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The defendants are charged with various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statutes, money laundering and aggravated identity theft. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services, including home health care, psychotherapy, physical and occupational therapy, durable medical equipment (DME) and pharmacy fraud. More than 44 of the defendants arrested are charged with fraud related to the Medicare prescription drug benefit program known as Part D, which is the fastest-growing component of the Medicare program overall.

“This action represents the largest criminal health care fraud takedown in the history of the Department of Justice, and it adds to an already remarkable record of enforcement,” said Attorney General Lynch.

“The defendants charged include doctors, patient recruiters, home health care providers, pharmacy owners, and others. They billed for equipment that wasn’t provided, for care that wasn’t needed, and for services that weren’t rendered. In the days ahead, the Department of Justice will continue our focus on preventing wrongdoing and prosecuting those whose criminal activity drives up medical costs and jeopardizes a system that our citizens trust with their lives. We are prepared – and I am personally determined – to continue working with our federal, state, and local partners to bring about the vital progress that all Americans deserve.”

“This Administration is committed to fighting fraud and protecting taxpayer dollars in Medicare and Medicaid,” said Secretary Burwell. “This takedown adds to the hundreds of millions we have...
saved through fraud prevention since the Affordable Care Act was passed. With increased resources that have allowed the Strike Force to expand and new tools, like enhanced screening and enrollment requirements, tough new rules and sentences for criminals, and advanced predictive modeling technology, we have managed to better find and fight fraud as well as stop it before it starts."

“Every day, the Criminal Division is more strategic in our approach to prosecuting Medicare Fraud,” said Assistant Attorney General Caldwell. “We obtain and analyze billing data in real-time. We target hot spots – areas of the country and the types of health care services where the billing data shows the potential for a high volume of fraud – and we are speeding up our investigations. By doing this, we are increasingly able to stop schemes at the developmental stage, and to prevent them from spreading to other parts of the country.”

“Health care fraud drives up health care costs, wastes taxpayer money, undermines the Medicare and Medicaid programs, and endangers program beneficiaries,” said HHS-OIG Inspector General Levinson. “Today’s takedown includes perpetrators of prescription drug fraud, home health care fraud, and personal care services fraud, three particularly harmful types of fraud plaguing our health care system. This record-setting takedown sends a message to would-be perpetrators that health care fraud is a risky way to line your pockets. Our agents and our law enforcement partners stand ready to protect these vital programs and ensure that those who would steal from federal health care programs ultimately pay for their crimes.”

The Medicare Fraud Strike Force operations are part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a joint initiative announced in May 2009 between the Department of Justice and HHS to focus their efforts to prevent and deter fraud and enforce current anti-fraud laws around the country. Since their inception in March 2007, Strike Force operations in nine locations have charged over 2,300 defendants who collectively have falsely billed the Medicare program for over $7 billion.

Including today’s enforcement actions, nearly 900 individuals have been charged in national takedown operations, which have involved more than $2.5 billion in fraudulent billings. Today’s announcement marks the first time that districts outside of Strike Force locations participated in a national takedown, and they accounted for 82 defendants charged in this takedown.

ICD 10 Procedures – Section X
“New Technology”

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2015, for all Health Insurance Portability and Accountability Act-covered entities. ICD-10-CM, including the “ICD-10-CM Official Guidelines for Coding and Reporting,” will replace International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after October 1, 2015.
ICD-10-PCS, including the “ICD-10-PCS Official Guidelines for Coding and Reporting,” will replace ICD-9-CM procedure codes. ICD-10-PCS will be used for reporting inpatient hospital procedures.

Section X New Technology is a section added to ICD-10-PCS beginning October 1, 2015. The new section provides a place for codes that uniquely identify procedures requested via the New Technology Application Process or that capture other new technologies not currently classified in ICD-10-PCS.

Section X was created in response to public comments received regarding New Technology proposals presented at ICD-10 Coordination and Maintenance Committee Meetings, and general issues facing classification of new technology procedures.

The new section is a separate place for certain new technology procedures, such as infusion of new technology drugs, and was created because the public did not support adding any more of these types of codes to the other sections of ICD-10-PCS. Section X does not introduce any new coding concepts or unusual guidelines for correct coding. In fact, Section X codes maintain continuity with the other sections in ICD-10-PCS by using the same root operation and body part values as their closest counterparts in other sections of ICD-10-PCS.

