Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

June 2013

In this issue

E/M interactive worksheet improves Medicare billing for providers

Since the Centers for Medicare & Medicaid Services (CMS) eliminated consultation codes from Medicare billing in 2010, medical practices have been increasing collaboration between providers and medical billing staff to raise claim approval rates.

Billing Medicare for a patient visit requires the selection of the evaluation and management (E/M) code that best represents the level of service performed. When E/M codes replaced consultation codes, many medical practices experienced difficulty selecting correct codes and providing the medical documentation needed to justify more complex examinations.

To help providers navigate through the documentation decisions necessary for a successful E/M claim submission, First Coast Service Options Inc. (First Coast) created the *E/M interactive worksheet.*

Patricia Matthews-Davis, a billing specialist with the Jacksonville Spine Center, uses the E/M interactive worksheet in a number of ways to help the Center improve its Medicare claims billing.

"The E/M worksheet is such a helpful tool. It really helps the physician see all of the factors involved in E/M coding and how the claim is broken down," Matthews-Davis said.

Matthews-Davis recently led a meeting that included four of the center's providers and demonstrated the interactive worksheet for each of them. She walked the group through each of the interactive sections, making use of the mouse-over displays that reveal information for providers to consider as they select key factors in a patient's history of present illness, review of systems, and family history.

Matthews-Davis said the results were almost immediate. "I could see improvement in their documentation the very next day," she said.

One of the providers working with her, Tim McConnell, PA-C, a physician assistant with the Jacksonville Spine Center, agrees that the E/M interactive worksheet promotes interaction and bridges information from medical documentation of what happens in the exam room to what is recorded on the Medicare claim.

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The *Medicare A Connection* is published monthly by First Coast Service Options Inc.'s Provider Outreach & Education division to provide timely and useful information to Medicare Part A providers.

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Articles included in the *Medicare A Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

E/M interactive worksheet *(continued)*

Patricia Matthews-Davis demonstrates First Coast's E/M interactive worksheet to Tim McConnell, a physician assistant with Jacksonville Spine Center.

As an example, McConnell points to the review of systems (ROS) section of the worksheet. He explained that some patients present issues that cross over several medical systems.

"You have to conjoin them," he said, noting one patient who presented concerns that were both psychiatric and neurological." To do this, there has to be some dialogue with us," he said, looking at Matthews-Davis.

In addition to working with the medical providers to improve medical documentation, Matthews-Davis also uses the E/M interactive worksheet for prepayment audits. "I have been using the interactive worksheet to audit our new providers' E/M service and have found it to be tremendously helpful.

Having a copy of the worksheet with their documentation helps them see where changes are required and get a better understanding of how the guidelines work," she said.

First Coast has a number of online tools available for medical providers to improve their Medicare billing. To learn more about E/M services and how to use the E/M interactive worksheet with your practice, *click here*.

"The E/M worksheet is such a helpful tool. It really helps the physician see all of the factors that go into E/M coding and how the claim is broken down."

- Patricia Matthews-Davis, Jacksonville Spine Center

Checklist: Evaluation and management documentation

Medicare pays physicians based on diagnostic and procedure codes derived from medical documentation. Use this checklist as an aid to respond to medical record documentation requests pertaining to evaluation and management services:

- Be sure the medical record documentation submitted is complete and legible.
- Submit records for all dates of service on the claim under review.
- Ensure medical records submitted prove services were ordered and rendered.
- Ensure the medical records provide justification supporting medical necessity for the service by submission of the following documentation:

__ office notes
__ physician's progress notes
__ initial history and physical
__ physician's orders
__ procedure notes
__ diagnostic tests, X-rays and laboratory results
__ legible signatures of providers

Regarding consultations, for dates of service prior to January 1, 2010, include:

__ copy of request for consultation
__ written report of consultation findings

Documentation based on counseling or coordination of care, to include:

__ total time
__ amount or percent of time involved in counseling or coordination of care
__ description of the discussion

To support the level of service (code), include documentation to address the following:

__ history
__ physical exam
__ medical decision-making
__ any other documentation necessary to support medical necessity of services billed
__ documentation specifically requested in the additional documentation request (ADR) letter

Providers are encouraged to use CMS' official documentation guidelines for evaluation and management services at *https://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html*.

Time to get on board with electronic health records

Medical practices eligible for Medicare's electronic health record (EHR) incentive programs can avoid negative payment adjustments if they demonstrate meaningful use of electronic health records usage in their practice by the end of 2013.

The Centers for Medicare & Medicaid Services (CMS) recently issued a call for greater participation in the EHR program among physician practices, or eligible professionals. Eligible professionals (EP) include doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatry, doctors of optometry, and chiropractors.

According to CMS, negative payment adjustments will begin January 1, 2015. To avoid the adjustments, CMS highly encourages EPs to get started immediately and begin participation in the EHR program in 2013.

EPs who first demonstrate meaningful use for a 90-day reporting period in 2013 may avoid payment adjustments in 2015.

CMS will determine the payment adjustments based on meaningful use data submitted in 2014. The pay adjustment is 1 percent per year, and cumulative for every consecutive year that a medical practice fails to demonstrate meaningful use. Medical practices must demonstrate meaningful use each year to avoid payment adjustments in subsequent years.

EPs that plan to begin participation in 2014 must do so for a 90-day period within the first nine months of the year. EPs must attest to meaningful use no later than October 1, 2014, in order to avoid the payment adjustments.

Payment adjustments will be applied to the Medicare physician fee schedule amount for covered professional services furnished by the practice in 2015.

Health practices which began participation in 2011 or 2012 and subsequently demonstrated meaningful use, are required to continue the demonstration for a full year in 2013.

Resources

For more information on EP payment adjustments, visit the *payment adjustments and hardship exceptions tipsheet for EPs*. More information is available on the *EHR Incentive Programs website*.

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

Outpatient therapy services functional reporting testing ends June 30

As required by Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012, the Centers for Medicare & Medicaid Services (CMS) implemented a new claims-based data collection system for outpatient therapy services by requiring reporting of functional limitations with 42 new non-payable G-codes and seven new modifiers on specified claims for physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services.

The claims-based data collection system is effective for outpatient therapy services with dates of service on and after January 1, 2013.

For functional reporting, a testing period is currently in effect until June 30, 2013. During the testing period, claims without the required G-codes and severity/complexity modifiers will continue to be processed and adjudicated by your carrier or Part B Medicare administrative contractor.

As of April 1, a remittance advice message has been alerting providers about missing information on select therapy claims.

Please note: institutional claims will not receive alert messages.

Therapy claims with dates of service on or after July 1, 2013, that do not contain the required functional G-codes and corresponding modifiers will be returned or rejected, as applicable.

Please read the following *MLN Matters*® articles for more information:

MM8166: "Outpatient Therapy Functional Reporting Non-Compliance Alerts."

MM8005: "Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services -- Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012."

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

Long-term care hospital quality reporting program reminders

Provider types affected

This *MLN Matters*® special edition article is intended for long-term care hospitals (LTCH) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

If a hospital is classified as an LTCH for purposes of Medicare payments (as denoted by the last four digits of its six-digit CMS certification number (CCN) in the range of 2000–2299), it is subject to the requirements of the LTCH Quality Reporting (LTCHQR) Program.

Provider action needed

Stop – impact to you

The LTCHQR program requires Medicare-certified LTCHs to submit quality data on all patient admissions and discharges. It began October 1, 2012. For fiscal year (FY) 2014, and each subsequent year, failure to submit required quality data will result in a reduction of two percentage points in your annual payment update.

Caution – what you need to know

LTCHs were required to start collecting and submitting data on all patients admitted on or after 12:00 a.m. on October 1, 2012, for three quality measures listed in Table 1-1, shown in the *Background* section.

These data affect the payment update determination for FY 2014. For 2013 (January 1, 2013, through December 31, 2013), LTCHs must continue to collect and submit data for the three quality measures listed in Table 1-1. These data will affect the payment update determination for FY 2015.

For 2014, LTCHs must continue to collect and submit data for the three quality measures listed in Table 1-1. Additionally, for April 1, 2014, through December 31, 2014, as proposed in the FY 2014 IPPS/LTCH PPS NPRM (78 FR 27720 through 27734, 78 FR 27751 through 27755), LTCHs need to begin to collect and submit data for one new quality measure listed in Table 1-2, shown in the *Background* section.

Further, for October 1, 2014, (or earlier, if the influenza vaccine is available before October 1) through March 31, 2015, as proposed in the FY 2014 IPPS/LTCH PPS NPRM (78 FR 27720 through 27734, 78 FR 27751 through 27755), LTCHs must begin to collect and submit data for one additional quality measure listed in Table 1-3, shown in the *Background* section. These data will affect the payment update determination for FY 2016.

Go – what you need to do

Make sure that your staff reviews the *Background* section for details of the LTCHQR program and that your LTCH can comply with the LTCHQR program's reporting requirements as well as data collection, registration, and submission deadlines.

Background

The Affordable Care Act, Section 3004(a), amended Section 1886(m) of the Social Security Act (the Act), and established the LTCHQR program. Under the LTCHQR program, for rate year 2014 and each subsequent rate year, any LTCH that does not submit data to the Secretary of Health and Human Services (HHS) in accordance with the program instructions for each rate year will have its annual update to a standard federal rate for discharges for the hospital during the rate year reduced by two percentage points.

The LTCHQR program was first implemented in the FY 2012 IPPS/LTCH PPS Final Rule (76 FR 51743 through 51756, and 51780 through 51781), Section VII.C, available at *http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf*.

The Centers for Medicare & Medicaid Services (CMS) adopted three measures for data collection and reporting for October 1, 2012, through December 31, 2012, for FY 2014 and FY 2015 payment update determinations, listed in Table 1-1 on the next page.

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LTCH *(continued)*

Table 1-1. Quality measures adopted for FY 2014 and retained for FY 2015, FY 2016, and subsequent annual payment update determination by National Quality Forum (NQF) number

NQF number	Measure name
NQF #0678	Percent of residents or patients with pressure ulcers that are new or worsened (Short-Stay)
NQF #0138	National Health Safety Network (NHSN) catheter-associated urinary tract infection (CAUTI) outcome measure
NQF #0139	National Health Safety Network (NHSN) central line-associated blood stream infection (CLABSI) outcome measure

In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53614 through 53637, and 53667 through 53672), available at *http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf*, CMS retained these three measures for FY 2016 and subsequent payment update determinations, as listed in Table 1-1.

Further, CMS adopted two new measures for the FY 2016 and subsequent payment determinations, as listed in Table 1-2 and Table 1-3.

Table 1-2. Additional quality measure adopted for FY 2016 and subsequent annual payment update determination, revised implementation date of April 1, 2014, proposed in FY 2014 IPPS/LTCH NPRM

NQF number	Measure name
NQF #0680	Percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine (short-stay)

Table 1-3. Additional quality measure adopted for FY 2016 and subsequent annual payment update determination, revised implementation date of October 1, 2014, (or when the vaccine becomes available), proposed in FY 2014 IPPS/LTCH NPRM

NQF number	Measure name
NQF #0431	Influenza vaccination coverage among healthcare personnel

LTCH quality reporting program requirements for the first quarter (October 1 - December 31, 2012)

For the first quarter of reporting (affecting the FY 2014 payment update determination), all Medicare-certified LTCHs should have completed submission of data for the period October 1, 2012, through December 31, 2012, for the three measures listed in Table 1-1.

- To avoid a reduction in your annual payment update (APU), data on the NHSN catheter-associated urinary tract infection (CAUTI) outcome measure (NQF #0138) and NHSN central line-associated bloodstream infection (CLABSI) outcome measure (NQF #0139) must have been reported to Centers for Disease Control's (CDC's) NHSN no later than 11:59 p.m. on May 15, 2013. This submission deadline for October 1, 2012-December 31, 2012, data that affects the FY 2014 payment update determination has passed.
- To avoid a reduction in your APU, data on the percent of patients or residents with pressure ulcers that are new or worsened (Short-Stay) (NQF #0678) must have been reported to CMS no later than 11:59 p.m. on May 15, 2013. This submission deadline for October 1, 2012-December 31, 2012, data that will affect the FY 2014 payment update determination has passed.

LTCH quality reporting program requirements for FY 2015 payment determination

For 2013, which affects FY 2015 payment determination, LTCHs will continue reporting data on the three measures listed in Table 1-1. The timeline for submission of the quality data that will affect the FY 2015 annual payment update determination can be found in Table 1-4 below.

Table 1-4. Data collection timeframe and final submission deadline for data related to FY 2015 payment update determination

Data collection timeframe	Final submission deadline for data related to FY 2015 payment determination
Q1 (January-March 2013)	August 15, 2013

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LTCH *(continued)*

Data collection timeframe	Final submission deadline for data related to FY 2015 payment determination
Q2 (April-June 2013)	November 15, 2013
Q3 (July-September 2013)	February 15, 2014
Q4 (October-December 2013)	May 15, 2014

LTCH quality reporting program requirements for FY 2016 payment determination

For 2014, which affects FY 2016 payment determination, LTCHs will continue reporting data on the three measures listed in Table 1-1. You will also begin collecting and submitting data on the measure listed in Table 1-2 starting April 1, 2014. You will also begin collecting and submitting data on the measure listed in Table 1-3 starting October 1, 2014.

These dates were proposed in the FY 2014 IPPS/LTCH PPS NPRM (78 FR 27720 through 27734, 78 FR 27751 through 27755) available at *http://www.gpo.gov/fdsys/pkg/FR-2013-05-10/pdf/2013-10234.pdf*. The timelines for submission of the quality data that will affect the FY 2016 annual payment update determination can be found in Table 1-5, Table 1-6, and Table 1-7 below.

Table 1-5. Data collection timeframe and final submission deadline for data related to FY 2016 payment update determination for NQF #0138, NQF #0139, and NQF #0678

Data collection timeframe	Final submission deadline for data related to FY 2016 payment determination
Q1 (January-March 2014)	May 15, 2014
Q2 (April-June 2014)	August 15, 2014
Q3 (July-September 2014)	November 15, 2014
Q4 (October-December 2014)	February 15, 2015

Table 1-6. Data collection timeframe and final submission deadline for data related to FY 2016 payment update determination for NQF #0680

Data collection timeframe	Final submission deadline for data related to FY 2016 payment determination
Q2 (April-June 2014)	August 15, 2014
Q3 (July-September 2014)	November 15, 2014
Q4 (October-December 2014)	February 15, 2015

Table 1-7. Data collection timeframe and final submission deadline for data related to FY 2016 payment update determination for NQF #0431

Data collection timeframe	Final submission deadline for data related to FY 2016 payment determination
October 1, 2014 (or when vaccine becomes available)-March 31, 2015	May 15, 2015

Requirements for the data submission for LTCH quality reporting program quality measures

Submitting pressure ulcer and patient seasonal influenza vaccine data using the LTCH continuity assessment record and evaluation (CARE) data set

The LTCH CARE data set should be used as the data collection tool for the percent of patients or residents with pressure ulcers that are new or worsened (short-stay) NQF #0678 measure and the percent of residents or

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LTCH *(continued)*

patients who were assessed and appropriately given the seasonal influenza vaccine (short-stay) NQF #0680. Data collection using the LTCH CARE data set is applicable to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under the Medicare program. It is not applicable to patients receiving services in LTCH units that are not designated as LTCHs under the Medicare program.

Starting October 1, 2012, the LTCH CARE data set version 1.01 has been in use for data collection and submission of the percent of patients or residents with pressure ulcers that are new or worsened (short-stay) (NQF #0678) measure.

Information on data collection and submission of this measure using the LTCH CARE data set version 1.01 is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html*. The LTCH CARE data set version 1.01 was approved on April 24, 2012, by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act. The OMB Control Number is 0938-1163. This version will remain in effect until March 31, 2014.

Per FY 2014 IPPS/LTCH PPS proposed rule, the LTCH CARE data set version 2.01 will go into effect, if finalized, starting April 1, 2014. On February 1, 2013, the CMS solicited comments on the LTCH CARE data set version 2.01 through a 60-day public notice under the Paperwork Reduction Act (78 FR 7433 through 7434).

On April 12, 2013, the CMS solicited comments on the LTCH CARE data set version 2.01 through a 30-day notice under the Paperwork Reduction Act (78 FR 21955 through 21956). Upon receiving approval from OMB and upon finalization of the proposal in the FY 2014 IPPS/LTCH PPS proposed rule, effective April 1, 2014, the LTCH CARE data set version 2.01 will be used for data collection and submission of the percent of patients or residents with pressure ulcers that are new or worsened (short-stay) (NQF #0678) measure and the percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine (short-stay) (NQF #0680) measure.

For data collection and submission of NQF #0678 during 2013 through March 31, 2014, please refer to the LTCHQR program manual version 1.01 available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html*. On May 8, 2013, an updated draft LTCHQR program manual version 2.0 for proposed implementation date of April 1, 2014 was released. This manual includes information on data collection and submission of the NQF #0678 and NQF #0680 measures using the LTCH CARE data set version 2.01.

LTCH assessment submission entry & reporting (LASER) software is a free, Java-based application that provides an option for LTCHs to collect and maintain their LTCH CARE data set for subsequent submission to the quality improvement and evaluation systems (QIES) assessment submission and processing (ASAP) system.

