider education regarding new demonstration codes for Skilled Nursing Facility (SNF) claims and payment of SNF claims for BPCI Model 2 beneficiaries who have not met the 3-day hospital stay requirement**

### Provider Types Affected

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This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

### What You Need to Know

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This article is based on Change Request (CR) 8792, which directs MACs to engage in provider education regarding use of a demonstration code when utilizing a waiver of the 3-day hospital stay requirement for SNF claims. Specifically, CR 8792 supports the continuing implementation of Model 2 of the Bundled Payments for Care Improvement initiative (BPCI) by informing SNFs of the policies surrounding use of the 3-day stay waiver. Make sure that your billing staffs are aware of these changes.

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## Background

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The Affordable Care Act provides a number of new tools and resources to help improve health care and lower health care costs for all Americans. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve the quality of care, and lower costs.

The Centers for Medicare & Medicaid Services (CMS) is working in partnership with providers to develop models of bundling payments through the BPCI. Section 1115A of the Social Security Act provides authority for CMS to test the BPCI models. Model 1 Awardees began the period of performance on or after April 1, 2013; Models 2, 3, and 4 Awardees began the period of performance on or after October 1, 2013.

The BPCI models link payments for multiple services that beneficiaries receive during an episode of care.

- Under Model 1, the episode includes the acute inpatient hospital stay for all Medicare fee-for-service (FFS) beneficiaries admitted for all Medicare Severity Diagnosis Related Groups (MS-DRGs).
- Under Models 2 - 4, CMMI has developed 48 clinical episodes of care that BPCI Awardees may select to test. Each episode of care is composed of a family of anchor MS-DRGs, and each Model has a different set of services included in the episode. Select clinically-unrelated readmissions are excluded from these episodes on an MS-DRG basis, and select clinically-unrelated Part B services are excluded from these episodes on a principle ICD-9 diagnosis code basis.

The following summarizes each of the models.

- In Model 1, the episode of care is defined as the acute inpatient hospital stay and includes all inpatient hospital services. Medicare pays the Awardee a discounted amount based on the payment rates established under the Inpatient Prospective Payment System (IPPS). For each performance year, the aggregate Part A and Part B expenditures on Model 1 beneficiaries in the 30-day period following discharge from the Model 1 hospitalization are calculated and compared to expected post-episode expenditures. If the aggregate Part A and Part B expenditures exceed the expected post-episode spending threshold by a calculated risk threshold, the Model 1 Awardee must repay Medicare for this Excess Spending Amount. All Model 1 Awardees are acute care hospitals paid under the IPPS.
- In Model 2, the episode of care is defined as the acute inpatient hospital stay and post-acute care and includes physician and nonphysician practitioner services, care by post-acute providers, related inpatient hospital readmissions, and other Medicare Part A and

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Part B covered services such as clinical laboratory services; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and Part B drugs. An admission to a Model 2 episode-initiating IPPS hospital, or to any IPPS hospital where the operating or attending physician is a member of a Model 2 episode-initiating physician group practice, that results in a discharge assigned to a selected MS-DRG initiates a BPCI Model 2 episode. The episode ends, at the Awardee's selection, either 30, 60, or 90 days after discharge. Payments to providers and suppliers are made at the usual fee-for-services rates through the usual claims processing, after which on a quarterly basis, the aggregate Medicare payments for services included in the episode are reconciled against a target price. The target price is set by calculating a baseline price using provider-specific historical data referenced to statewide or regional data, trending that baseline price to the performance period, and then subtracting a predetermined discount percentage from that baseline. Any reduction in expenditures beyond the discount reflected in the target price is paid to the Awardee; any expenditures above the target price must be repaid to Medicare by the Awardee. Awardees are also liable for any Excess Spending Amount. Model 2 Awardees can be Medicare providers or suppliers, or conveners of health care providers caring for Medicare fee-for-service beneficiaries in IPPS hospitals.