For example, the two new codes for the infusion of ceftazidime-avibactam, a new technology antibiotic that requires unique procedure codes for October 1, 2015, use the same root operation (Introduction) and body part values (Central Vein and Peripheral Vein) in section X as the infusion codes in section 3 Administration, which are their closest counterparts in the other sections of ICD-10-PCS.

In ICD-10-PCS, the information specified in the seventh character is called the qualifier, and the type of information specified depends on the section. In section X, the seventh character is used exclusively to indicate the new technology group.

The New Technology Group is a number or letter that changes each year that new technology codes are added to the system. For example, Section X codes added for the first year have the seventh character value 1, New Technology Group 1, and the next year that Section X codes are added have the seventh character value 2, New Technology Group 2, and so on. This is a much simpler use of the qualifier than in many other sections of ICD-10-PCS, such as the Medical and Surgical section.

Because it is only used to indicate the update year the code was created, there are no special coding instructions or requirements for the use of the qualifier, because all codes for a particular new technology procedure will all have the same qualifier. Therefore, the New Technology Group has no impact for correct coding. Its function is to allow the section to maintain consistency between the root operation and body part values of the other sections, as described above, and to allow the section to evolve over time, as medical technology evolves.

Section X codes are standalone codes. They are not supplemental codes. Section X codes fully represent the specific procedure described in the code title, and do not require any additional codes from other sections of ICD-10-PCS. When section X contains a code title which describes a specific new technology procedure, only that X code is reported for the procedure. There is no need to report a broader, non-specific code in another section of ICD-10-PCS.

The New Technology section codes are easily found by looking in the ICD-10-PCS Index or the Tables. In the Index, the name of the new technology device, substance or technology for a section X code is included as a main term. In addition, all codes in section X are listed under the main term New Technology.

The new technology code index entry for ceftazidime-avibactam is shown below.

**New Technology**

**Ceftazidime-Avibactam Anti-infective XWO**

In the Tables, New Technology codes are displayed like all other ICD-10-PCS tables, with a separate table for each root operation and body system. All section X codes for the root operation Introduction valid for October 1, 2015, are shown in the table on the next page:
Accreditation for Ventilators – Compliance Notice for October 1, 2015

A new MedLearn Matters Special Edition (SE 1513) article alerts providers that all items in the ventilator policy group at: https://www.dmepdac.com/ are included in the DME frequent and substantial servicing payment classification for items requiring frequent and substantial servicing, and should not be confused with Positive Airway Pressure (PAP) devices such as Continuous PAP devices or Bi-level PAP devices.

The ventilator policy group includes ventilators used with both invasive and non-invasive interfaces which are classified by law as requiring frequent and substantial servicing in order to avoid risk to the patient’s health. The Medicare monthly rental amount for these ventilators includes payment for the equipment and all related items and services necessary to ensure that the patient has access to equipment in good working order at all times. More information can be found here.

Section 1834(a)(3) of the Social Security Act defines the items requiring frequent and substantial servicing and excludes PAP devices.

PAP devices produce positive airway pressure used in the treatment of conditions specified in both National and Local Coverage Determinations, and are reimbursed as capped-rental items. These devices include both Continuous PAP devices and Bi-level PAP devices:

- **HCPCS code E0601** - Continuous positive airway pressure (CPAP) device; and
- **HCPCS code E0470** - Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g. nasal or facial mask (intermittent assist device with continuous positive airway pressure device); and
- **HCPCS code E0471** - Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)

To further distinguish ventilators from PAP devices, CMS is revising the descriptor language on the 855S application form for ventilators. This revision will also make clear that suppliers who furnish ventilators must meet all applicable requirements for accreditation such as ensuring that frequent...
and substantial servicing is provided so that the patient has access to functioning equipment at all times.

Most suppliers who currently furnish products in the ventilator policy group to Medicare beneficiaries are already in compliance with the ventilator accreditation requirements and Appendix A of the DMEPOS Quality Standards. The accreditation organizations will require all suppliers who furnish HCPCS codes in the ventilator policy group to meet accreditation requirements for items classified as frequent and substantial servicing, to ensure the beneficiary has access to functioning equipment at all times. Suppliers who submit claims with dates of service on or after October 1, 2015, must be in compliance with these accreditation requirements and Appendix A of the DMEPOS Quality Standards. After this date, Medicare suppliers furnishing products in the ventilator policy group that are not in compliance must stop furnishing these items to Medicare beneficiaries until these requirements are met.

Click to review the [DMEPOS Quality Standards Booklet](#).