For further information, including a downloadable version of LASER and LASER WebEx training videos, please refer to information available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html* and select LTCH assessment submission entry & reporting (LASER) software in the *Related Links* section.

Submitting CAUTI, CLABSI, and influenza vaccination coverage among healthcare personnel data to NHSN

The CDC NHSN should be used as the data submission for the NHSN CAUTI outcome measure (NQF #0138), NHSN CLABSI Outcome Measure (NQF #0139), and influenza vaccination coverage among healthcare personnel (NQF #0431) measure. Data for CAUTI and CLABSI measures must be submitted starting October 1, 2012, through December 31, 2012, for FY 2014 payment update determination.

Data submission for CAUTI (NQF #0138) and CLABSI (NQF #0139) measures must continue for 2013 and 2014 for FY 2015 and 2016 payment update determination, respectively. Data for influenza vaccination coverage among healthcare personnel (NQF #0431) must be submitted starting October 1, 2014, through March 31, 2015, for FY 2016 payment update determination.

Information on data collection and submission of these three measures can be found in Chapter 5 of the LTCHQR program manual version 2.00, available as a download on *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html*.

To report data for the LTCHQR program through CDC's NHSN, the LTCH must enroll in NHSN as an individual long-term acute care facility and complete several mandatory online training modules. For detailed information about how to enroll your LTCH with NHSN for the purpose of submitting quality data, please visit the NHSN LTCH page at *http://www.cdc.gov/nhsn/LTACH/enroll.html*.

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LTCH *(continued)*

The deadline for NHSN enrollment for the October 1, 2012, through December 31, 2012, data reporting quarter for FY 2014 payment update determination was December 31, 2012. If at the time of publication of this MLN article, you have not enrolled your LTCH in the CDC's NHSN, contact NHSN by e-mail at *nhsn@cdc.gov* for guidance. *Frequently asked questions* about the NHSN enrollment process are available on the CDC website.

Educational materials for the LTCH quality reporting (LTCHQR) program

You are encouraged to refer to the materials available on the LTCHQR program website. These materials, which include the LTCHQR program manual, and a current *Frequently Asked Questions* document, are available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/*.

LTCHQR Program Provider Training Slide Decks

Training slides from the May 2012 LTCH provider training conference are also available on the Internet.

- Part 1 is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient- Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-Training-Slide- Decks_Part1.zip*.
- Part 2 is available at *http://www.cms.gov/Medicare/Quality- Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-Training-Slide-Decks_Part2.zip*.

Operational guidance for LTCHs to report CLABSI data to CDC's NHSN for the purpose of fulfilling CMS' LTCH quality reporting program requirements

This is available at *http://www.cdc.gov/nhsn/PDFs/LTACH/8-6-2012-LTCH-CLABSI-Guidance.pdf*.

Operational guidance for LTCHs to report CAUTI data to CDC's NHSN for the purpose of fulfilling CMS' quality reporting program requirements

This is available at *http://www.cdc.gov/nhsn/PDFs/LTACH/8-6-2012-LTCH-CAUTI-Guidance.pdf*.

Operational Guidance for LTCHs to report long-term acute care hospital surveillance for healthcare personnel vaccination data for the purpose of fulfilling CMS' quality reporting program requirements

This is available at *http://www.cdc.gov/nhsn/LTACH/hcp-flu-vac/index.html* on the CDC website. If you would like to receive email notifications with announcements about the LTCHQR program, you may sign-up in two ways:

- Select the following link to go directly to the sign-up page *https://public.govdelivery.com/accounts/USCMS/subscriber/new* available on the Internet; or
- Go to the LTCHQR program website *http://www.cms.gov/Medicare/Quality-Initiatives- Patient-Assessment-Instruments/LTCH-Quality-Reporting/* and, under *Related Links*, select all open door forum mailing list sign-up.

Additional information

Questions and comments regarding information presented in the LTCHQR program manual should be directed to *LTCHQualityQuestions@cms.hhs.gov*.

Questions and comments related to technical submission specifications and technical issues related to the completion, submission, and correction of LTCH CARE data set should be directed to *LTCHTechIssues@cms.hhs.gov*. Questions related to accessing QIES, LTCH assessment submission entry reporting (LASER), submission and validation reports and certification and survey provider enhancement reports (CASPER), should be directed to the QIES technical support office at *help@qtso.com* or by phone at 1-800-339-9313.

For assistance with completing the National Healthcare Safety Network (NHSN) enrollment process, and for any questions related to the CLABSI, CAUTI and influenza vaccination coverage among healthcare personnel data to the NHSN, contact the Centers for Disease Control and Prevention (CDC) NHSN Helpdesk at *nhsn@cdc.gov*.

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Expedited determinations for provider service terminations

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), hospices, and skilled nursing facilities (SNFs) providing services to Medicare beneficiaries.

What you need to know

Medicare beneficiaries, or a representative acting for a beneficiary, can appeal their provider service terminations to a quality improvement organization (QIO) through the expedited determinations process. You have provider responsibilities in this process which, if not completed correctly, could impact your reimbursement.

CR 7903, from which this article is taken, provides new information to the *Medicare Claims Processing Manual*; in accordance with the 42 Code of Federal Regulations (CFR), Part 405 Medicare Program, Expedited Determination Procedures for Provider Service Terminations: Final Rule (Final Rule), published November 26, 2004. The manual addition ensures consistency with provisions of the final rule and clarifies operating instructions.

Background

Excerpts from these manual changes are summarized within this article.

Health care settings in which the expedited determination process is available to beneficiaries

This expedited determination process is available to beneficiaries whose Medicare covered services are being terminated in the following settings:

- Home health agencies (HHA)
- Comprehensive outpatient rehabilitation facilities (CORF)
- Hospice

Skilled nursing facilities (SNF), including services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy).

For example, a beneficiary exhausts their SNF Part A 100 day benefit, but remains in the facility under a private pay stay and receives covered physical and occupational therapy under Medicare Part B.

A notice of Medicare non-coverage (NOMNC) must be delivered by the SNF at the end of a Part A stay or when all of the Part B therapies are ending.

Note: Skilled nursing facilities include beneficiaries receiving Part A and B services in swing beds.

Care settings in which NOMNC delivery does not apply

The following care settings do not qualify for NOMNC delivery for termination of services:

- When beneficiary never received Medicare covered care in one of the covered settings (for example, an admission to a SNF will not be covered due to the lack of a qualifying hospital stay, or a face-to-face visit was not conducted for the initial episode of home health care);
- When services are being reduced (for example, an HHA providing physical therapy and occupational therapy discontinues the occupational therapy);
- When beneficiaries are moving to a higher level of care (for example, home health care ends because a beneficiary is admitted to a SNF);
- When beneficiaries exhaust their benefits (for example, a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit);
- When beneficiaries end care on their own initiative (for example, a beneficiary decides to revoke their Hospice benefit and return to standard Medicare coverage);
- When a beneficiary transfers to another provider at the same level of care (for example, a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay); or
- When a provider discontinues care for business reasons (for example, an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

Notice of Medicare non-coverage (NOMNC)

Medicare providers are responsible for the delivery of the NOMNC. You must deliver a NOMNC to all beneficiaries eligible for the expedited determination process, even if they agree with the termination of services.

The NOMNC is two page documents, subject to the Paperwork Reduction Act process and approval by the Office of Management and Budget (OMB). As such, it can only be modified according to its accompanying instructions, as unapproved modifications may invalidate it.

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Terminations *(continued)*

Further, while you may include your business logo and contact information at the top of the notice, this cannot cause a shift in text – the NOMNC must remain two pages. You can also include information in the optional "*Additional information*" section relevant to the beneficiary's situation. Please note that including information in this section that would normally be found in the detailed explanation of non-coverage (DENC), does not satisfy your responsibility to deliver the DENC, if otherwise required. You can find the notices and accompanying instructions online at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html*.

NOMNC preparation and delivery

When you prepare the NOMNC, you must use the OMB approved form (CMS-10123), and type or write in the appropriate fields: 1) The patient's name; 2) the Medicare patient number; 3) The type of coverage ((SNF, home health, CORF, or hospice); and 4) The effective date (last day of coverage), which is always the last day beneficiaries will receive coverage for their services.

While you may formally delegate the delivery of the notices to a designated agent such as a courier service, you should remember that all of the requirements of valid notice delivery apply to designated agents. It should be delivered to the beneficiary at least two days before Medicare covered services end, or the second to last day of service if care is not being provided daily, or no later than the next to last visit before Medicare covered services end for home health services that are being provided less frequently than daily.

Note: Beneficiaries have no liability for services received on this date, but may face charges for services received the day following the effective date of the NOMNC for home health, hospice, and CORF services. Because SNFs cannot bill the beneficiary for services furnished on the day of (but before the actual moment of) discharge, beneficiaries may leave a SNF the day after the effective date and not face liability for such services.

There are some exceptions to these required delivery timeframes:

1. You may deliver the NOMNC earlier than two days preceding the end of covered services; however, its delivery should be closely tied to the impending end of coverage;

2. You should not routinely give the notice at the time services begin, unless the services are expected to last fewer than two days; and

3. You should deliver the NOMNC sooner than two days or the next to last visit before coverage ends when a beneficiary receiving home health services is unexpectedly found to no longer be homebound, and thus ineligible for covered home health care.

Finally, you must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that they received the notice and understand that the termination decision can be disputed. If the beneficiary refuses to sign the NOMNC, you should annotate the notice to that effect and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Please note that beneficiaries who refuse to sign the NOMNC still remain entitled to an expedited determination.

You may deliver NOMNC to representatives whom the beneficiary has authorized and appointed to act on their behalf during the appeal process. A beneficiary may designate an appointed representative via the "Appointment of representative" form, the CMS-1696 which can be found at *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf*.

You should inform the representative of the beneficiary's right to appeal a coverage termination decision, and include the following information:

- The beneficiary's last day of covered services, and the date when the beneficiary's liability is expected to begin;
- The beneficiary's right to appeal a coverage termination decision;
- A description of how to request an appeal by a QIO;
- The deadline to request a review as well as what to do if the deadline is missed; and
- The telephone number of the QIO to request the appeal.

If you choose to contact the representative by telephone, the date you communicate the information is considered the NOMNC's receipt date. You should annotate the NOMNC to document the telephone contact with the beneficiary on the day that you make telephone contact, reflecting that all of the information indicated above was included in the communication. The annotated NOMNC should also include the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. You must place a dated copy of the annotated NOMNC in the beneficiary's medical file, and mail a NOMNC to the representative the day the telephone contact is made.

If you choose to communicate the information in writing, a hard copy of the NOMNC must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g. FedEx, UPS). You should keep in mind that the burden is on you to demonstrate that timely contact was attempted with the representative and that the

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Terminations *(continued)*

notice was delivered. The date that someone at the representative's address signs (or refuses to sign) the receipt is considered the date received. Place a copy of the annotated NOMNC in the beneficiary's medical file.

As an alternative to both telephone or hardcopy contact, if both you and the representative agree, you may send the notice by fax or email; however your fax and e-mail systems must meet the HIPAA privacy and security requirements.

Finally, in all cases of delivering the NOMNC, you must retain the original signed document in the beneficiary's file; and send the beneficiary copies of all notices that include all of the required information such as the effective date and covered service at issue.

Amending the NOMNC date

If you have already delivered the initial NOMNC to a beneficiary and the effective date has changed, you should amend the notice to reflect the new date; and verbally notify the beneficiary, and deliver the amended NOMNC to the beneficiary (retaining a copy in their file). Further, if an expedited determination is already in progress, you must immediately notify the QIO of the change and also provide them an amended notice.

Beneficiary responsibilities

A beneficiary who receives a NOMNC, and disagrees with the termination of services, may request an expedited determination by the appropriate QIO for the state where the services were provided. The beneficiary must contact the QIO (either by telephone or in writing) by noon of the day before the NOMNC's effective date. (If the QIO is unable to accept the request, the beneficiary must submit the request by noon of the next day the QIO is available).

The beneficiary: 1) Must be available to answer questions or supply information requested by the QIO;

2) May (but is not required to) supply additional information to the QIO that he or she believes is pertinent to the case; and 3) Must obtain a physician certification stating that failure to continue (home health or CORF services only) is likely to place his or her health at significant risk.

Without such a certification statement a QIO may not make a determination for service terminations in these settings, although the beneficiary may request an expedited determination from a QIO before obtaining this certification of risk. Once the QIO is aware of a review request, it will instruct the beneficiary on how to obtain the necessary certification from a physician.

Note: You may not bill a beneficiary who has timely filed an expedited determination for disputed services until the review process (including reconsideration by a QIO, if applicable) is complete. If the beneficiary makes an untimely request (by not meeting the timeliness requirements described above), the QIO will accept the request for review, but is not required to complete the review within its usual 72-hour deadline.

Beneficiaries have up to 60 days from the effective date of the NOMNC to make an untimely request to a QIO. When the beneficiary is still receiving services, the QIO must make a determination and notify the parties within 7 days of receipt of the request. When the beneficiary is no longer receiving services, the QIO will make a determination within 30 days of the request. You should also be aware that the coverage protections discussed above will not apply to a beneficiary who makes an untimely request to the QIO.

"When the beneficiary is still receiving services, the QIO must make a determination and notify the parties within 7 days of receipt of the request. When the beneficiary is no longer receiving services, the QIO will make a determination within 30 days of the request."

Provider responsibilities

When a QIO notifies you of a beneficiary request for an expedited determination, you must deliver the beneficiary a DENC by close of business the day they are notified, supply the QIO with copies of the NOMNC and DENCs by close of business of the day of the QIO notification, and also supply (by telephone, in writing, or electronically) all information, including medical records, that the QIO requests. If you do this by telephone, you must place a written record of the information you that you provided into the patient record.

In addition, you must (at their request) furnish the beneficiary with access to, or copies of, any documentation you provide to the QIO. You may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation, which must be provided to the beneficiary by close of business of the first day after the material is requested.

The DENC is subject to the Paperwork Reduction Act process and approval by the Office of Management and Budget. OMB-approved notices may only be modified as per their accompanying instructions. Unapproved modifications may invalidate the DENC. The DENC must contain the following information:

- A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered;
- A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review; and

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Terminations *(continued)*

- The facts specific to the beneficiary's discharge and provider's determination that coverage should end.

You should make insertions on the notice in Spanish, if necessary. If this is impossible, additional steps should be taken to ensure that the beneficiary comprehends the content of the notice. Providers may resource CMS multilingual services provided through the 1-800-MEDICARE help line if needed.

The delivery must occur in person by close of business of the day the QIO notifies you that the beneficiary has requested an expedited determination. You may also choose to deliver the DENC with the NOMNC. It does not require a signature, but should be annotated in the event of a beneficiary's refusal to sign upon delivery.

Please note that an HHA is not required to make a separate trip to the beneficiary's residence solely to deliver a DENC. Upon notification from the QIO of a beneficiary's request for an expedited determination, an HHA may telephone the beneficiary to provide the information contained on the DENC, annotate the DENC with the date and time of telephone contact, and file it in the beneficiary's records.

A hard copy of the DENC should be sent to the beneficiary via tracked mail or other personal courier method by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. The burden is on the provider to demonstrate that timely contact was attempted with the beneficiary and that the notice was delivered.

Effect of QIO determination on continuation of care

If the QIO decision extends coverage beyond a point covered by the physician's orders (either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care) providers cannot deliver care.

In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue, and be given the opportunity to reinstate orders.

The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider. The expedited determination process does not override regulatory or state requirements that physician orders are required for a provider to deliver care.

If a QIO decision is favorable to the beneficiary and the beneficiary resumes covered services, a new NOMNC should be delivered for the new course of care per the usual requirements described above. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

The QIO decision will also affect the necessity of subsequent advance beneficiary notice (ABN) deliveries.

Example 1: If covered home health care continues following a favorable QIO decision for the beneficiary, the HHA would resume issuance of home health advance beneficiary notices (HHABN) as warranted for the remainder of this home health episode. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA even though Medicare will not pay, an HHABN with option box 1(use when item (s) and/or services (s) may be provided that will not be paid for by Medicare) must be issued to the beneficiary since this would be an initiation of non-covered care.

Example 2: If covered SNF care continues, following a favorable QIO decision for the beneficiary, but later ends due to the end of Medicare coverage; and the patient wishes to continue receiving uncovered care at the SNF, a skilled nursing facility advance beneficiary notice (SNFABN) must be issued to the beneficiary.

Please keep in mind that delivery of the NOMNC does not replace the required delivery of other mandatory notices, including ABNs. Notice of delivery must be determined by the individual NOMNC requirements (per cite) and ABN delivery requirements per Section 1879 of the Social Security Act and guidance found in the *Medicare Claims Processing Manual*, Chapter 30 (Financial Liability Protections). In certain instances, both the NOMNC and an ABN may be required, whereas in others, one, two, or even no notices may be required.

Example when one notice is required: The following is an example of an instance in which only one notice may be required when Medicare covered care is ending: A beneficiary is receiving comprehensive outpatient rehabilitation facility (CORF) services, and all covered CORF care is ending. A NOMNC must be delivered at least two days, or two visits, prior to the end of coverage. If the beneficiary does not wish to continue the CORF services, an ABN should not be given.