- In Model 3, the episode of care is defined as post-acute care including physician and nonphysician practitioner services, care by post-acute providers, related inpatient hospital readmissions, and other Medicare Part A and Part B covered services such as clinical laboratory services; DMEPOS; and Part B drugs. The episode is initiated upon admission to or initiation of post-acute services within 30 days of discharge from an IPPS hospital for a selected MS-DRG, with the Awardee's episode-initiating post-acute care provider (home health agency, skilled nursing facility, long term care hospital, or inpatient rehabilitation facility) or upon initiation of post-acute care at any post-acute care provider where the operating or attending physician for the hospitalization was a member of a Model 3 episode-initiating physician group practice. The episode ends, at the Awardee's selection, either 30, 60, or 90 days after the episode is initiated. Payments to providers and suppliers are made at the usual fee-for-services rates, through the usual claims processing, after which on a quarterly basis, the aggregate Medicare payment for the episode is reconciled against a target price. The target price is set by calculating a baseline price using provider-specific historical data referenced to statewide or regional data, trending that baseline price to the performance period, and then subtracting a predetermined discount percentage from that baseline. Any reduction in expenditures beyond the discount reflected in the target price is paid to the Awardee; any expenditures above the target price must be repaid to Medicare by the Awardee. Awardees are also liable for any Excess Spending Amount. Model 3 Awardees can be Medicare providers or suppliers, or conveners of health care providers caring for Medicare fee-for-service beneficiaries receiving post-acute services.

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- In Model 4, the episode of care is defined as the acute inpatient hospital stay and includes inpatient hospital services, Part B services furnished during the hospitalization, and hospital and Part B services furnished during related readmissions. A single, prospectively determined bundled payment is made to the episode-initiating hospital to encompass all services furnished to all beneficiaries with the selected MS-DRG during the inpatient stay by the hospital, physicians, and non-physician practitioners. Awardees are liable for any Readmissions Amount, the dollar amount of the aggregate Medicare payments made for a clinically related readmission of a Model 4 beneficiary at a hospital other than the episode-initiating hospital; any Opt-out Physicians Amount, the dollar amount of any fee-for-service payments made to physicians declining payment under Model 4 for services covered in an episode; and any Excess Spending Amount. Awardees can be Medicare providers or suppliers, or conveners of participating health care providers.

Medicare providers that provide the initial care to beneficiaries in an Episode are referred to as Episode Initiators. Episode Initiators are generally Acute Care Hospitals paid under the IPPS (under Models 1, 2, and 4) or SNFs, long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and home health agencies (HHAs) (under Model 3). Note that physician group practices (PGPs) are also eligible Episode Initiators under Models 2 and 3.

Awardees assuming financial risk under the BPCI models have signed a participation agreement with CMS, agreeing to BPCI model payment policies and obligating the Awardees to repay the Medicare Trust Funds any outstanding amounts owed, as determined at the end of each quarter. Single Awardees are those individual Medicare providers or suppliers that assume financial risk under the model and that are the sole Episode Initiator. Awardee Conveners are parent companies, health systems, or other organizations that assume financial risk under the model on behalf of other Episode Initiators, but may or may not be Episode Initiators themselves. Awardee Conveners may or may not be Medicare providers/suppliers themselves. Additionally, Facilitator Conveners are entities that serve administrative and technical assistance functions on behalf of Designated Awardees (which occupy roles identical to those of Single Awardees) and Designated Awardee Conveners (which occupy roles identical to those of Awardee Conveners).

Participants in BPCI Model 2 may qualify for a waiver of the Medicare payment policy requiring a 3-day hospital stay prior to coverage of SNF services for a given beneficiary. Under current SNF payment policy, as a prerequisite for Part A coverage of “extended care” services in a SNF, section 1861(i) of the Social Security Act (the Act) requires a beneficiary to have a qualifying hospital stay of at least 3 consecutive days (counting the day of hospital admission but not the day of discharge). For SNF claims included in an episode under Model 2, CMS may waive the 3-day hospital stay requirement. This waiver is granted on a Model 2 Awardee-specific basis, in response to an Awardee’s request to use the waiver and CMS’ determination that the Awardee meets all the associated requirements for waiver use.

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CR8792 supports the continuing implementation of Model 2 of the Bundled Payments for Care Improvement initiative by informing Medicare providers of the policies surrounding use of the 3-day stay waiver.

For Model 2 participants who qualify for use of the waiver and are granted use by CMS, the post-hospital extended care services furnished by SNFs during a Model 2 episode of care are covered under Medicare Part A in the case of Model 2 beneficiaries who are discharged from an inpatient hospital stay of less than 3 days, as long as all other coverage requirements for such services are satisfied. In order to qualify for use of the waiver, the majority of the Awardee's identified SNF partners as reported to CMS must have in effect a quality rating of 3 or more stars under the CMS 5-Star Quality Rating System, as reported on the Nursing Home Compare website, for at least 7 out of the preceding 12 months. CMS monitors the Awardee's use of this waiver to ensure that discharges to a SNF are medically appropriate and that the majority of the Model 2 beneficiaries that are discharged to a SNF after an inpatient hospital stay of less than 3 days are cared for at SNFs rated 3-stars or better.