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### Changes to the Laboratory National Coverage Determination (NCD) Software for July 2015

Change Request (CR) 9124 announces the changes that will be included in the July 2015 quarterly release of the edit module for clinical diagnostic laboratory services.

The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective April 1, 2003.

These changes are effective on or after October 1, 2015, for International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10). (There are no ICD-9 updates in the July update.) The four changes to the edit module follow:

- **Delete ICD-10-CM code I513** from the list of ICD-10-CM codes that are covered by Medicare for the Partial Prothrombin Time (PTT) (190.16) NCD;
- **Add ICD-10-CM code S069X3A** to the list of ICD-10-CM codes that are covered by Medicare for the Partial Prothrombin Time (PTT) (190.16) NCD;
- **Delete ICD-10-CM codes I513 and T560X4A** from the list of ICD-10-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD; and
- **Add ICD-10-CM code S069X3A** to the list of ICD-10-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.

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### ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to National Coverage Determinations

Publication 100-20, One-time Notification Transmittal 1504 Change Request 9087 is the second maintenance update of ICD-10 conversions and ICD-9 coding updates specific to national coverage.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates. 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. Make sure that your billing staffs are aware of these spreadsheets attached to CR9087 for the NCD codes on the following page:
<table>
<thead>
<tr>
<th>NCD</th>
<th>NCD Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.29</td>
<td>Hyperbaric Oxygen Therapy</td>
</tr>
<tr>
<td>20.9.1</td>
<td>Ventricular Assist Devices</td>
</tr>
<tr>
<td>50.3</td>
<td>Cochlear Implantation</td>
</tr>
<tr>
<td>80.2</td>
<td>Photodynamic Therapy</td>
</tr>
<tr>
<td>80.2.1</td>
<td>Ocular Photodynamic Therapy (OPT)</td>
</tr>
<tr>
<td>80.3</td>
<td>Photosensitive Drugs</td>
</tr>
<tr>
<td>80.3.1</td>
<td>Verteporfin</td>
</tr>
<tr>
<td>110.10</td>
<td>Intravenous Iron Therapy</td>
</tr>
<tr>
<td>150.3</td>
<td>Bone (Mineral) Density Studies</td>
</tr>
<tr>
<td>160.18</td>
<td>Vagus Nerve Stimulation</td>
</tr>
<tr>
<td>180.1</td>
<td>Medical Nutrition Therapy</td>
</tr>
<tr>
<td>210.2</td>
<td>Screening Pap Smears and Pelvic Examinations</td>
</tr>
<tr>
<td>250.3</td>
<td>Intravenous Immune Globulin for the Treatment</td>
</tr>
</tbody>
</table>

Some coding details are as follows:

1. The ICD-10 diagnosis/procedure codes associated with the NCDs attached to CR9087 are not to be implemented until October 1, 2015, or until ICD-10 is implemented.

2. 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 non-covered 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).

3. When denying claims associated with the attached NCDs, except where otherwise indicated, your MAC 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 (indicating signed ABN 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).

**NOTE:** For modifier GZ, use CARC 50 and MSN 8.81 (If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/supplier).

Click to download the entire transmittal:
FY 2016 Release of ICD-10-CM

The Fiscal Year (FY) 2016 release of ICD-10-CM is available now (FY 2016 begins Oct 1, 2015). There were no changes to the FY 2016 ICD-10-CM Tabular or Index files over the FY 2015 ICD-10-CM.

Although the FY 2016 ICD-10-CM is now available for public download and viewing, the codes in ICD-10-CM are not currently valid for any purpose or use.

On July 31, 2014, the U.S. Department of Health and Human Services issued a final rule finalizing October 1, 2015 as the new compliance date to transition to the ICD-10 code sets. The rule also requires HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

ICD-10. It’s closer than it seems.

New HCPCS Effective July 1

The July 2015 HCPCS file includes a new HCPCS code for biosimilar filgrastim, Q5101, injection, filgrastim (G-CSF), biosimilar, 1 microgram. Contractors will have until July 1, 2015 to incorporate this code into their systems, but the code will be effective for dates of service after the FDA approval of the first biosimilar version of filgrastim March 6, 2015.

The July 2015 HCPCS file also includes three additional HCPCS codes:

- **Q9977**, compounded drug, not otherwise classified (NOC) has been added with a status indicator of “N” (no additional payment, payment included in line items with APCs for incidental service)
- **Q9976**, injection, ferric pyrophosphate citrate solution, 0.1 mg of iron, is being added with status indicator E (services not paid, non-allowed item or service)
- **Q9978**, netupitant 300 mg and palonesetron 0.5mg, oral, is being added with status indicator G (additional payment for drug/biological pass-through).