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Terminations *(continued)*

Example when two notices are required: The following is an example of an instance in which two notices may be required when Medicare covered care is ending: A beneficiary's Part A stay is ending because a skilled level of care is no longer medically necessary and the beneficiary wishes to remain in the SNF receiving custodial-level care. The beneficiary must receive the NOMNC two days prior to the end of coverage and a SNFABN must also be delivered before custodial level care begins.

Example when no notice is required: As mentioned above, it is also possible that no notice is required when Medicare coverage is ending. The following is an example of such an instance: A beneficiary exhausts the 100-day benefit in a SNF. In this instance, neither the NOMNC nor the SNFABN should be delivered, although the latter can be issued voluntarily, as a courtesy to the beneficiary.

Finally, please keep in mind that a beneficiary for whom coverage is denied, continues to receive services of the type at issue in the expedited determination after the coverage end date, may appeal the denial within the standard claims appeal process (See the *Medicare Claims Processing Manual*, Chapter 29 Appeals of Claims Decisions), which you can find at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html*.

Additional information

You can find more information about expedited determinations for provider service terminations by going to CR 7903, located at *http://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/Downloads/R2711CP.pdf*. You will find the updated *Medicare Claims Processing Manual*, Chapter 30, as an attachment to that CR.

If you have any questions, please contact your FI or 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*.

MLN Matters® Number: MM7903
Related Change Request (CR) #: CR 7903
Related CR Release Date: May 24, 2013
Effective Date: August 26, 2013
Related CR Transmittal #: R2711CP
Implementation Date: August 26, 2013

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Seniors and caregivers urged to join the fight against fraud

In mailboxes across the country, people with Medicare will soon see a redesigned statement of their claims for services and benefits that will help them better spot potential fraud, waste, and abuse.

These newly redesigned *Medicare summary notices* are just one more way the Obama Administration is making the elimination of fraud, waste, and abuse in health care a top priority.

Because of actions like these and new tools under the Affordable Care Act, the number of suspect providers and suppliers thrown out of the Medicare program has more than doubled in 35 states.

The redesigned notice will make it easier for people with Medicare to understand their benefits, file an appeal if a claim is denied, and spot claims for services they never received. The Centers for Medicare & Medicaid Services (CMS) will send the notices to Medicare beneficiaries on a quarterly basis.

Medicare beneficiaries and caregivers are critical partners in the fight against fraud. In April of this year, CMS announced *a proposed rule* that would increase rewards – up to $9.9 million – paid to Medicare beneficiaries and others whose tips about suspected fraud lead to the successful recovery of funds.

Update on CMS anti-fraud efforts

The Affordable Care Act enabled CMS to expand efforts to prevent and fight fraud, waste and abuse. Over four years, the Obama administration recovered over $14.9 billion in healthcare fraud judgments, settlements, and administrative impositions, including record recoveries in 2011 and 2012.

Since the Affordable Care Act was implemented, CMS has revoked 14,663 providers and suppliers' ability to bill in the Medicare program since March 2011. These providers were removed from the program because they had felony convictions, were not operational at the address CMS had on file, or were not in compliance with CMS rules.

In 18 states, the number of revocations has quadrupled since CMS put the Affordable Care Act screening and review requirements in place, as well as the implementation of proactive data analysis to identify potential license discrepancies of enrolled individuals and entities. These efforts are ensuring that only qualified and legitimate providers and suppliers can provide health care products and services to Medicare beneficiaries.

The full text of this excerpted *CMS press release is available here*.

Providers with diabilities may use a rubber stamp for signature

Provider types affected

This *MLN Matters*® article is intended for all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs) and A/B Medicare administrative contractors (MACs) and durable medical equipment (DME) MACs) for services provided to Medicare beneficiaries.

What you need to know

For medical review purposes, the Centers for Medicare & Medicaid Services (CMS) requires that services ordered/provided be authenticated by a handwritten or electronic signature. With few exceptions, stamped signatures are not acceptable as described in Chapter/ Section 3.3.2.4 of the *Medicare Program Integrity Manual*. Change request (CR) 8219 adds another exception to that manual.

Under the added exception, CMS will permit the use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability.

By affixing the rubber stamp, the provider is certifying that they have reviewed the document.

Additional information

The official instruction, CR 8219 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R465PI.pdf* on the CMS website.

If you have any questions, please contact your Medicare contractor 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*.

MLN Matters® Number: MM8219
Related Change Request (CR) #: CR 8219
Related CR Release Date: May 17, 2013
Effective Date: June 18, 2013
Related CR Transmittal #: R465PI
Implementation Date: June 18, 2013

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Find fees faster: Try First Coast's fee schedule lookup

Now you can find the fee schedule information you need faster than ever before with First Coast's redesigned fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp*.

This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Update to provider enrollment section of the *Program Integrity Manual*

Note: This article was revised on May 20, 2013, to reflect an updated change request (CR). The CR removed changes that were made to Section 15.5.20 of the PIM. The CR release date, transmittal number and link to the transmittal were also changed. It was published previously in the March 2013 edition of *Medicare A Connection*, Pages 11-12. All other information remains the same.

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare carriers, A/B Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), or Medicare regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 8155 to alert providers of updates to Chapter 15 of the *Medicare Program Integrity Manual* (PIM). Chapter 15 deals with Medicare provider enrollment and CR 8155 highlights the issues below. Make sure your staff is familiar with the *Key points* of this *MLN Matters*® article.

Key points

The following are the provider enrollment issues addressed in CR 8155:

1. Owning and managing individuals: If your Medicare contractor is unsure as to whether the officers and directors/board members of the enrolling provider or supplier's corporate owner/parent also serve as the enrolling provider or supplier's officers and directors/board members, your contractor will contact you for clarification.

2. Change in address: If there is a change in correspondence or special payments address/change of electronic funds transfer (EFT) Information, your Medicare contractor may confirm the change with the contract person listed.

3. Rejections: Your Medicare contractor may reject an application that was signed more than 120 days prior to the date on which the contractor received the application—assuming the provider or supplier failed to furnish a new, appropriately-signed certification statement within 30 days of the contractor's request to do so.

4. Timeframe: Absent a CMS instruction or directive to the contrary, your Medicare contractor will send a rejection letter no later than five business days after the contractor concludes that the provider or supplier's application should be rejected.

5. Be aware: If your contractor rejects an application, it will either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.

6. Potential identity theft or other fraudulent activity: In conducting the verification activities described in Section 15.7.5 of Chapter 15, if the contractor believes that a case of identity theft or other fraudulent activity likely exists, the contractor will notify its provider enrollment operations group business function lead (PEOG BFL) at CMS immediately.

7. Non-certified suppliers and individual practitioners: Absent a CMS instruction or directive to the contrary, an approval letter under Section 15.9.1 of Chapter 15 will be sent no later than five business days after the contractor concludes that the provider or supplier meets all Medicare requirements and that his/her/its application can be approved.

8. Unsolicited additional information: Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request; rather, it is considered to be and will be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first will be processed to completion prior to the second one being processed to completion.

9. Miscellaneous policies: In situations where a provider with multiple PTANs is to be deactivated for non-billing, the contractor will only deactivate the non-billing PTAN(s).

10. Partnerships: Only partnership interests in the enrolling provider need be disclosed in section 5 of the Form CMS-855. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in section 5.

11. Processing and approval of corrective action plans (CAPs): The contractor shall process a CAP within 60

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Update to claim reconsideration section of the *Program Integrity Manual*

Provider types affected

This *MLN Matters*® article is intended for physicians, providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8222, which makes several revisions to Chapter 15 of the Centers for Medicare & Medicaid Services (CMS) *Medicare Program Integrity Manual*. The key clarification is as follows:

Sections 15.25.1.2 and 15.25.2.2 (Reconsideration Requests) are revised as follows: Consistent with 42 CFR 498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request of a provider enrollment denial or revocation at any time prior to the Hearing Officer's (HO's) decision. The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:

- The initial determination itself,
- The findings on which the initial determination was based,
- The evidence considered in making the initial determination, and
- Any other written evidence submitted under 42 CFR 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

Additional information

The official instruction, CR 8222 issued to your FI, RHHI, carrier, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R461PI.pdf*.

If you have any questions, please contact your FI, RHHI, carrier or 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*.

MLN Matters® Number: MM8222
Related Change Request (CR) #: CR 8222
Related CR Release Date: April 26, 2013
Effective Date: May 28, 2013
Related CR Transmittal #: R461PI
Implementation Date: May 28, 2013

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Update *(continued)*

days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request.

If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless stated otherwise in another CMS directive or instruction - the effective date is based on the date the supplier came into compliance with all Medicare requirements.

Additional information

You can find the official instruction, CR 8155, issued to your carrier, FI, A/B MAC, or RHHI by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R462PI.pdf* on the CMS website.

The entire revised Chapter 15 of the PIM is attached to that CR.

To review other changes to Chapter 15 issued in November of 2012, you may refer to MM8019 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8019.pdf*.

If you have any questions, please contact your carrier or 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*.

MLN Matters® Number: MM8155 (Revised)
Related Change Request (CR) #: CR 8155
Related CR Release Date: May 16, 2013
Effective Date: March 18, 2013
Related CR Transmittal #: R462PI
Implementation Date: March 18, 2013

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Change to payment liability for therapy cap denials

Section 603(c) of the American Taxpayer Relief Act of 2012 (ATRA) changed the payment liability for denials resulting from the outpatient therapy caps from beneficiaries to providers effective January 1, 2013. Medicare systems were not updated in time to accurately represent this change on provider remittance advices (RAs). Medicare contractors may have already processed therapy cap denials for services provided in 2013. These denials incorrectly report on RAs beneficiary liability (group code "PR") when liability legally rests with the provider (group code "CO").

Due to differing claim processing system constraints, this inaccurate RA reporting will be corrected beginning on different dates for different claim formats.

For institutional claims, the correct liability will be reported beginning on June 24, 2013. For professional claims, the correct liability will be reported beginning on January 1, 2014.

Since Medicare's payment amount for these claims is correct, Medicare administrative contractors will not adjust claims processed before these dates to correct the group code.

To do so could create disruptions for providers' accounts receivable. Instead, therapy providers should review any therapy cap denials for dates of service on or after January 1, 2013, to determine whether any payments have been collected from beneficiaries. Providers should refund any beneficiary payments they find for these services.

Additionally, providers should cease to collect payments for therapy cap denials unless the beneficiary was appropriately notified via an advanced beneficiary notice of noncoverage (ABN).

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

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Ocular photodynamic therapy with verteporfin for macular degeneration

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8292, which instructs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) will expand coverage of ocular photodynamic therapy (OPT) (*CPT® 67221/67225*) with verteporfin (HCPCS J3396) for "wet" age-related macular edema (AMD).

CMS is revising the requirements for testing to permit either optical coherence tomography (OCT) or fluorescein angiogram (FA) to assess treatment response. All other coverage criteria would continue to apply.

Make sure that your billing staffs are aware of these changes. Contractors will not retroactively adjust claims from April 3, 2013, through the implementation of this CR. However, contractors may adjust claims that are brought to their attention.

Background

CMS received a formal written request from the American Academy of Ophthalmology (AAO) to review and update national coverage determination (NCD) 80.3.1 (Ocular Photodynamic Therapy (OPT) with verteporfin) since this coverage decision was from 2004, prior to the emergence of targeted anti-VEGF intravitreal treatments.

These newer therapies have largely supplanted OPT as initial management of AMD and OPT is largely relegated to patients in whom the newer therapies have failed.

When the policy was written, an initial FA was ordered to determine if the lesions were considered classic choroidal neovascular (CNV) lesions. Then the patients were followed monthly with additional FAs to determine the need for retreatment. The NCD requirement for follow-up FA with OPT with verteporfin is no longer supportable for these "end-stage" patients.

(**Note**: The request specifies Section 80.3.1 of the *NCD Manual*, but the requirement for follow-up FA also appears in Sections 80.2, 80.2.1, and 80.3 of the *NCD Manual*).

CMS will expand coverage of OPT with verteporfin for "wet" AMD. CMS is revising the requirements for testing to permit either OCT or FA to assess treatment response. All other coverage criteria would continue to apply. All other coverage criteria would continue to apply.

Effective for claims with dates of service on or after April 3, 2013, Medicare shall accept, process, and pay for subsequent follow-up visits with either an FA (procedure code *92235*) or OCT (procedure codes *92133* or *92134*), prior to treatment.

Additional information

The official instruction, CR 8292, issued to your FI, carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2728CP.pdf*.

The second transmittal updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R155NCD.pdf*.

If you have any questions, please contact your carrier or 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*.

MLN Matters® Number: MM8292
Related Change Request (CR) #: CR 8292
Related CR Release Date: June 14, 2013
Effective Date: April 3, 2013
Related CR Transmittal #: R2728CP and R155NCD
Implementation Date: July 16, 2013

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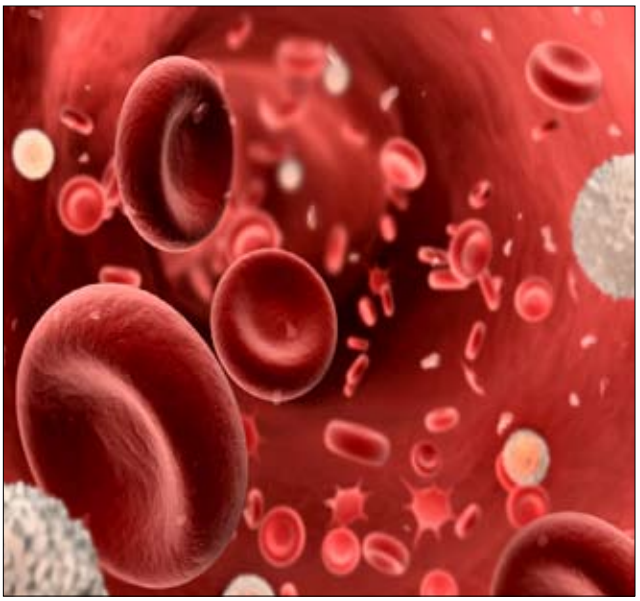
Autologous platelet-rich plasma for chronic non-healing wounds

Note: This article was revised May 24, 2013, to add a descriptor for code G0460 and June 13, 2013, to reflect changes made to change request (CR) 8213 to delete a reference to "randomized clinical trial." Also, the CR release date, transmittal numbers and the Web address for accessing the CR were also revised. This article was previously published in the March 2013 edition of *Medicare A Connection*, Pages 20-23. All other information remains the same.

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.



Provider action needed

Stop – Impact to you

If you provide Medicare beneficiaries PRP for the treatment of chronic non-healing wounds, this national coverage determination (NCD) could impact your reimbursement.

Caution – What you need to know

Effective for claims with dates of service on or after August 2, 2012, CMS will cover PRP for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only when provided under a clinical research study that meets specific requirements to assess the health outcomes of PRP for the treatment of chronic non-healing diabetic, venous and/or pressure wounds.

Go – What you need to do

Please refer to the *Background* section, below for details.

Background

PRP is produced by centrifuging a patient's own blood to yield a concentrate that is high in both platelets and plasma proteins; and includes whole white and red cells, fibrinogen, stem cells, macrophages, and fibroblasts. Frequently administered as a spray, or a gel; physicians have used it in clinical or surgical settings, for a variety of purposes such as an adhesive in plastic surgery and filler for acute wounds. In addition, it is being used, now, on chronic, non-healing cutaneous wounds that persist for 30 days or longer.

Since 1992, the Centers for Medicare & Medicaid Services (CMS) has issued national non-coverage determinations for platelet-derived wound healing formulas intended to treat patients with chronic, non-healing wounds.

In December 2003, CMS issued a national non-coverage determination specifically for the use of autologous PRP in treating chronic non-healing cutaneous wounds except for routine costs when used in accordance with the clinical trial policy defined in section 310.1 (Routine Costs in Clinical Trials (Effective July 9, 2007)) of the *National Coverage Determinations (NCD) Manual*.

Currently, as of March 2008, CMS has non-coverage determinations for the use of autologous blood-derived products for the treatment of acute wounds where PRP is applied directly to the closed incision site, and for dehiscent wounds, as well as non-coverage for chronic, non-healing cutaneous wounds.

On October 4, 2011, CMS accepted a formal request to reopen and revise Section 270.3 of the *Medicare NCD Manual*, which addresses autologous blood-derived products for chronic non-healing wounds. The request was for a reconsideration of the coverage of autologous PRP for the treatment of the following chronic wounds: diabetic, venous, and/or pressure ulcers.

It was requested that CMS cover PRP through an NCD with data collection as a condition of coverage; and requested that this would provide a practical means by which CMS could obtain the necessary data to evaluate the performance of PRP and to confirm the outcomes presented in their request.

Effective August 2, 2012, upon reconsideration, CMS determined that PRP is covered for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only

1. The patient is enrolled in a clinical trial that addresses the questions listed below using validated and reliable methods of evaluation. Clinical study applications for coverage pursuant to this NCD must be approved by August 2, 2014. Any clinical study approved by August 2, 2014, will adhere to the timeframe designated in the approved clinical study protocol. when the following

(continued on next page)

Wounds *(continued)*

conditions are met:
If there are no approved clinical studies on or before August 2, 2014, CED for PRP only for the treatment of chronic non-healing diabetic, venous and/or pressure wounds will expire.