**When submitting claims to Medicare that require a waiver of the 3-day hospital stay requirement for Part A SNF coverage, SNF billing staff must enter a "62" in the Treatment Authorization Code Field. This allows MACs to appropriately pay SNFs treating beneficiaries during Model 2 episodes.**

In order to determine if use of the demonstration code "62" is appropriate, the following circumstances must be met:

- The hospitalization must not meet the prerequisite hospital stay requirement of at least 3 consecutive days for Part A coverage of "extended care" services in a SNF. If the hospital stay would lead to covered post-acute SNF treatment in the absence of the waiver, no demonstration code should be reported by the SNF;
- Model 2 Awardee (hospital, physician group practice, or Awardee Convener) responsible for the episode-initiating hospital or physician member of the episode-initiating physician group practice has been approved by CMS to use the 3-day stay waiver for the period of time of the beneficiary's hospitalization;
- The beneficiary's discharge MS-DRG is included in a Model 2 episode selected by the episode-initiating hospital or episode-initiating physician group practice;
- The beneficiary must have been discharged from a Model 2 episode-initiating hospital or an IPPS hospital where the beneficiary was treated by a physician member of a Model 2 episode-initiating physician group practice; and
- The beneficiary must have been discharged from an IPPS hospital within 30 days of the initiation of SNF services.

Any SNF with questions about determination of the above steps should consult with the episode-initiating hospital or physician group practice to identify the Model 2 Awardee that

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has documentation from CMS applicable to the use of the waiver for episodes during a certain performance quarter.

The policies described above are enforced through the MACs, who receive quarterly updates from CMS to ensure that use of Treatment Authorization Code 62 is appropriate. If a SNF claim does not meet the above requirements, then there shall be no waiver of the 3-day stay requirement for that SNF claim.

## Additional Information

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The official instruction, CR 8792, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R106DEMO.pdf> 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.

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



Revised product from the Medicare Learning Network® (MLN)

- [“Inpatient Rehabilitation Facility Prospective Payment System”](#) Fact Sheet, ICN 006847, downloadable

MLN Matters® Number: MM8586

Related Change Request (CR) #: CR 8586

Related CR Release Date: January 24, 2014

Effective Date: December 1, 2013

Related CR Transmittal #: R13340TN

Implementation: February 25, 2014

## Occurrence Span Code 72; Identification of Outpatient Time Associated with an Inpatient Hospital Admission and Inpatient Claim for Payment

**Note:** This article was revised on April 8, 2014, to add a reference to SE1403 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1403.pdf>) that alerts providers that a focused prepayment review strategy for MACs is being implemented to review inpatient hospital Part A claims with dates of admission between October 1, 2013, and March 31, 2014, for appropriateness of inpatient admission under the revised 2-midnight benchmark. All other information is unchanged.

### Provider Types Affected

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

### Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8586 to provide clarification to hospitals regarding the billing of inpatient hospital stays and the 2-Midnight Rule, codified under the Fiscal Year 2014 Inpatient Prospective Payment System Final Rule CMS-1599-F.

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The 2-Midnight Rule allows hospitals to account for total hospital time (including outpatient time directly preceding the inpatient admission) when determining if an inpatient admission order should be written based on the expectation that the beneficiary will stay in the hospital for 2 or more midnights receiving medically necessary care. Because currently the inpatient claim only permits CMS to accurately track inpatient time after formal inpatient order and admission (i.e., utilization days/midnights), CMS would also like to use Occurrence Span Code 72 to track the total, contiguous outpatient care prior to inpatient admission in the hospital. This will enable CMS to identify claims in which the beneficiary received care as an outpatient for 1 or more midnights and was subsequently admitted as an inpatient based on the expectation that the beneficiary would require 2 or more midnights of hospital care.

## Background

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The change in billing instruction is associated with CMS-1599-F, in which CMS clarifies and modifies its guidance regarding the proper billing of inpatient hospital stays. Under the rule, surgical procedures, diagnostic tests, and other treatments (not specifically designated as inpatient-only) are generally appropriate for inpatient hospital payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses at least 2 midnights and admits the beneficiary to the hospital based on that expectation.