Ambulatory Surgical Centers (ASCs) will have three new HCPCS Level II codes with OPPS pass-through status for reporting certain drugs and biologicals:

- **C9453** Injection, nivolumab, 1 mg
- **C9454** Injection, pasireotide long acting, 1 mg
- **C9455** Injection, siltuximab, 10 mg

CMS is also establishing a one-time new HCPCS Level II device pass-through category for the Outpatient Prospective Payment PS.

- **C2613** Lung biopsy plug with delivery system

The Payment indicator (PI) for C2613 is J7 OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced. The device offset from payment for C2613 is $24.83.

CMS will take a devices offset when C2613 is billed with CPT code 32405, Biopsy, lung or mediastinum, percutaneous needle. The ASC Code Pair file will also be used to reduce payment for procedure 32405 by 2.36 percent when billed with C2613.

CMS and ICD-10 Facts

1. *The ICD-10 transition date is October 1, 2015.*

The government, payers, and large providers alike have made a substantial investment in ICD-10. This cost will rise if the transition is delayed, and further ICD-10 delays will lead to an unnecessary rise in health care costs. Get ready now for ICD-10.

2. *You don’t have to use 68,000 codes.*

Your practice does not use all 13,000 diagnosis codes available in ICD-9. Nor will it be required to use the 68,000 codes that ICD-10 offers. As you do now, your practice will use a very small subset of the codes.
3. Outpatient and office procedure codes aren’t changing.

The transition to ICD-10 for diagnosis coding and inpatient procedure coding does not affect the use of CPT for outpatient and office coding. Your practice will continue to use CPT.

4. If you cannot submit ICD-10 claims electronically, Medicare offers several options.

CMS encourages you to prepare for the transition and be ready to submit ICD-10 claims electronically for all services provided on or after October 1, 2015. But if you are not ready, Medicare has several options for providers who are unable to submit claims with ICD-10 diagnosis codes due to problems with the provider’s system.

Each of these requires that the provider be able to code in ICD-10:

- Free billing software that can be downloaded at any time from every Medicare Administrative Contractor (MAC)
- In about ½ of the MAC jurisdictions, Part B claims submission functionality on the MAC’s provider internet portal
- Submitting paper claims, if the Administrative Simplification Compliance Act waiver provisions are met
- If you take this route, be sure to allot time for you or your staff to prepare and complete training on free billing software or portals before the compliance date.

5. Practices that do not prepare for ICD-10 will not be able to submit claims for services performed on or after October 1, 2015.

Unless your practice is able to submit ICD-10 claims, whether using the alternate methods described above or electronically, your claims will not be accepted. Only claims coded with ICD-10 can be accepted for services provided on or after October 1, 2015.

6. Reimbursement for outpatient and physician office procedures will not be determined by ICD-10 codes.

Outpatient and physician office claims are not paid based on ICD-10 diagnosis codes but on CPT and HCPCS procedure codes, which are not changing. However, ICD-10-PCS codes will be used for hospital inpatient procedures, just as ICD-9 codes are used for such procedures today. Also, ICD diagnosis codes are sometimes used to determine medical necessity, regardless of care setting.

7. Costs could be substantially lower than projected earlier.

Recent studies have found many EHR vendors are including ICD-10 in their systems or upgrades at little or no additional cost to their customers.

8. It’s time to transition to ICD-10.

ICD-10 is foundational to modernizing health care and improving quality. ICD-10 serves as a building block that allows for greater specificity and standardized data that can:

- Improve coordination of a patient’s care across providers over time
- Advance public health research, public health surveillance, and emergency response through detection of disease outbreaks and adverse drug events
- Support innovative payment models that drive quality of care
- Enhance fraud detection efforts

Visit CMS for additional information and resources:
Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability

From The Office of the Inspector General (OIG) June 9 2015

Physicians who enter into compensation arrangements such as medical directorships must ensure that those arrangements reflect fair market value for bona fide services the physicians actually provide. Although many compensation arrangements are legitimate, a compensation arrangement may violate the anti-kickback statute if even one purpose of the arrangement is to compensate a physician for his or her past or future referrals of Federal health care program business. OIG encourages physicians to carefully consider the terms and conditions of medical directorships and other compensation arrangements before entering into them.