2. The clinical research study must meet the requirements specified below to assess PRP's effect on the treatment of chronic non-healing diabetic, venous and/or pressure wounds. The clinical study must address:

Prospectively, do Medicare beneficiaries, with chronic non-healing diabetic, venous and/or pressure wounds, who receive well-defined optimal usual care along with PRP therapy, experience clinically significant health outcomes compared to patients who receive only well-defined optimal usual care for such wounds; as indicated by addressing at least one of the following:

a. Complete wound healing?

b. Ability to return to previous function and resumption of normal activities?

c. Reduction of wound size or healing trajectory which results in the patient's ability to return to previous function and resumption of normal activities?

3. The required PRP clinical trial must adhere to the following standards of scientific integrity and relevance to the Medicare population:

- Its principal purpose is to test whether PRP improves the participants' health outcomes;
- It is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;
- It does not unjustifiably duplicate existing studies;
- Its design is appropriate to answer the research question being asked in the study;
- It is sponsored by an organization or individual capable of executing the proposed study successfully;
- It is in compliance with all applicable federal regulations concerning the protection of human subjects found at 45 CFR Part 46;
- All of its aspects are conducted according to appropriate standards of scientific integrity set by the International Committee of Medical Journal Editors (*http://www.icmje.org*);
- It has a written protocol that clearly addresses,

or incorporates by reference, the standards listed here as Medicare requirements for coverage with evidence development (CED);

- It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR §312.81(a) and the patient has no other viable treatment options;
- It is registered on the ClinicalTrials.gov website (*http://www.clinicaltrials.gov/*) by the principal sponsor/investigator prior to the enrollment of the first study subject;
- Its study protocol:

a) Specifies the method and timing of public release of all pre-specified outcomes to be measured, including the release of outcomes that are negative or that the study is terminated early;

The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors (*http://www.icmje.org*). However a full report of the outcomes must be made public no later than three (3) years after the end of data collection;

b) Must explicitly discuss: 1) Subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies; 2) How the inclusion and exclusion criteria effect enrollment of these populations, and 3) A plan for the retention and reporting of said populations on the trial.

If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are

(continued on next page)

Wounds *(continued)*

necessary.

c) Explicitly discusses how the results are, or are not, expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability or Medicaid eligibility.

Note: Consistent with Section 1142 of the Social Security Act (the Act), the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that CMS determines meet the above-listed standards and address the above-listed research questions.

Coding and payment details

Healthcare Common Procedure Coding System (HCPCS) codes

Effective for claims with dates of service on or after August 2, 2012, contractors will accept and pay PRP claims, HCPCS code G0460 (Autologous PRP for ulcers), for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only in the context of an approved clinical study, when all of the following are present:

- ICD-9/ICD-10 CM diagnosis code from the list of diagnosis codes to be maintained by the contractors
- Diagnosis code V70.7 (secondary dx) (ICD-10 Z00.6)
- Condition code 30 (institutional claims only)
- Clinical trial modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved research study)
- Value Code D4 with an 8-digit clinical trial number (optional, institutional claims only)

Medicare contractors will return to provider/return as unprocessable your PRP claims that do not include ALL of this diagnosis coding and additional billing requirements. Should they return your PRP claims for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only in the context of an approved clinical study, they will use the following messages:

- CARC 16 - "Claim/service lacks information which is needed for adjudication."
- RARC M16 - "Alert: See our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision." and
- RARC MA130 – "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."

Type of bill

Your contractor will pay claims for PRP services in the following settings:

- Hospital outpatient departments type of bills (TOB) 12x and 13x based on OPPS;
- Skilled nursing facilities (SNF) TOBs 22x and 23x based on MPFS;
- Rural health clinics (RHC) TOB 71x based on all inclusive;
- Comprehensive outpatient rehabilitation facilities (CORF) TOB 75x based on MPFS;
- Federally qualified health centers (FQHC) TOB 77x based on all-inclusive,
- Critical access hospitals (CAH) TOB 85x based on reasonable cost, and
- CAHs TOB 85x and revenue codes 096x, 097x, or 098x based on MPFS.

They will pay for PRP services in Maryland hospitals under the jurisdiction of the Health Services Cost Review Commission (HSCRC) on an outpatient basis, TOB 13x, in accordance with the terms of the Maryland waiver.

Contractors will deny claims for PRP services (HCPCS code G0460) when provided on other than TOBs 12x, 13x, 22x, 23x, 71x, 75x, 77x, and 85x using:

- CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

  NOTE: Refer to the 832 healthcare policy identification segment (loop 2110 service payment information REF), if present";
- RARC N428 – "Service/procedure not covered when performed in this place of service"; and
- Group code: CO

Place of service (POS) professional claims

Effective for claims with dates of service on or after August 2, 2012, you should use place of service (POS) codes 11 (office), 22 (outpatient hospital), and 49 (independent clinic) for PRP services. Your contractor will deny all other POS codes using the following messages:

- CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service";
- RARC N428 – "Service/procedure not covered

(continued on next page)

Wounds *(continued)*

when performed in this place of service"; and

- Group code: CO.

Note: Contractors will not retroactively adjust claims from August 2, 2012, through the implementation of this CR. However, contractors may adjust claims that are brought to their attention.

Additional information

- CR 8213 is being released in two transmittals which may be found at: *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R154NCD.pdf* and
- *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2720CP.pdf*.

Both transmittals (R152NCD and R2666CP) contain a listing of relevant ICD-9 and ICD-10 diagnostic codes.

You can find information regarding clinical trials in the *Medicare Claims Processing Manual,* Chapter 32, Section 69 (Qualifying Clinical Trails), for information regarding clinical trials, at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf*.

If you have any questions, please contact your FI, carrier or 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*.

MLN Matters® Number: MM8213 (Revised)
Related Change Request (CR) #: CR 8213
Related CR Release Date: June 10, 2013
Effective Date: August 2, 2012
Related CR Transmittal #: R154NCD, R2720CP
Implementation Date: July 1, 2013

Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Medicare coverage of hepatitis B vaccine and its administration

Medicare regulations cover hepatitis B vaccine and its administration if furnished to an individual who is at high or intermediate risk of contracting hepatitis B.

The regulations were modified in 2012 to add "persons diagnosed with diabetes mellitus" under the high-risk group category for coverage under this benefit. Change request 8275 makes the *Medicare Benefit Policy Manual* provisions consistent with these modified regulatory requirements.

Procedure to diagnosis editing

As a result of the regulation changes, effective for claims with dates of service on or after June 10, 2013, *CPT*® codes *90739, 90740, 90743, 90744, 90746, 90747*, and *90748* billed without one of the following diagnosis codes will be denied, as well as the associated vaccine administration (HCPCS code G0010).

Diagnoses added to editing of hepatitis B

• 042	• 079.53	• 090.0-099.9	• 249.00-250.93
• 286.0-286.9	• 287.1	• 302.0	• 302.52
• 304.00-304.03	• 304.10-304.13	• 304.20-304.23	• 304.30-304.33
• 304.40-304.43	• 304.50-304.53	• 304.60-304.63	• 304.70-304.73
• 304.80-304.83	• 304.90-304.93	• 305.20-305.23	• 305.30-305.33
• 305.40-305.43	• 305.50-305.53	• 305.60-305.63	• 305.70-305.73
• 305.80-305.83	• 305.90-305.93	• 585.1-585.9	• V02.60-V02.69
• V02.8	• V05.3	• V08	• V11.0-V11.9
• V45.11	• V69.2		

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical coverage Web page at *http://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Contents

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an advance beneficiary notification (ABN) signed by the beneficiary. **Note:** Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

Revisions to LCDs

Doxorubicin, liposomal (Doxil/Lipodox) – revision to the Part A LCD

LCD ID number: L28827 (Florida)

LCD ID number: L28860 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for doxorubicin, liposomal (Doxil/Lipodox) was most recently revised January 1, 2013.

Since that time, based on the Centers for Medicare and Medicaid Services (CMS) change request (CR) 8286, Transmittal 2695, dated May 2, 2013 (Quarterly HCPCS Drug/Biological Code Changes), CR 8317, transmittal 2704, dated May 17, 2013 (July 2013 Integrated Outpatient Code Editor [I/OCE] Specifications), and CR 8338, transmittal 2718, dated June 7, 2013 (July 2013 update of the hospital OPPS), the "Indications and Limitations of Coverage and/or Medical Necessity" and "*CPT*®/HCPCS Codes" sections of the LCD were revised to remove HCPCS code J9002 (Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg) and replace it with HCPCS code Q2050 (Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg).

Effective date

This LCD revision is effective for services rendered **on or after July 1, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction (J9), please click *here*.

Duplex scanning – revision to the Part A LCD

LCD ID number: L28830 (Florida)

LCD ID number: L28863 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for duplex scanning was most recently revised April 16, 2013. Since that time, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add diagnosis codes 608.89 (Other specified disorders of male genital organs, other) and 608.9 (Unspecified disorder of male genital organs) for *CPT*® codes *93975* and *93976*.

Effective date

This LCD revision is effective for claims processed **on or after June 18, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction (J9), please click *here*.

Gemcitabine (Gemzar®) – revision to the Part A LCD

LCD ID number: L28847 (Florida)

LCD ID number: L28880 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for gemcitabine (Gemzar®) was most recently revised November 15, 2011. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to add the off-labeled indication of malignant pleural mesothelioma. In addition, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add diagnosis code range 163.0 -163.9 (malignant neoplasm of pleura).

Effective date

This LCD revision is effective for services rendered **on or after June 18, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction (J9), please click *here*.

Revision to LCDs

Noncovered services – revision to the Part A LCD

LCD ID number: L28991 (Florida)

LCD ID number: L29023 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for non-covered services was most recently revised June 4, 2013.

Since that time, based on the Centers for Medicare and Medicaid Services (CMS) change request (CR) 8317, transmittal 2704, dated May 17, 2013 (July 2013 integrated outpatient code editor [I/OCE] specifications) and CR 8338, transmittal 2718, dated June 7, 2013 (July 2013 update of the hospital OPPS), *CPT*® code *90686* was removed from the "Local Noncoverage Decisions-Drugs and Biologicals" section of the LCD. This LCD revision is effective for claims processed **on or after July 1, 2013**, for services rendered **on or after January 1, 2013**.

Based on CR 8338, transmittal 2718, dated June 7, 2013 (July 2013 update of the hospital OPPS), the descriptor was revised for HCPCS code C9734. This LCD revision is effective for services rendered **on or after July 1, 2013**. In addition, based on CR 5969, transmittal 1483, dated March 25, 2008 (April 2008 integrated outpatient code editor [I/OCE] specifications), HCPCS code J7307 was removed from the "Local Noncoverage Decisions – Devices" section of the LCD.

This LCD revision is effective for claims processed **on or after July 1, 2013**, for services rendered **on or after January 1, 2008**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction (J9), please click *here*.

Vinorelbine tartrate (Navelbine®) – revision to the Part A LCD

LCD ID number: L29004 (Florida)

LCD ID number: L29036 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for vinorelbine tartrate (Navelbine®) was effective for services rendered on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to add the off-labeled indication of malignant pleural mesothelioma. In addition, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add diagnosis code range 163.0-163.9 (malignant neoplasm of pleura).

Effective date

This LCD revision is effective for services rendered **on or after June 18, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction (J9), please click *here*.

First Coast Service Options Inc provides current and draft local coverage determinations (LCDs), when they exist, for Medicare-covered procedure codes. Not every procedure code is covered by an LCD. *Click here* **to look up current LCDs**

Bisphosphonates intravenous (IV) and monoclonal antibodies in osteoporosis treatment and other indications – revision to the Part A LCD

LCD ID number: L32110 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates intravenous (IV) and monoclonal antibodies in the treatment of osteoporosis and their other indications was most recently revised September 1, 2012.

Since that time, based on the Centers for Medicare and Medicaid Services (CMS) change request (CR) 8286, transmittal 2695, dated May 2, 2013 (Quarterly HCPCS Drug/ Biological Code Changes), CR 8317, transmittal 2704, dated May 17, 2013 (July 2013 Integrated Outpatient Code Editor [I/OCE] Specifications), and CR 8338, transmittal 2718, dated June 7, 2013 (July 2013 update of the hospital OPPS), the status indicators for HCPCS codes J3487 and J3488 were changed to an "E" (not payable by Medicare). HCPCS codes J3487 and J3488 were replaced with new HCPCS code Q2051.

Therefore, the "*CPT*®/HCPCS Codes" and "ICD-9 Codes that Support Medical Necessity" sections of the LCD were updated to remove HCPCS codes J3487 and J3488 and add HCPCS code Q2051.

Effective date

This LCD revision is effective for services rendered **on or after July 1, 2013**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction (J9), please click *here*.

Additional information

C9285: Synera™ topical patch

Synera™ (lidocaine 70 mg/tetracaine 70 mg) topical patch (HCPCS code C9285) is indicated for use on intact skin to provide local dermal analgesia for superficial venous access and superficial dermatological procedures such as excision, electrodessication and shave biopsy of skin lesions.

Based on literature review and review of the Food and Drug Administration (FDA) approval letter/clinical pharmacology information, it has been determined that effective for claims processed **on or after May 30, 2013**, for services rendered **on or after May 28, 2013**, Synera™ topical patch is considered noncovered because it is not deemed a "medical necessity" by the payer.

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

July 2013 integrated outpatient code editor specs version 14.2

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and A/B Medicare administrative contractors (MACs)) for outpatient services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency not under the home health prospective payment system or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider action needed

This article is based on CR 8317, which describes changes to the I/OCE and OPPS to be implemented in the July 2013 OPPS and I/OCE updates.

Be sure your billing staff is aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

The full list of I/OCE specifications can now be found at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html* on the Centers for Medicare & Medicaid Services (CMS) website.

There is a summary of the changes for July 2013 in Appendix M of Attachment A of CR 8317 and that summary is captured in the following key points.

Key points of CR 8317

- Effective August 2, 2012, Medicare will implement mid-quarter NCD approval coverage for code G0460. Edit 68 is affected.
- Effective July 1, 2013, Medicare will make HCPCS/APC/SI changes as specified by CMS (data change files).
- Effective July 1, 2013, Medicare will update the skin substitute product list.
- Effective July 1, 2013, Medicare will implement version 19.2 of the NCCI (as modified for applicable institutional providers). Edits 20 and 40 are affected.
- Effective January 1, 2013, Medicare will update procedure/device edit requirement. Edit 71 is affected.
- Effective July 1, 2013, Medicare will add new modifier JE (Administered Via Dialysate) to the list of valid modifiers. Edit 22 is affected.

Additional information

The official instruction, CR 8317 issued to your FI, RHHI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2724CP.pdf* on the CMS website.

If you have any questions, please contact your FI, RHHI or 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*.

MLN Matters® Number: MM8317
Related Change Request (CR) #: CR 8317
Related CR Release Date: June 12, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2724CP
Implementation Date: July 1, 2013

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Claim status category and claim status codes update

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME/MACs) and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8320 which requires Medicare contractors to use only national code maintenance committee-approved claim status category codes and claim status codes when sending Medicare healthcare status responses (277 transactions) to report the status of your submitted claim(s). Proprietary codes may not be used in the x12 276/277 to report claim status.

All code changes approved during the June 2013 Committee meeting will be posted on or about July 1, 2013, 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*. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national code maintenance committee-approved claim status category codes and Claim Status Codes to explain the status of submitted claims. These codes, which have been adopted as the national standard to explain the status of submitted claim(s), are the only such codes permitted for use in the x12 276/277 health care claim status request and response format.

The national code maintenance committee meets three times each year (February, June, and October) in conjunction with the accredited standards committee (ASC) x12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes.

The committee has decided to allow the industry six months for implementation of the newly added or changed codes. Therefore, on the date of implementation of CR 8320 (October 7, 2013), your Medicare contractor must:

1. Complete the entry of all applicable code text changes and new codes;
2. Terminate the use of deactivated codes;
3. Use these new codes for editing all x12 276 transactions and reflect them in the x12 277 transactions that they issue.

Additional information

The official instruction, CR 8320 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2713CP.pdf*.

If you have any questions, please contact your Medicare contractor 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*.

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Related Change Request (CR) #: CR 8320
Related CR Release Date: May 24, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2713CP
Implementation Date: October 7, 2013

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Coding requirements for laboratory specimen collection update

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8339, which advises you that the current Centers for Medicare & Medicaid Services (CMS) instructions found at the *Medicare Claims Processing Manual*, Chapter 16, Section 60.1.4, are being updated due to questions received from the laboratory industry.

The CR corrects the codes listed in the manual for claims for laboratory specimen collection services. There is no change in policy or in claims processing. CMS is just updating the manual.

Background

Current CMS instructions have a terminated code listed in the manual for the routine venipuncture for collection of specimens.

CMS is releasing this update to these manual instructions to list the active code and address questions received from the laboratory industry. Since the fee schedules and systems were updated when the coding change occurred, there is no need to include any system or fee schedule updates.

The *Medicare Claims Processing Manual*, Chapter 16, Section 60.1.4 - Coding Requirements for Specimen Collection, is revised to add the following:

"The following Health Care Common Procedure Coding System (HCPCS) codes and terminology must be used:

- *36415 - Collection of venous blood by venipuncture*
- P96l5 - Catheterization for collection of specimen(s)"

The allowed amount for specimen collection in each of the above circumstances is included in the laboratory fee schedule distributed annually by CMS.