The final rule emphasizes the need for a formal order of inpatient admission to begin inpatient status and time, but permits the physician and the medical reviewer to consider all time a beneficiary has already spent in the hospital receiving outpatient services (including observation services and treatment in the emergency department, operating room, or other treatment area) in guiding their 2-midnight expectation. This rule is available in the Federal Register on Page 50508 at <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf> on the Internet.

The redefinition of occurrence span code 72 allows providers to voluntarily identify those claims in which the 2- midnight benchmark was met because the beneficiary was treated as an outpatient in the hospital prior to the formal inpatient order and admission. In other words, it permits providers and subsequently review contractors to identify the “*contiguous outpatient hospital services [midnights] that preceded the inpatient admission,*” as well as the total number of midnights after formal inpatient order and admission, on the face of the claim.

While MACs may still select this claim type for medical review, the use of occurrence span 72 will help support the medical record and the MAC’s review decision. Since the 2 midnight benchmark allows hospitals to account for *total* hospital time in determining if the beneficiary is expected to meet the 2 midnight benchmark, CMS has provided examples scenarios below, to illustrate circumstances in which an outpatient midnight was pertinent to the inpatient admission decision. In the future, occurrence span 72 may also be used to guide the claim selection process at CMS’ discretion.

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Examples in which the 2-Midnight Benchmark was met based on *total* (outpatient and inpatient) hospital time. CMS would like to track the outpatient time on an automated basis, using occurrence span code 72, so we may focus medical review as needed:

**Example 1:** Beneficiary is an outpatient and is receiving observation services at 10PM on 12/1/2013, and is still receiving observation services at one minute past midnight on 12/2/2013 and continues as an outpatient until admission. Beneficiary is admitted as an inpatient on 12/2/2013 at 3 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. Beneficiary is discharged on 12/3/2013 at 8AM. Total time in the hospital meets the 2 midnight benchmark.

**Example 2:** Beneficiary having arrived at the hospital and begun treatment in the ED at 8PM on 12/11/2013 is still in the Emergency Department (ED) at one minute past midnight on 12/12/2013 and continues as an outpatient until admission. The beneficiary is admitted as an inpatient on 12/12/2013 at 2 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. The beneficiary is discharged on 12/13/2013 at 8AM. Total time in the hospital meets the 2-midnight benchmark.

**Example 3:** Beneficiary in an outpatient Surgical Encounter at 6PM on 12/21/2013 is still in the Outpatient Encounter at one minute past midnight on 12/22/2013 and continues as an outpatient until admission. Beneficiary is admitted as an inpatient on 12/22/2013 at 1 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. Beneficiary is discharged on 12/23/2013 at 8AM. Total time in the hospital meets the 2 midnight benchmark.

## Additional Information

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The official instruction, CR8586, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1334OTN.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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



In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the [“mailing list for referral agents”](#) subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

MLN Matters® Number: MM8494 **Revised**

Related Change Request (CR) #: CR 8494

Related CR Release Date: January 31, 2014

Effective Date: October 1, 2014

Related CR Transmittal #: R2865CP

Implementation Date: January 6, 2014

## Changes to the Laboratory National Coverage Determination (NCD) Software for ICD-10 Codes

**Note:** This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the Change Request may not reflect the new date, CMS has made the date change. All other information is unchanged.

### Provider Types Affected

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

### Provider Action Needed

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CR8494, from which this article is taken, provides that the Laboratory National Coverage Determination (NCD) Edit Software will be updated to accommodate the processing of the

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International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes. This is a follow-up to CR8202 [Changes to the Laboratory National Coverage Determination \(NCD\) Software for ICD-10](#) (dated February 1, 2013), that extended the ICD-9 to ICD-10 implementation date to October 1, 2015. (You can find this CR at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1174OTN.pdf> on the CMS website.)

## Background

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In accordance with the "Medicare Claims Processing Manual", Chapter 16 (Laboratory Services), Section 120.2 (Implementation and Updates of Negotiated National Coverage Determinations (NCDs) for Clinical Diagnostic Laboratory Services), the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintaining codes in the negotiated NCDs and for biannual updates of the ICD-9-CM codes.

CR 8494, from which this article is taken, instructs the Medicare Shared Systems Maintainers to update the Laboratory NCD Edit Software to accommodate the processing of the ICD-10 diagnosis codes. There are no updates to the laboratory NCD code lists for this quarter.

## Additional Information

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The official instruction, CR 8494 issued to your A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2865CP.pdf> on the CMS Website.

If you have any questions, please contact your A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS Website.

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