OIG recently reached settlements with 12 individual physicians who entered into questionable medical directorship and office staff arrangements. OIG alleged that the compensation paid to these physicians under the medical directorship arrangements constituted improper remuneration under the anti-kickback statute for a number of reasons, including that the payments took into account the physicians’ volume or value of referrals and did not reflect fair market value for the services to be performed, and because the physicians did not actually provide the services called for under the agreements.

OIG also alleged that some of the 12 physicians had entered into arrangements under which an affiliated health care entity paid the salaries of the physicians’ front office staff. Because these arrangements relieved the physicians of a financial burden they otherwise would have incurred, OIG alleged that the salaries paid under these arrangements constituted improper remuneration to the physicians.

OIG determined that the physicians were an integral part of the scheme and subject to liability under the Civil Monetary Penalties Law.

Those who commit fraud involving Federal health care programs are subject to possible criminal, civil, and administrative sanctions.

For more information on physician relationships, see OIG’s “Compliance Program Guidance for Individual and Small Group Physician Practices” and OIG’s “A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse.”

CMS Announces Finalized Rules for Medicare Shared Savings Program

The Centers for Medicare & Medicaid Services (CMS) released on June 4th 2015, a final rule updating the Medicare Shared Savings Program to encourage the delivery of high-quality care for Medicare beneficiaries and build on the early successes of the program and of the Pioneer Accountable Care Organization (ACO) Model. This final rule is an effort to provide support for the care provider community in creating a delivery system with better care, smarter spending, and healthier people.

The Medicare Shared Savings Program final rule will both enhance the focus on primary care services and provide additional flexibility in the
Palmetto GBA Lands Major Medicare Contract

The federal Centers for Medicare & Medicaid Services (CMS) has named Palmetto GBA as the Medicare Administrative Contractor for Jurisdiction M, which includes North Carolina, South Carolina, Virginia and West Virginia.

The Jurisdiction M contract replaces the Jurisdiction 11 contract, which covered the same territory and has been held by Palmetto GBA since 2010. These contracts are awarded under a competitive bid process.

“Palmetto GBA works continuously to improve the administration of the Medicare program by offering innovative solutions to complex problems,” said Palmetto GBA President and Chief Operating Officer Joe Johnson. “We look forward to continuing to serve the beneficiaries and health care providers of Jurisdiction M.”

Johnson said Palmetto GBA will administer the Medicare Part A and Part B benefit in the four Jurisdiction M states. The company will also administer the home health and hospice benefit in 16 states as part of this Jurisdiction M contract.

The five-year contract will employ more than 600 administrative and professional employees within Palmetto GBA offices in Georgia, Ohio and South Carolina.

According to CMS, Jurisdiction M includes more than 3.2 million Medicare beneficiaries, more than 59,000 physicians and 327 hospitals that serve Medicare patients.

Review the Jurisdiction M Award Fact Sheet here.

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Passport Medical Necessity ICD-10-CM FAQ’s

1. **How will my facility know when the New ICD-10-CM LCD/NCD’s for my MAC Jurisdiction are available?**
   Notifications of ICD-10-CM LCD availability will be e-mailed as each state or region’s content is migrated into their product.

2. **Will I be able to view and re-screen procedures using ICD-9-CM diagnoses on and after October 1, 2015?**
   ICD-9-CM screening will be available for at least two years post the transition to ICD-10-CM and is based on the date of service entered as part of the routine workflow.

3. **Will I have to change my permissions or settings to change from screening in ICD-9-CM to ICD-10-CM?**
   No, based on the date of service the correct nomenclature will be used.

4. **Do you have any ICD-9-CM to ICD-10-CM crosswalk tools available?**
   Yes, our ICD-9-CM to ICD-10-CM Translator is available on OneSource under “Codes” for use by any Passport user. ICD-9 PCS to ICD-10 PCS translations will be also available on OneSource in the near future.
   Our ICD-9-CM to ICD-10-CM translation logic has been integrated into OrderChecker and eCare NEXT using date criteria to automatically launch diagnosis code translations the User screens for medical necessity using customary workflow.

5. **Will I need to update my PreDefined Diagnoses before October 1?**
   No, if after October 1, if an ICD-9-CM Predefined diagnosis code is selected, OrderChecker and eCare NEXT will automatically present the ICD-10-CM alternatives for selection.

6. **I have an LCD subscription with Passport; will there be any additional cost for the LCD transition to ICD-10?**
   No; all LCD subscriptions will be automatically transitioned to ICD-10 in September 2015.

7. **Will my NCCI Edit subscription be affected by the transition to ICD-10?**
   No, CCI is not affected by the transition to ICD-10-CM.