Additional information

The official instruction, CR 8339 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2730CP.pdf*.

If you have any questions, please contact your Medicare contractor 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*.

MLN Matters® Number: MM8339
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Implementation Date: July 16, 2013

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Change in electronic remittance advice for inpatient claims

Medicare Part A electronic remittance advices generated on or after July 22, 2013, will no longer include service line payment information on inpatient claims.

Based on instruction in the *835 Health Care Claim Payment/Advice Implementation Guide*, service line payment information is not supported for inpatient claims. All claim adjustment information will be reported at the claim level.

If providers have an automated process for posting inpatient Part A claims, a change may be required on your part to accept the modified remittance advice. This change is applicable to inpatient claims, type of bill 11x; skilled nursing facility claims, type of bills 18x, 21x, 28x, and 51x; and religious non-medical hospital claims, type of bill 41x.

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

October 2013 average sales price Medicare Part B drug pricing files

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries, carriers, regional home health intermediaries, durable medical equipment Medicare administrative contractors and A/B Medicare administrative contractors) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8340 which instructs Medicare contractors to download and implement the October 2013 average sales price (ASP) drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the July 2013, April 2013, January 2013, and October 2012 ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 7, 2013, with dates of service October 1, 2013, through December 31, 2013. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Make sure that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA) Section 303(c) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The average sales price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf*.) The following table shows how the quarterly payment files will be applied:

Files	Effective Dates of Service
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012

Note: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

Additional information

The official instruction, CR 8340 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2715CP.pdf*.

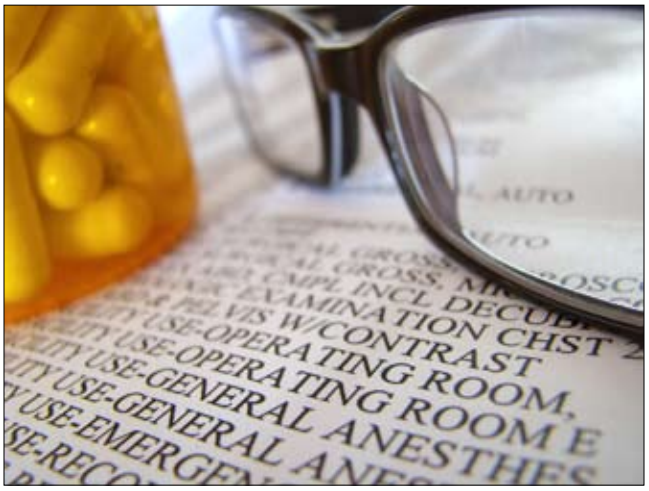
If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8340
Related Change Request (CR) #: CR 8340
Related CR Release Date: May 31, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2715CP
Implementation Date: October 7, 2013

Annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

Provider types affected

This *MLN Matters*® article is intended for Medicare hospitals submitting claims to fiscal intermediaries (FIs) and Part A Medicare administrative contractors (A MACs) for inpatient services to Medicare beneficiaries.



Provider action needed

Change request (CR) 8355, from which this article is taken, provides your FI or A MAC their annual reminder of the ICD-9-CM update that is effective for dates of service (or for inpatient discharge dates) on and after October 1, 2013.

Background

ICD-9 information

Effective October 1, 2003, ICD-9-CM codes are required for all paper and electronic claims that you bill to Medicare contractors including ambulance claims (specialty type 59) submitted in the 5010 electronic claim format.

Additionally, ICD-9-CM codes are required for all professional claims (for example, for physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs)), and for all institutional claims. They are not required for ambulance supplier claims. Finally, ICD-9-CM procedure codes are required for inpatient hospital Part A claims only.

Note: The Centers for Medicare & Medicaid Services (CMS) updates the ICD-9-CM codes annually, and posts the new, revised, and discontinued ICD-9-CM diagnosis codes at *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/summarytables.html*.

Partial code freeze for ICD-9-CM and ICD-10

The ICD-9-CM Coordination and Maintenance Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10. (Refer to *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/Downloads/Partial_Code_Freeze.pdf*.)

As a result of this partial code freeze, CR 8355 is adding only changes to ICD-9-CM procedure codes. There are no new diagnosis codes for fiscal year 2014. Please be aware, also, that this change does not affect B MACs or durable medical equipment Medicare administrative contractors (DME MAC).

ICD code changes

1. Your FI or A MAC will accept the following new ICD-9-CM procedure codes for claims with inpatient hospital discharges on or after October 1, 2013.

ICD-9-CM Code	Description
00.96	Infusion of 4-Factor Prothrombin Complex Concentrate Infusion of 4F-PCC
14.81	Implantation of epiretinal visual prosthesis
14.82	Removal of epiretinal visual prosthesis
14.83	Revision or replacement of epiretinal visual prosthesis

2. Your FI or A MAC will be aware of the following new exclusion for ICD-9-CM procedure code 99.06, for inpatient hospitals claims with discharges on or after October 1, 2013.

ICD-9-CM Code	Description
99.06	Transfusion of coagulation factors

(continued on next page)

ICD-9 *(continued)*

3. Your FI or A MAC will note that the appropriate ICD-10 codes are listed below. They will track the ICD-10 code/edits (and add the codes/edits to their system when applicable), and ensure that the updated edit is functional as part of the ICD-10 implementation.

ICD-10 Code	Description
30280B1	Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Open Approach
30283B1	Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Percutaneous Approach
08H005Z	Insertion of Epiretinal Visual Prosthesis into Right Eye, Open Approach
08H105Z	Insertion of Epiretinal Visual Prosthesis into Left Eye, Open Approach
08P00JZ	Removal of Synthetic Substitute from Right Eye, Open Approach
08P10JZ	Removal of Synthetic Substitute from Left Eye, Open Approach
08W00JZ	Revision of Synthetic Substitute in Right Eye, Open Approach
08W10JZ	Revision of Synthetic Substitute in Left Eye, Open Approach

For more information pertaining to ICD-10, please see *http://www.cms.gov/Medicare/Coding/ICD10/index.html*.

As mentioned earlier, the updated diagnosis and procedure codes are effective for dates of service/discharges on and after October 1; and you can view the new updated codes, in June, at *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/summarytables.html*. You can also visit the National Center for Health Statistics (NCHS) website at *http://www.cdc.gov/nchs/icd.htm*; where the new ICD-9-CM Addendum will be posted, also in June.

Additional information

The official instruction, CR 8355 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2727CP.pdf*.

If you have any questions, please contact your Medicare contractor 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*.

MLN Matters® Number: MM8355
Related Change Request (CR) #: CR 8355
Related CR Release Date: June 14, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2727CP
Implementation Date: October 7, 2013

Institutional services split claims ICD-10 billing instructions

Provider types affected

This *MLN Matters*® special edition article is intended for providers who submit claims to fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

SE1325 clarifies the policy for processing claims for certain institutional encounters that span the International Classification of Diseases, 10th Edition (ICD-10) implementation date of October 1, 2014.

Background

In this special edition article, the Centers for Medicare & Medicaid Services (CMS) clarifies the policy for processing split claims for certain institutional encounters that span the ICD-10 implementation date (that is, when ICD-9 codes are effective for that portion of the services rendered on September 30, 2014, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2014, and later)

The following excerpt from a table in change request (CR) 7492 provides you further guidance for such split claims. (You can find the associated *MLN Matters*® article, MM7492, Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10), which was released on August 19, 2011 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7492.pdf*.)

Table A – Institutional providers

Bill type	Facility type/ services	Claims processing requirement	Use FROM or THROUGH Date
12x	Inpatient Part B hospital services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
13x	Outpatient hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
14x	Non-patient laboratory services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
22x	Skilled nursing facilities (Inpatient Part B)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

(continued on next page)

ICD-10 *(continued)*

Bill type	Facility type/ services	Claims processing requirement	Use FROM or THROUGH Date
23x	Skilled Nursing Facilities (Outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
34x	Home Health – (Outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
71x	Rural Health Clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
72x	End Stage Renal Disease (ESRD)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
74x	Outpatient Therapy	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
75x	Comprehensive Outpatient Rehab facilities	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later	FROM
76x	Community Mental Health Clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

(continued on next page)

ICD-10 *(continued)*

Bill type	Facility type/ services	Claims processing requirement	Use FROM or THROUGH Date
77x	Federally qualified health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
81x	Hospice-hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
82x	Hospice – non hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
85x	Critical access hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

Important details

1. Please note that creating multiple/interim claims on a single encounter is not a new concept, and that these instructions will apply to relatively few claims per institution because only claims that span this single implementation date (October 1, 2014) will be impacted.

2. When you split claims for an encounter spanning the ICD-10 implementation date, remember to maintain all charges with the same line item date of service (LIDOS) on the correct corresponding claim for the encounter.

- Single item services whose time-frame cross over midnight on September 30, 2014 (e.g., emergency room visits and observation) are not split into 2 separate charges, rather the single item service should be placed in the claim based upon the LIDOS: 1) For ER encounters the LIDOS is the date the patient enters the ER; and 2) for observation encounters it is the date that observation care begins.
- (Please refer to the *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (including inpatient hospital Part B and OPPS)), Sections 180.6 emergency room (ER) Services That Span Multiple Service Dates and 290.2.2 (Reporting Hours of Observation for observation services); respectively, for more information about Emergency Department and observation claims. You can find this manual at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.
- If there is no service for the encounter with a LIDOS on the split claim with an October 2014 date, do not send an October 2014 claim to Medicare for payment.
- If there are services with a LIDOS on the split claim with an October date, but there is no payment allowed on any of the charges (i.e., all charges are packaged), you should maintain a log of these charges for cost reporting purposes.

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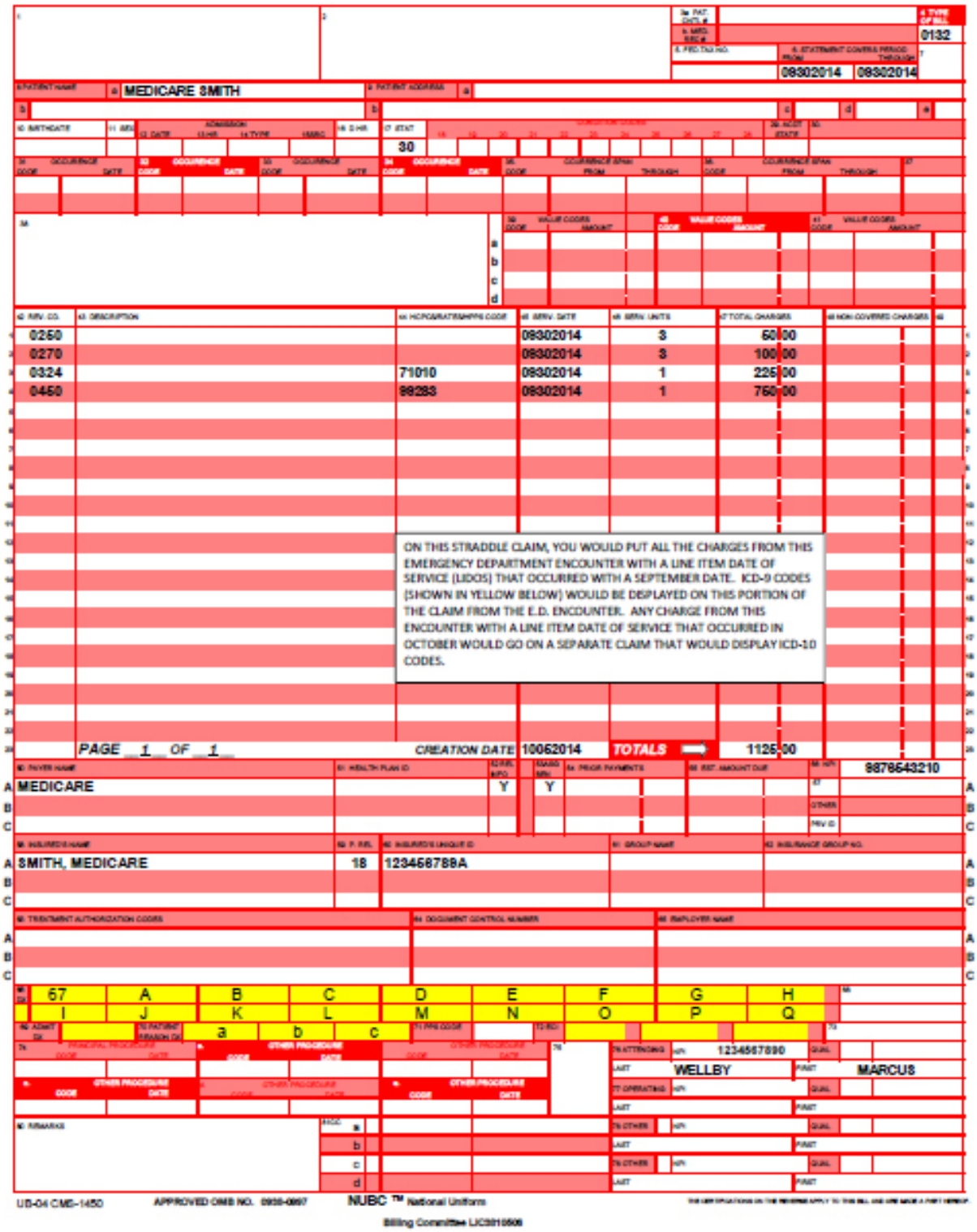
ICD-10 *(continued)*

Claim examples

Emergency department and observation service encounters are the most common scenarios for which CMS has received requests for clarification about interim billing.

The following ED and observation service examples are provided to help you better understand the split billing concept. This concept can be applied to any of the encounters that require split billing.

Example 1A: ED Visit Encounter – 1st Claim



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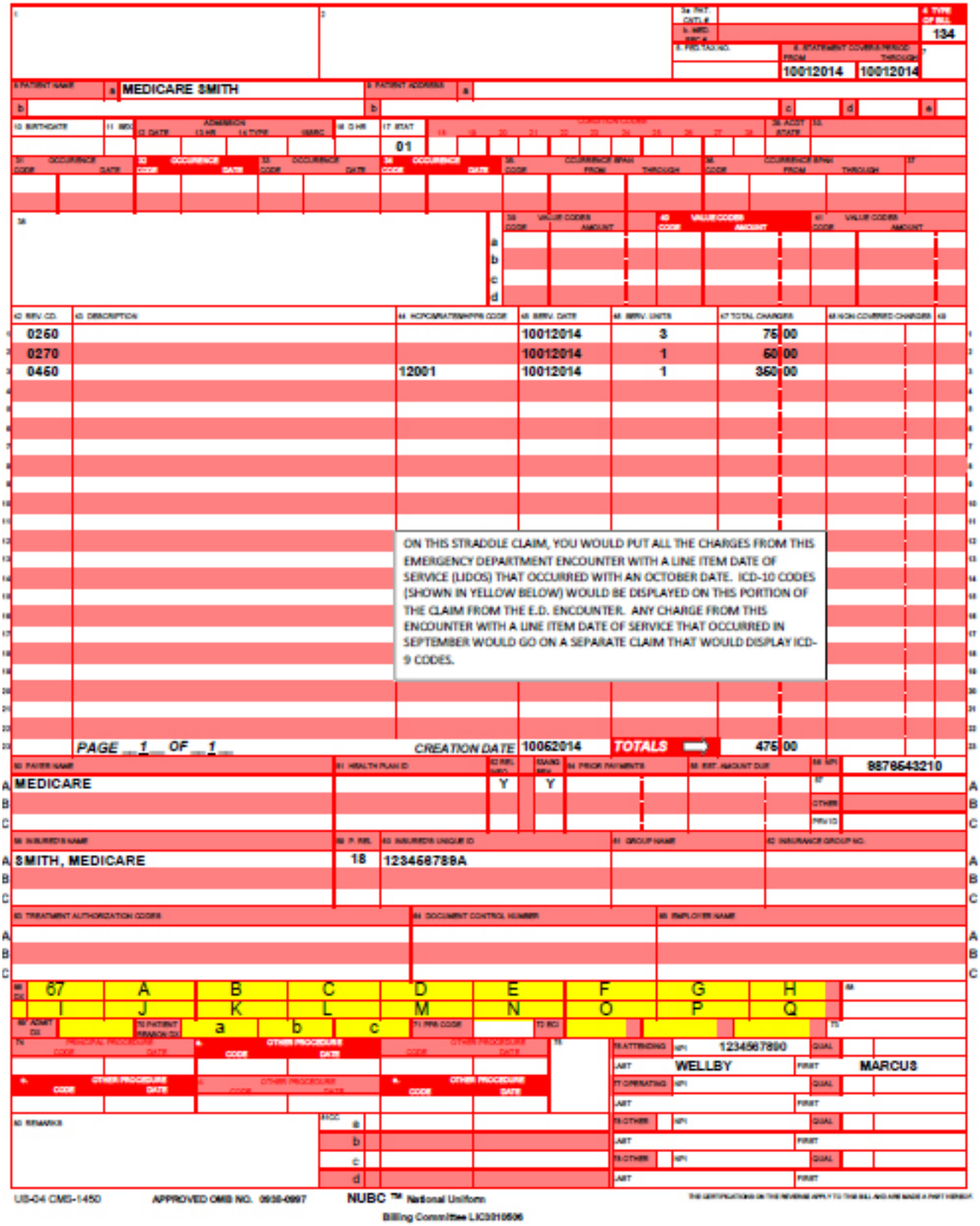
ICD-10 *(continued)*

Example 1B: ED Visit Encounter – 2nd Claim



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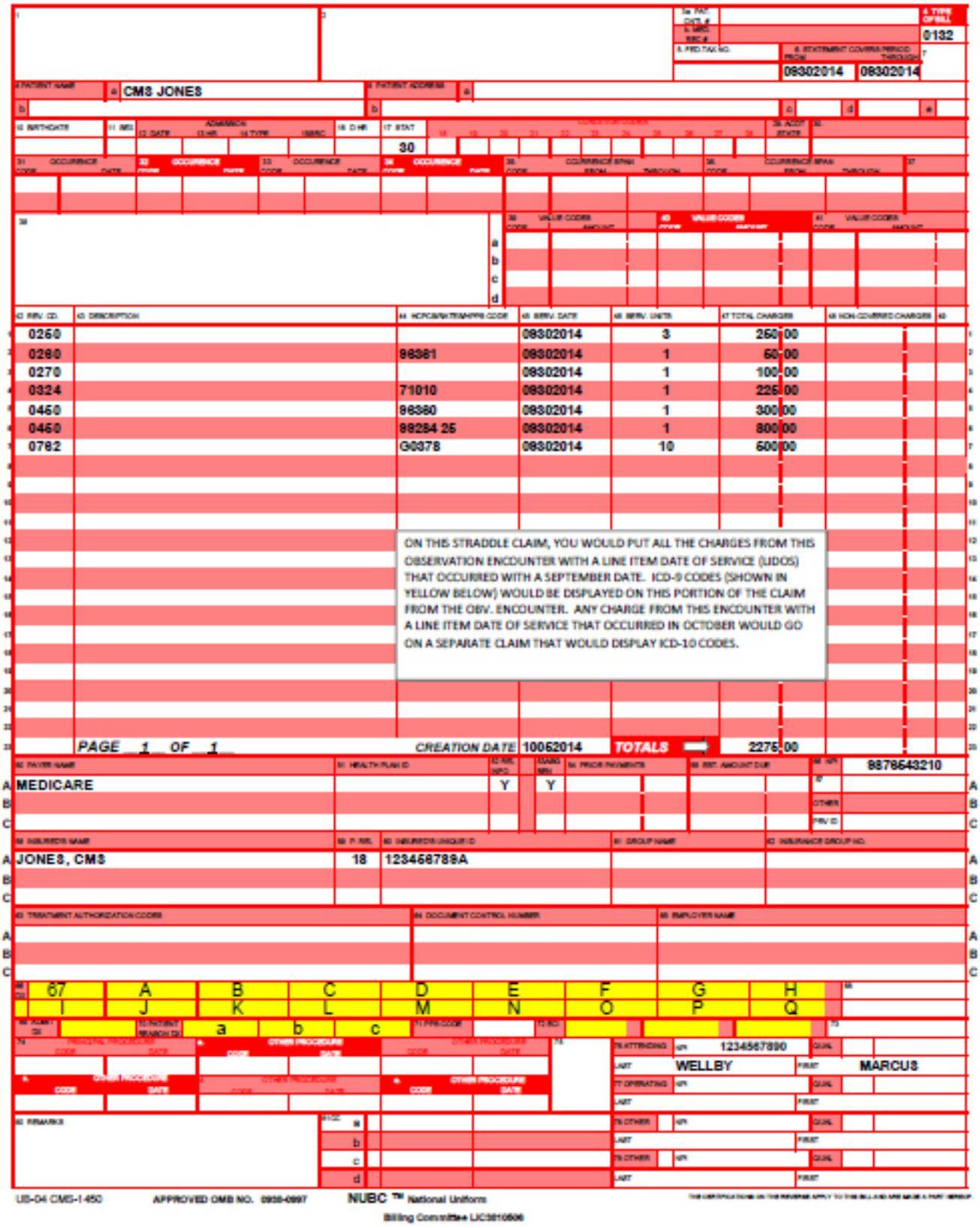
ICD-10 *(continued)*

Example 2A: Observation Encounter – 1st Claim



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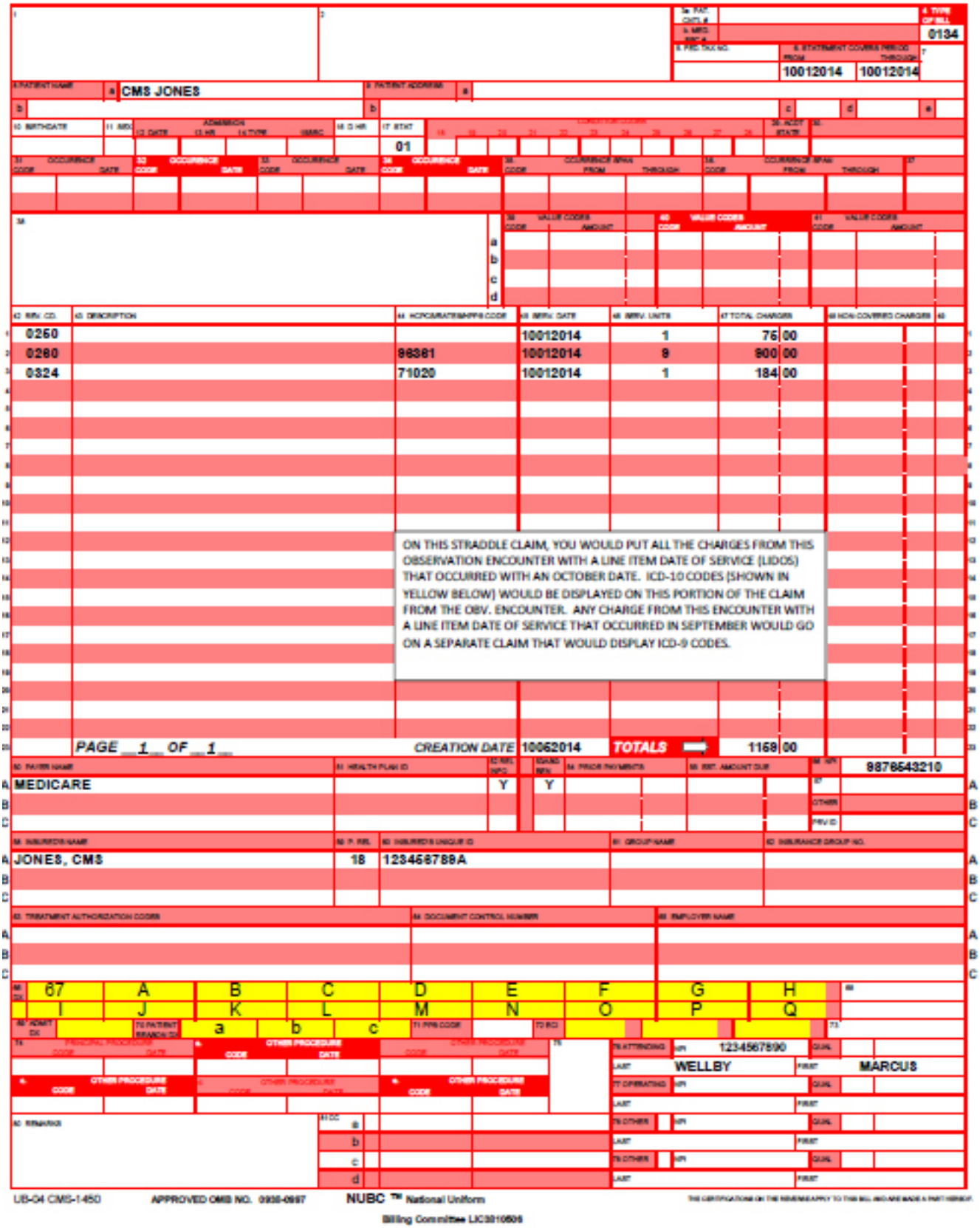
ICD-10 *(continued)*

Example 2B: Observation Encounter – 2nd Claim



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ICD-10 *(continued)*

Please remember to follow the ICD-9-CM and ICD-10-CM official coding guidelines (covering both inpatient and outpatient guidelines), which you can find on the Internet at *http://www.cdc.gov/nchs/icd/icd9cm.htm#addenda* and *http://www.cdc.gov/nchs/icd/icd10cm.htm*, respectively.

When coding an encounter that straddles implementation, you should use an ICD-9 code on the September interim claim for the encounter and a corresponding ICD-10 code on the October interim claim for the encounter (you can use the *General Equivalence Mappings* (GEM) for translation). You can learn more about the mapping of these codes in the *Diagnosis Code Set General Equivalence Mappings*, ICD-10-CM to ICD-9-CM and ICD-9-CM to ICD-10-CM, *2013 Version, Documentation and User's Guide*, which is available at *http://www.cms.gov/Medicare/Coding/ICD10/2013-ICD-10-CM-and-GEMs.html*.

Additional information

If you have any questions, please contact your Medicare contractor 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*.

MLN Matters® Number: SE1325
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

The role of clearinghouses in the ICD-10 transition

Practices preparing for the October 1, 2014, ICD-10 deadline are looking for resources and organizations that can help them make a smooth transition. It is important to know that while clearinghouses can help, they cannot provide the same level of support for the ICD-10 transition as they did for the version 5010 upgrade.

ICD-10 describes a medical diagnosis or hospital inpatient procedure and must be selected by the provider or a resource designated by the provider as their coder, and is based on clinical documentation.

During the change from version 4010 to version 5010, clearinghouses provided support to many providers by converting claims from version 4010 to version 5010 format. For ICD-10, clearinghouses can help by:

- Identifying problems that lead to claims being rejected
- Providing guidance about how to fix a rejected claim (e.g., the provider needs to include more or different data)

Clearinghouses cannot, however, help you identify which ICD-10 codes to use unless they offer coding services. Because ICD-10 codes are more specific, and one ICD-9 code may have several corresponding ICD-10 codes, selecting the appropriate ICD-10 code requires medical knowledge and familiarity with the specific clinical event.

While some clearinghouses may offer third-party billing/coding services, many do not. And even third-party billers cannot translate ICD-9 to ICD-10 codes unless they also have the detailed clinical documentation required to select the correct ICD-10 code. As you prepare for the October 1, 2014, ICD-10 deadline, clearinghouses are a good resource for testing that your ICD-10 claims can be processed -- and for identifying and helping to remedy any problems with your test ICD-10 claims.

Keep up to date on ICD-10

Visit the Centers for Medicare & Medicaid Services (CMS) *ICD-10 Web page* for the latest news and resources to help you prepare for the October 1, 2014, deadline. Sign up for CMS ICD-10 industry email updates and follow CMS on Twitter.

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

Transitional care management services (*CPT*® codes *99495* and *99496*)

Provider types affected

Note: As of January 1, 2013, Medicare pays for two *Current Procedural Terminology* (*CPT*®) codes to report care management services for a patient following a discharge from a hospital, SNF, or CMHC stay, outpatient observation, or partial hospitalization. This article clarifies aspects regarding these services.

Effective January 1, 2013, Medicare pays for two *CPT*® codes used to report care management services for a patient following a discharge from a hospital, skilled nursing facility (SNF), or community mental health center (CMHC) stay, outpatient observation, or partial hospitalization. The corresponding *CPT*® codes used by physicians or qualifying non-physician practitioners are *99495* and *99496*. This policy is discussed in the 2013 physician fee schedule final rule published on November 16, 2012 (77 *Federal Register* (FR) 68978 through 68994).

Transitional care management (TCM) services are comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction.

The 30-day period for the TCM service begins on the date of discharge and continues for the next 29 days. The reported date of service should be the 30th day. Because the TCM codes describe 30 days of services, and the TCM codes are new codes beginning on January 1, 2013, only 30-day periods beginning on or after January 1, 2013, are payable. Thus, the first payable date of service for any TCM services is January 30, 2013. The place of service reported on the claim should correspond to the place of service of the required face-to-face visit. CMS has established both a facility and non-facility payment for this service.

Below are the related requirements of the TCM *CPT*® codes:

- *CPT*® *99495* – Transitional care management services (moderate complexity):
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days (post-discharge).
  - Medical decision-making of at least moderate complexity during the service period.
  - Face-to-face visit, within 14 calendar days post-discharge.
- *CPT*® *99496* – Transitional care management services (high complexity):
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days (post-discharge).
  - Medical decision-making of high complexity during the service period.
  - Face-to-face visit, within 7 calendar days post-discharge.

This first patient contact post-discharge is included in the TCM code and not reported separately. Although the provider is required to conduct the face-to-face visit within the 7-14 days (dependent upon the situation, described above), the billing of the TCM code would not occur until the 30th day after the discharge. However, any additional E/M services provided afterwards (during those 30 days) may be reported with a separate evaluation and management (E/M) code accordingly. Distinct, separately identifiable E/M services may be provided with any services and separately billed, provided they are not bundled with the other services.

Medicare will only pay the first eligible claim submitted during the 30-day period that commences with the day of discharge. Other practitioners may continue to report other reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days. During the 30-day period of TCM, other reasonable and necessary Medicare services may be reported, with the exception of those services that cannot be reported according to *CPT*® guidance and Medicare HCPCS codes G0181 and G0182 (care plan oversight services).

Medicare encourages practitioners to follow *CPT*® guidance in reporting TCM services. Regarding "licensed clinical staff under his or her direction," Medicare requires that when a practitioner bills Medicare for services and supplies commonly furnished in physician offices, the practitioner must meet the "incident to" requirements described in Chapter 15 Section 60 of the *Medicare Benefit Policy Manual* 100-02. Additionally, transitional care management services will follow established E/M regulations and guidance.

CMS recently posted frequently asked questions (FAQs) to the CMS website, which addresses many aspects of these codes. Here is the link to the FAQs: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf*

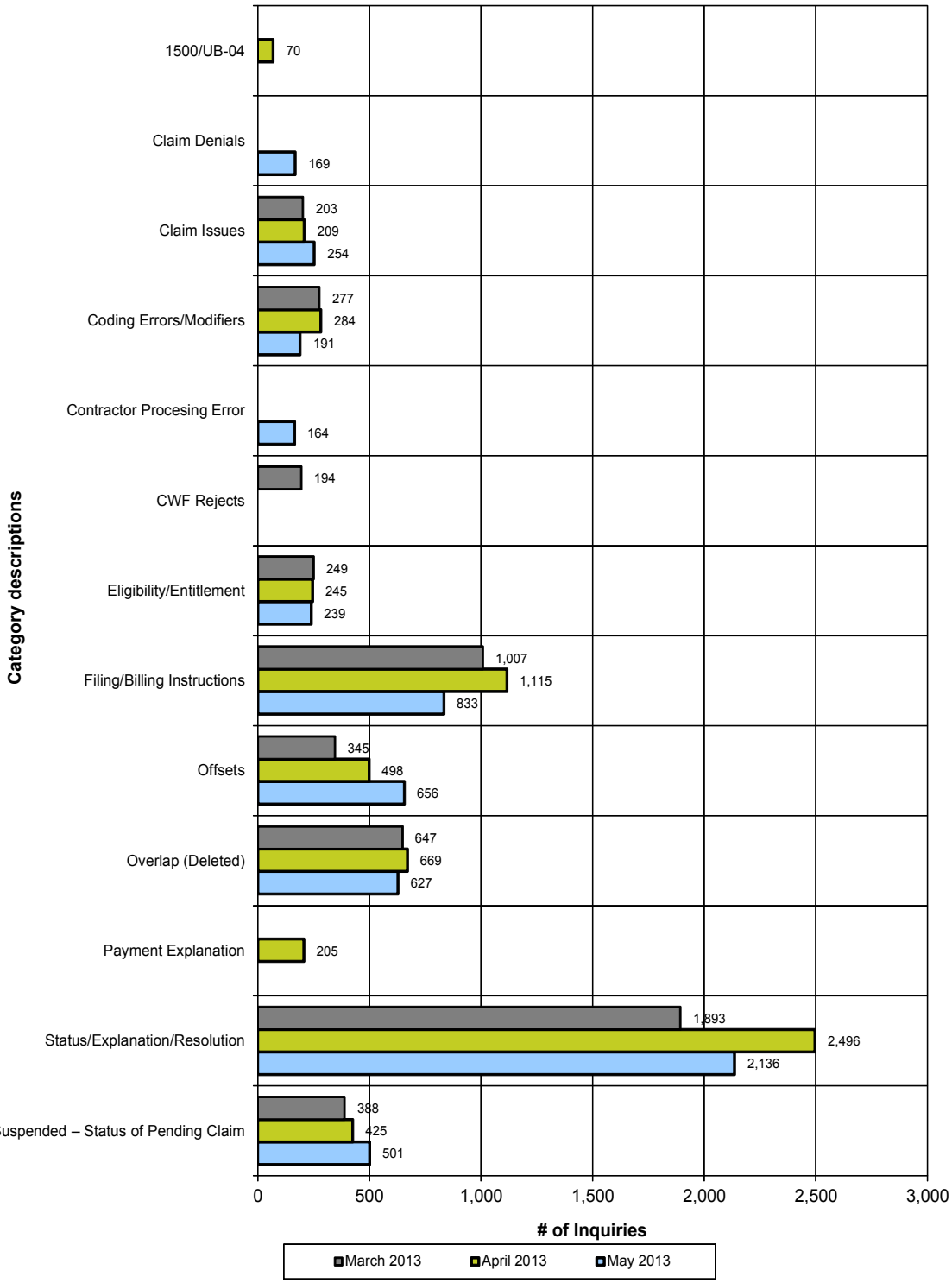
Source: American Medical Association (AMA) *CPT*® Manual 2013; *CMS Transitional Care Management (TCM) frequently asked questions (FAQs)*

Top inquiries, rejects, and return to provider claims March 2013 - May 2013

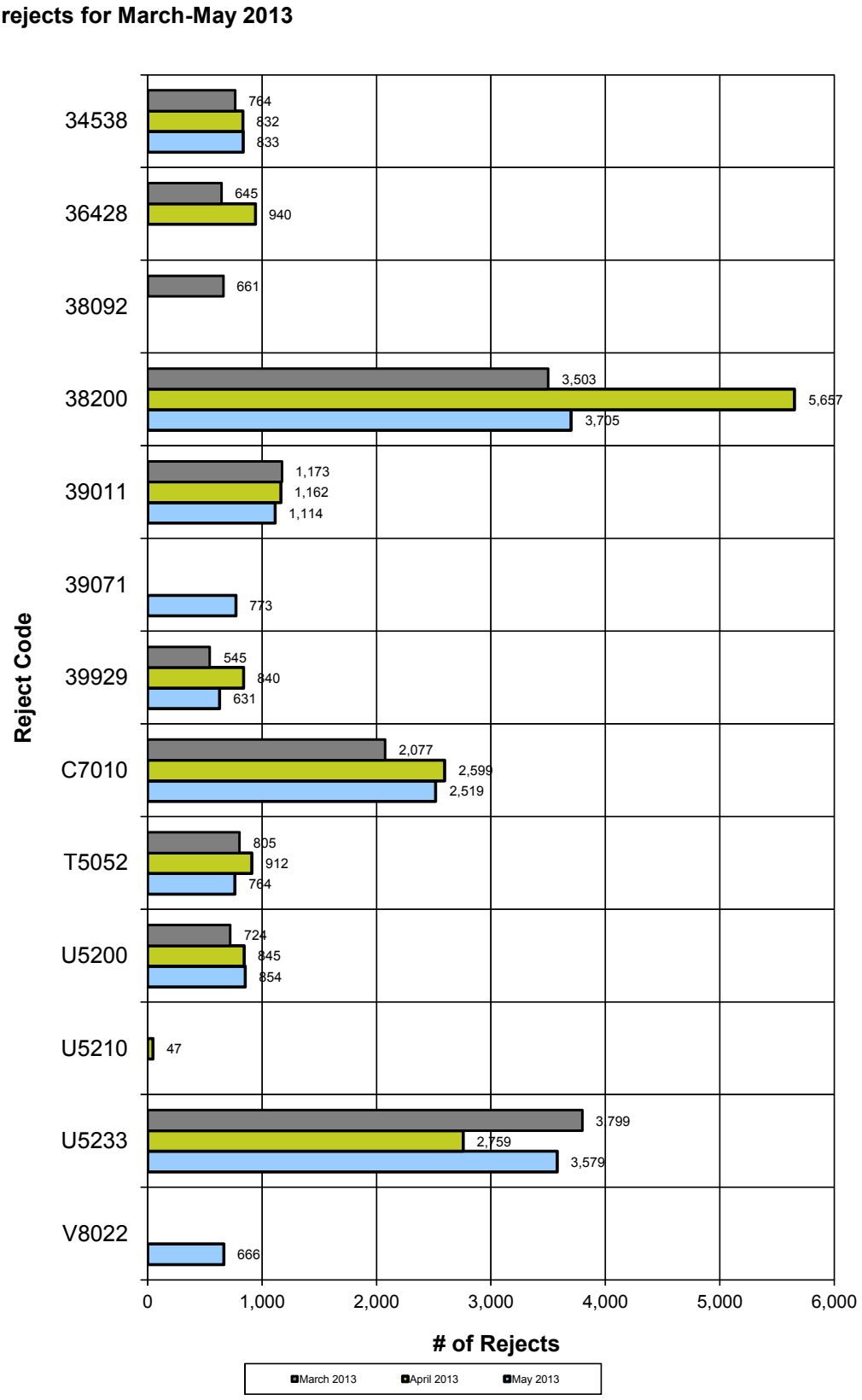
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during March 2013 through May 2013.

For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Top inquiries for March-May 2013

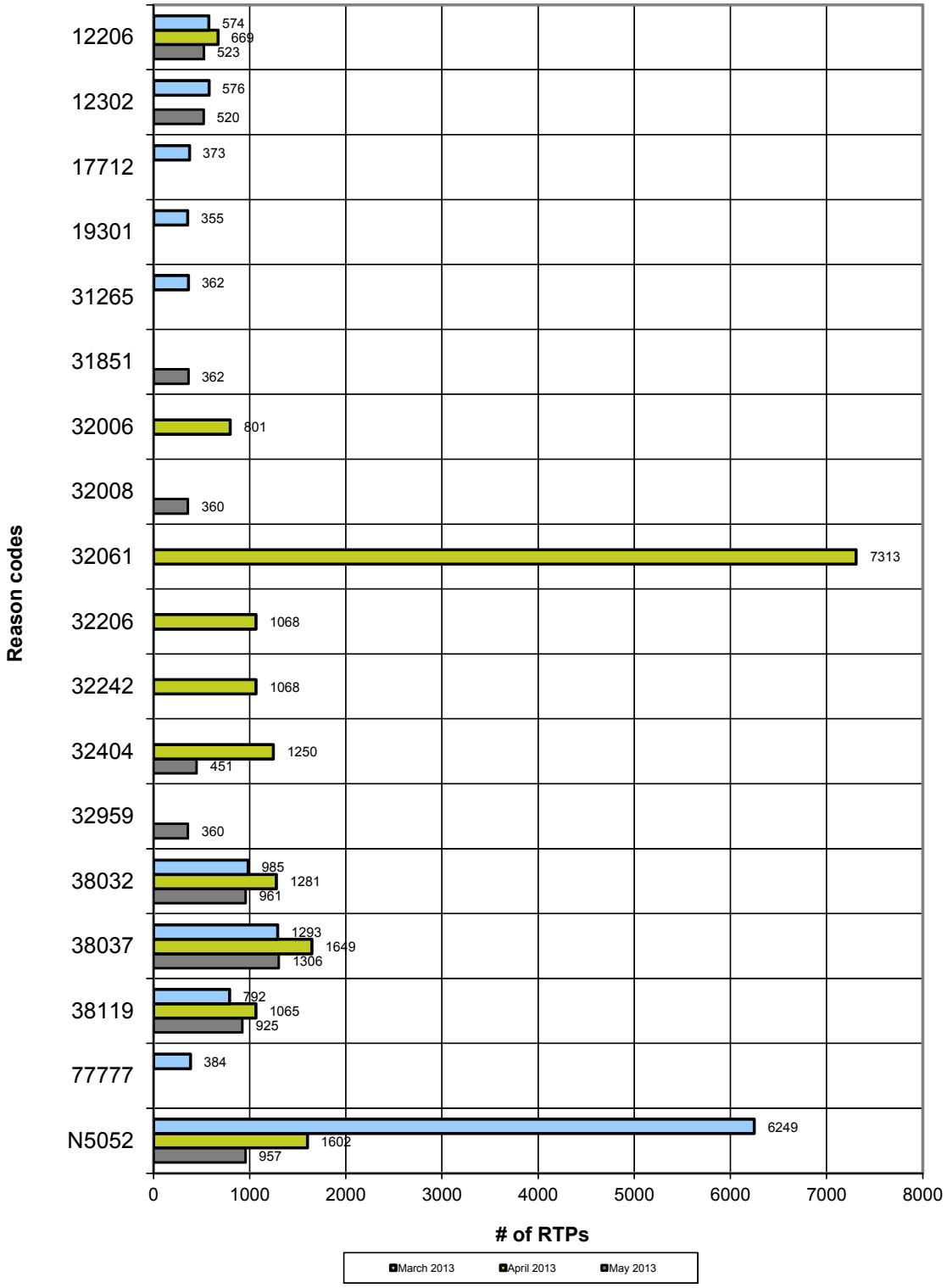


Part A top rejects for March 2013 through May 2013



Part A top return to providers (RTPs) for March 2013 through May 2013

Top RTPs for March-May 2013



Enrollment denials when overpayment exists

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers, including current owners of an enrolling provider or supplier or the enrolling physician or non-physician practitioner, submitting enrollment applications to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, durable medical equipment (DME) Medicare administrative contractors (MACs), and A/B MACs).

What you need to know

This article, based on change request (CR) 8039, informs you that Medicare contractors may deny a Form CMS-855 enrollment application if the current owner of the enrolling provider or supplier or the enrolling physician or non-physician practitioner has an existing or delinquent overpayment that has not been repaid in full at the time an application for new enrollment or change of ownership is filed.

Background

Under 42 *Code of Federal Regulations* (CFR) Section 424.530(a)(6), an enrollment application may be denied if the current owner (as that term is defined in 42 CFR Section 424.502) of the applying provider or supplier, or the applying physician or non-physician practitioner has an existing or delinquent overpayment that has not been repaid in full at the time the application was filed.

(Under 42 CFR 424.502, the term "owner" means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in Sections 1124 and 1124A(A) of the Social Security Act) of the applying provider or supplier)

Overpayments are Medicare payments that a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor to the United States Government.

Upon receipt of a CMS-855A, CMS-855B, or CMS-855S application, the Medicare contractor will determine –whether any of the owners listed in Section 5 or 6 of the application has an existing or delinquent Medicare overpayment.

Upon receipt of a CMS-855I application, the Medicare contractor will determine whether the physician or non-physician practitioner has an existing or delinquent Medicare overpayment. (For purposes of this requirement, the term "non-physician practitioner" includes physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.)

If an owner, physician, or non-physician practitioner has such an overpayment, the contractor shall deny the application, using 42 CFR 424.530(a)(6) as the basis. The denial shall be issued regardless of:

- Whether the person or entity is on a Medicare-approved plan of repayment or payments are currently being offset:
- Whether the overpayment is currently being appealed;
- The reason for the overpayment.

Note that CR 8039 applies only to initial enrollments and new owners in a CHOW. Note also that if the Medicare contractor determines that the overpayment existed at the time the application was filed, but the debt was paid in full by the time the contractor performed its review, the contractor will not deny the application because of that overpayment.

Additional information

The official instruction, CR 8039, issued to your Medicare contractor may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R469PI.pdf*.

If you have any questions, please contact your Medicare contractor 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*.

MLN Matters® Number: MM8039
Related Change Request (CR) #: CR 8039
Related CR Release Date: May 31, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R469PI
Implementation Date: October 7, 2013

CMS ruling 1455-R – Medicare Part B billing in hospitals

Provider types affected

This *MLN Matters*® article is intended for hospitals submitting claims to Medicare contractors (fiscal intermediaries (FIs) and Part A Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8277, which provides the instructions for implementing CMS ruling 1455-R (the ruling) until the operating instructions in CR 8185 are implemented. The ruling permits you to bill for Part B services when an inpatient Part A claim is denied by a Medicare contractor for the reason that the inpatient admission was not reasonable and necessary. The ruling provides an interim policy to address certain Part A appeal decisions by administrative law judges (ALJs) and the Medicare appeals council, while CMS establishes permanent policy changes through notice and comment rulemaking under CMS-1455-P, issued concurrently with CMS-1455-R.

Background

- On March 13, 2013 the Centers for Medicare & Medicaid Services (CMS) issued ruling 1455-R which establishes an interim process for hospitals to bill Medicare for Part B inpatient and/or outpatient services following a denial of a Part A claim on the basis that an inpatient admission was not reasonable and necessary. (You can find this ruling at *http://www.cms.gov/Regulations-and-Guidance/Guidance/rulings/Downloads/CMS1455R.pdf*).
- Subsequently, CMS issued CR 8185 – Administrative ruling: Part A to Part B Rebilling of Denied Hospital Inpatient Claims, March 22, 2013, which sets forth the requirements for Medicare contractors to implement the ruling, effective for claims processed after July 1, 2013. (The associated *MLN Matters*® article can be found at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8185.pdf*.
- CR 8277, from which this article is taken, provides the instructions for implementing the ruling until such time as the operating instructions in CR 8185 are implemented.

CMS ruling 1455R

The ruling established an interim process for hospitals to bill Medicare for Part B inpatient and/or outpatient services following a denial of a Part A inpatient admission claim as not being reasonable and necessary. As explained in the ruling, in an increasing number of cases, hospitals that have appealed Part A inpatient claim denials to ALJs and to the Medicare appeals council have received decisions upholding the Medicare review contractor's determination that the inpatient admission was not reasonable and necessary, but also ordering payment of the services as if they were rendered at an outpatient or "observation level" of care. Moreover, these decisions required payment regardless of whether the subsequent hospital claim(s) for payment under Part B were submitted within the otherwise applicable time limit for filing Part B claims.

The ALJ and Medicare appeals council decisions providing for payment of all reasonable and necessary Part B services under these circumstances are contrary to CMS' longstanding policies that permit billing for only a limited list of Part B inpatient services and require that the services be billed within the usual timely filing restrictions. (Detailed information regarding the agency's previous policy is included for your reference in the ruling and in CR 8277.)

While decisions issued by the ALJs and the Medicare appeals council do not establish Medicare payment policy, Medicare is bound to effectuate each individual decision. The increasing number of these types of decisions has created numerous operational difficulties. The ruling acquiesces to the approach taken in these decisions on the issue of subsequent Part B billing following the denial of a Part A hospital inpatient claim on the basis that the admission was not reasonable and necessary, and establishes a standard, interim policy for effectuating these decisions until CMS establishes a final policy on the issue through notice and comment rulemaking.

The policy announced in the ruling: 1) became effective upon issuance; 2) supersedes any other statements of policy on the issues therein; and 3) remains in effect until the effective date of the final regulations for the currently issued proposed rule, CMS-1455-P, "Medicare Program; Part B Billing in Hospitals", issued concurrently with the ruling. (You

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1455-R *(continued)*

can find CMS-1455-P in the *Federal Register* / Vol. 78, No. 52 / Monday, March 18, 2013 / Proposed Rules at *www.gpo.gov/fdsys/pkg/FR-2013-03-18/pdf/2013-06163.pdf*.

When does this ruling apply?

CMS ruling 1455-R only applies to denials of Part A hospital inpatient claims when the inpatient admission was determined to be not reasonable and necessary by a Medicare review contractor (provided payment was not made under the waiver of liability provision (Section 1879 of the Act), and repayment of any Part A overpayment was not waived (Section 1870 of the Act)).

In this situation, under the ruling, you may submit a Part B inpatient claim for all Part B services that would have been payable to you had the beneficiary originally been treated as an a hospital outpatient rather than admitted as an a hospital inpatient, except when those services specifically require an outpatient status (for example, outpatient visits, emergency department visits, and observation services).

Note: The services requiring an outpatient status cannot be billed for the period of time that the beneficiary was an inpatient, and cannot be included on the Part B inpatient claim.

The ruling applies to the claim denials described above made: 1) while the ruling is in effect; 2) prior to the effective date of the ruling (March 13, 2013), but for which the timeframe to file an appeal had not expired as of the effective date of the ruling (March 13, 2013); or 3) prior to the effective date of the ruling (March 13, 2013), but for which an appeal is pending. It does not apply to Part A hospital inpatient claim denials for which the timeframe to appeal had expired prior to the ruling's effective date, nor does it apply to inpatient admissions that the hospital, itself, deemed to be not reasonable and necessary (for example, through utilization review or other hospital self-audit).

"CMS ruling 1455-R only applies to denials of Part A hospital inpatient claims when the inpatient admission was determined to be not reasonable and necessary by a Medicare review contractor (provided payment was not made under the waiver of liability provision (Section 1879 of the Act), and repayment of any Part A overpayment was not waived (Section 1870 of the Act))."

Treatment of pending appeals and appeal rights under the ruling

The ruling provides you with notice of your right to submit Part B claims following the denial of a claim for a Part A hospital inpatient admission as described above, provided you withdraw any pending appeal of the Part A claim denial. Requests for withdrawal of pending Part A claim appeals must be sent to the adjudicator with whom the appeal is currently pending.

Until and unless an appeal is withdrawn by the appellant, your Medicare contractor will continue processing all pending Part A appeals that are subject to the ruling. Your withdrawal request must identify the claims being appealed and explain that the appeal request is being withdrawn so you may submit Part B claim(s) in accordance with the ruling. Medicare contractors will use the model language in the draft dismissal notice in Attachment 1 in CR 8277 when dismissing an appeal in response to a withdrawal request.

The ruling also established a policy for handling appeals remanded from the ALJ level to the qualified independent contractor (QIC) level. Remanded cases will be returned to the ALJ level for adjudication of the Part A claim appeal. Information regarding requests for withdrawal is available to appellants on the Office of Medicare Hearings and Appeal's (OMHA's) public website at *http://www.hhs.gov/omha* on the Internet.

If your Medicare contractor determines that you have submitted a Part B claim, under the ruling, for payment while a Part A appeal is pending (i.e., the request has not been withdrawn and a decision on the request has not been issued), the Part B claim for payment will be denied as a duplicate and the Part A appeal will continue.

Once a Part B claim under the ruling is submitted, parties will no longer be able to request further appeals of the Part A claim. Rather, parties will be able to exercise their appeal rights for the subsequent Part B claim under existing procedures in 42 CFR part 405 Subpart I. If a Part A appeal is mistakenly processed after submission of a Part B claim under the ruling, no additional payment will be made with respect to the Part A claim in effectuating the Part A decision.

Scope of review for Part A hospital inpatient claim denials

As explained in the ruling, you are solely responsible for both submitting claims for items and services furnished to beneficiaries and determining whether submission of a Part A or Part B claim is appropriate. Once you have submitted a claim, your Medicare contractor can make an initial determination and determine any payable amount. Accordingly, an appeals adjudicator's scope of review is limited to the claim(s) that are before them on appeal, and appeals adjudicators may not order payment for items or services that have not yet been billed or

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1455-R *(continued)*

have not yet received an initial determination. If you submit an appeal of a determination that a Part A hospital inpatient admission was not reasonable and necessary, the only issue before an adjudicator is the propriety of the Part A claim, not any issue regarding any potential Part B claim, not yet submitted.

Billing Part B claims under the ruling

Under the interim policy described in the ruling, the beneficiary's patient status remains inpatient as of the time of the inpatient admission and is not changed to outpatient, because the beneficiary was formally admitted as an inpatient and there is no provision to change a beneficiary's status after he or she is discharged from the hospital.

To that end, to receive payment under the ruling, you must submit the Part B claims that are required under the policy preceding the ruling, i.e., a Part B inpatient 12x TOB. Services furnished after the time of the hospital inpatient admission must be billed on the 12x TOB, and services furnished in the three day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission must be billed on a 13x Part B outpatient TOB.

On the 12x and 13x claims, you must recode the services that were furnished as Part B services, and must, when available, provide the Healthcare Common Procedure Coding System (HCPCS) code(s), *Current Procedure Terminology*® (*CPT*®) code(s) and/or revenue code(s) that describe the medically necessary services that were ordered and rendered in accordance with Medicare rules and regulations, and that are documented in the medical record.

For 12x claims billed under the ruling, until the system changes set forth in CR 8185 are implemented in the July quarterly release, CMS will use system logic implemented with the Part A to Part B (A/B) rebilling demonstration to process claims as follows.

- Until the July quarterly release, providers will follow billing instructions contained in the business requirements in CR 8277, restated in the section titled, "Claims Submission Instructions for Part B Inpatient Claims,". You will initially be paid the amount that would have been paid under the demonstration, i.e., at 90 percent of the net amount that would be payable (after subtracting deductibles and co-insurance) if you had originally submitted a claim for hospital outpatient services based on the OPPS pricer amount or other applicable fee schedule amount (For Maryland waiver providers, the 90 percent will be based on the Part B payment that would have been available if the claim were originally paid as an outpatient claim.). Payments are claim, not line, level.
- When CR 8185 is implemented in July, contractors will mass adjust all 12x TOB claims that are processed under this temporary methodology in accordance with the ruling for full Medicare payment.

Medicare contractors have been instructed to update the provider file to allow you the ability to bill under these methods which were used for the A/B rebilling demonstration, and will remove any termination dates in the rebill code field.

Additionally, contractors will bypass timely filing edits on Part B outpatient claims (type of bill 13x) when billed using the instructions in CR 8277. Medicare contractors will no longer accept claims with a treatment authorization code of "SPN66" indicating that the claim is being rebilled due to a hospital self-audit, because the provisions of the ruling do not apply to hospital self-audit.

Time period for submitting Part B bills

Under the ruling, Part B inpatient and Part B outpatient claims subject to the ruling that are filed later than one calendar year after the date of service are not to be rejected as untimely by Medicare's claims processing system as long as the corresponding denied Part A inpatient claim was filed timely (in accordance with 42 CFR 424.44). (You can find more information about the timing of such claims in the *MLN Matters*® article MM6960, Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months (released May 7, 2010), which you can find at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6960.pdf*).

1. If you have a pending appeal for a Part A hospital inpatient claim denial subject to the ruling and you withdraw the appeal, you will have 180 days from the date of receipt of the dismissal notice to file your Part B claim(s).
2. If you have a pending appeal for a Part A hospital inpatient claim denial subject to the ruling, and you do not withdraw your appeal, you have 180 days from the date of receipt of the final or binding unfavorable appeal decision (or subsequent

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1455-R *(continued)*

dismissal notice following a withdrawal) to submit your Part B claim(s). For example, you receive an unfavorable reconsideration decision but decide not to request a hearing before an ALJ, or the time to request a hearing expires, the reconsideration decision becomes binding, and the Part B claim(s) may be filed within 180 days of the date of receipt of the reconsideration decision.

3. If you receive a denial of a Part A hospital inpatient claim subject to the ruling for which there is no pending appeal, and the denial is not subsequently appealed, you will have 180 days from the date of receipt of the initial or revised determination on the Part A claim (that is, the date of the remittance advice) to submit your Part B claim(s).

Note: The date of receipt of an initial or revised determination, or an appeal decision or dismissal notice is presumed to be 5 days after the date of such notice or decision, unless there is evidence to the contrary.

As noted in the model language in CR 8277's Attachment 2 (Medicare redetermination notice (MRN) – MAC Decision), your FI or MAC will include additional language in the Medicare redetermination notice explaining your available options for submitting Part B claim(s), which are to either: 1) submit Part B inpatient and/or outpatient claims; or 2) continue to appeal your Part A claim under existing procedures in 42 CFR Part 405 Subpart I.

Some additional important information regarding pending appeals

- If your Medicare contractor determines that you have submitted a Part B inpatient and/or outpatient claim under the ruling for the same beneficiary and the same dates of service, they will dismiss a request for redetermination for a Part A claim consistent with the provisions of the ruling, using the model language in the dismissal notice provided in CR 8277's Attachment 3 – Order of Dismissal Pursuant to CMS ruling 1455-R: Invalid Part A Appeal Request When a Part B Claim Has Been Submitted
- If you have submitted a Part B claim under the ruling, and a party subsequently files a request for redetermination of the Part B inpatient claim, the contractor will process the appeal request in accordance with existing procedures in the *Medicare Claims Processing Manual*, Chapter 29 (Appeals of Claims Decisions) available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf*.
- If you have submitted a Part B claim under the ruling without withdrawing a pending Part A appeal, your Medicare contractor will not issue any payment for the Part A inpatient admission in response to a fully favorable appeal decision or an effectuation notice regarding the admission. The ruling requires that all Part A appeals must be withdrawn prior to the submission of a Part B claim.

Claims submission instructions for Part B inpatient claims

Until CR 8185 is implemented, for Part B claims:

1. Submit 121 TOB (Hospital, Inpatient (Medicare Part B only, Admit thru Discharge Claim)) claims with a demonstration code SPN No. 65 (Rebilled claims due to auditor denials).
2. Place the appropriate treatment authorization code into Loop 2300 REF02 (REF01 = G1) as follows: REF*G1*SPN65~

   For DDE or paper Claims, use fields: 5/MAP1715 (for DDE) or treatment authorization field #63 (for paper) and the following format:

   SPN65 The original, denied Part A inpatient claim (CCN/DCN/ICN) number, last adjudication date, and provider attestation of compliance with the requirements of ruling CMS-1455-R will be included in the billing notes loop 2300/NTE (NTE01 = ADD) in the format: NTE*ADD*12345678901234-99999999-CMS1455R.
3. For DDE or paper claims, include the original, denied Part A inpatient DCN/CCN/ICN, last adjudication date, and provider attestation of compliance with the ruling CMS-1455-R to the remarks field (form locator #80) as follows: 12345678901234-99999999-CMS1455R.

   Note: The numeric string above (12345678901234) is meant to represent original Part A inpatient claim CCN/DCN/ICN numbers from the inpatient denial and the second number string above (99999999) is meant to represent the most recent adjudication date in mmddyyyy format.

   The last adjudication date means, as applicable, the date of denial from the remittance advice for a Part A claim that has not been appealed, or the date of a final or binding appeal decision, or the date of a dismissal notice in response to a request for withdrawal of an appeal.

Note: Your FI or MAC will manually review and bypass timely filing edits for claims in which the receipt date of the original 121 TOB is within the 180 days of the last adjudication date found in remarks (plus an additional five calendar days for mailing).

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1455-R *(continued)*

Claims submission instructions for Part B outpatient claims

Until CR 8185 is implemented, for claims for services rendered as part of the three day payment window:

1. Submit TOB 131 (hospital, outpatient, admit thru discharge claim).
2. Include the original, denied Part A inpatient claim (CCN/DCN/ICN) number, last adjudication date, and provider attestation of compliance with the requirements of ruling CMS-1455-R in the Billing Notes loop 2300/NTE (NTE01 = ADD) in the format: NTE*ADD*12345678901234-99999999-CMS1455R.
3. For DDE or paper claims, include the original, denied Part A inpatient DCN/CCN/ICN and provider attestation of compliance with the requirements of ruling CMS-1455 to the remarks field (form locator #80) as follows: 12345678901234-99999999-CMS1455R

   Note: The numeric strings above (12345678901234) are meant to represent original Part A inpatient claim CCN/DCN/ICN numbers from the inpatient denial and the second number string above (99999999) is meant to represent the last recent adjudication date in mmddyyyy format. The last adjudication date means, as applicable, the date of denial from the remittance advice for a Part A claim that has not been appealed, or the date of a final or binding appeal decision, or the date of a dismissal notice in response to a request for withdrawal of an appeal.

Additional information

The official instruction, CR 8277 issued to your FI or MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1247OTN.pdf*.

If you have any questions, please contact your FI or 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*.

MLN Matters® Number: MM8277
Related Change Request (CR) #: CR 8277
Related CR Release Date: May 31, 2013
Effective Date: March 13, 2013
Related CR Transmittal #: R1247OTN
Implementation Date: July 1, 2013

July quarterly update for 2013 DMEPOS fee schedule

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (A/B Medicare administrative contractors (MACs), carriers, regional home health intermediaries (RHHIs) and durable medical equipment MACs (DME MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider action needed

This article is based on change request (CR) 8325 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable and to apply changes in payment policies.

The quarterly update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

Key points of CR 8325

- CR 8325 updates fees for Healthcare Common Procedure Coding System (HCPCS) codes E2378, L5859, and L7902. These HCPCS codes were added to the HCPCS file effective January 1, 2013. Previously these items were paid on a local fee schedule. If claims for these codes with dates of service on or after January 1, 2013 have already been processed, they will be adjusted to reflect the new fees if you bring the claims to your contractor's attention.
- As part of this update fee schedule amounts are also established for HCPCS code K0009 (Other Manual Wheelchair/Base). Payment on a fee schedule basis is mandated for all DME by section 1834(a) of the Social Security Act (the Act), other than items that meet the definition of customized DME at 42 CFR Section 414.224 of the regulations.

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DMEPOS *(continued)*

Effective July 1, 2013, payment for claims for manual wheelchairs, that receive a HCPCS code verification of K0009 by the pricing data analysis and coding (PDAC) contractor, will be made on a capped rental basis with the fee schedule amounts established and updated in accordance with Section 1834 (a)(8) of the Act using data for all manual wheelchair codes effective in 1986.

Diabetic testing supplies

Effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the American Taxpayer Relief Act (ATRA), the fee schedule amounts for non-mail order diabetic supplies are adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established in implementing the national mail order competitive bidding program under Section 1847 of the Act.

The national competitive bidding program for mail order diabetic supplies takes effect July 1, 2013. Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as described by the HCPCS codes below:

- A4233 replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each.
- A4234 Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each.
- A4235 Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each.
- A4236 Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each.
- A4253 Blood glucose test or reagent strips for home glucose monitor, per 50 strips.
- A4256 Normal, low and high calibration solution / chips.
- A4258 Spring-powered device for lancet, each.
- A4259 Lancets, per box of 100.

Also, the fee schedule amounts for non-mail order diabetic supplies listed above will be adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established under the national mail order competition for diabetic testing supplies each time the single payment amounts are updated, which can happen no less often than every three years as contracts are recompeted.

The rules related to assignment of claims for non-mail order diabetic testing supplies are not affected by this new law. The definitions of mail order item and non-mail order item set forth in 42 CFR 414.402 are:

- Mail order item (KL HCPCS modifier) – any item shipped or delivered to the beneficiary's home, regardless of the method of delivery; and
- Non-mail order item (KL modifier not applicable) – any item that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront.

Effective July 1, 2013, only national mail order contract suppliers will be paid by Medicare for diabetic testing supplies other than those that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront.

The single payment amount public use file for the national mail order competitive bidding program is available at *http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts*

Additional information

The official instruction, CR 8325 issued to Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2709CP.pdf*.

If you have any questions, please contact your Medicare contractor 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*.

MLN Matters® Number: MM8325
Related Change Request (CR) #: CR 8325
Related CR Release Date: May 17, 2013
Effective Date: January 1, 2013 - for implementation of fee schedule amounts for codes in effect on January 1, 2013; July 1, 2013 for all other changes
Related CR Transmittal #: R2709CP
Implementation Date: July 1, 2013

July 2013 update of the hospital outpatient prospective payment system

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare contractors (fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries and paid under the OPPS.

Provider action needed

This article is based on change request (CR) 8338 which describes changes and billing instructions for various payment policies implemented in the July 2013 outpatient prospective payment system (OPPS) update.

The July 2013 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), status indicator (SI), HCPCS Modifier, and revenue code additions, changes, and deletions identified in CR 8338. CR 8338 also updates the *Medicare Claims Processing Manual*, Chapter 4, Sections 61.4.1 (Billing for Brachytherapy Sources) and 61.4.5 (Payment for New Brachytherapy Sources) which is included as an attachment.

The July 2013 revisions to I/OCE data files, instructions, and specifications are provided in CR 8317. A related *MLN Matters*® article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8317.pdf*. Be sure that your billing staff is aware of these changes.

Background

The key changes in the July 2013 OPPS update are as follows:

Changes to device edits for July 2013

The most current list of device edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/*. Failure to pass these edits will result in the claim being returned to the provider.

New service

The new service, listed in Table 1 below, is assigned for payment under the OPPS, effective July 1, 2013.

Table 1 – New service payable under OPPS effective July 1, 2013

HCPCS code	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9736	7/1/2013	T	0131	Lap ablate uteri fibroid rf	Laparoscopy, surgical, radiofrequency ablation of uterine fibroid(s), including intraoperative guidance and monitoring, when performed	$3,487.15	$1,001.89

New long descriptor for C9734

Table 2 reflects a new long descriptor for HCPCS code C9734, effective July 1, 2013. HCPCS code C9734 must be performed with magnetic resonance (MR) guidance.

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Outpatient *(continued)*

Table 2 – New long descriptor for C9734 effective July 1, 2013

HCPCS code	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9734	4/01/2013	S	0067	U/S trtmt, not leiomyomata	Focused ultrasound ablation/ therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance	$3,300.64	$660.13

Deletion of HCPCS code C1879 and use of A4648

Consistent with the Centers for Medicare & Medicaid Services (CMS) general policy of using permanent HCPCS codes rather than using temporary HCPCS codes under the OPPS in order to streamline coding, CMS is deleting HCPCS code C1879 (Tissue marker, implantable) on June 30, 2013, because it is described by HCPCS code A4648 (Tissue marker, implantable, any type). Therefore, effective July 1, 2013, when using implantable tissue markers with any services provided in the OPPS, providers should report the use and cost of the implantable tissue marker with HCPCS code A4648 only.

Category III *CPT*® codes

The American Medical Association (AMA) releases Category III *Current Procedural Terminology*® (*CPT*®) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

For the July 2013 update, CMS is implementing in the OPPS six Category III *CPT*® codes that the AMA released in January 2013 for implementation on July 1, 2013. Of the six, four Category III *CPT*® codes are separately payable under the hospital OPPS. The status indicators and APCs for these codes are shown in Table 3. Payment rates for these services can be found in Addendum B of the "July 2013 OPPS Update" that is posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Table 3 – Category III *CPT*® codes implemented as of July 1, 2013

Code	Long descriptor	SI	APC
0329T	*Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report*	E	N/A
0330T	*Tear film imaging, unilateral or bilateral, with interpretation and report*	S	0230
0331T	*Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;*	S	0398
0332T	*Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT*	S	0398
0333T	*Visual evoked potential, screening of visual acuity, automated*	E	N/A
0334T	*Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (e.g., CT or fluoroscopic)*	T	0208

Billing for drugs, biologicals, and radiopharmaceuticals

1. Drugs and biologicals with payments based on average sales price (ASP) effective July 1, 2013

In the 2013 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2013 release of the OPPS pricer.

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Outpatient *(continued)*

The updated payment rates, effective July 1, 2013, will be included in the July 2013 update of the OPPS Addendum A and Addendum B, which will be posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

2. Drugs and biologicals with OPPS pass-through status effective July 1, 2013

Two drugs and biologicals have been granted OPPS pass-through status effective July 1, 2013. These items, along with their descriptors and APC assignments, are identified in Table 4, below.

Table 4 – Drugs and biologicals with OPPS pass-through status effective July 1, 2013

HCPCS code	Long descriptor	APC	Status indicator effective 7/1/13
C9131*	Injection, ado-trastuzumab emtansine, 1 mg	9131	G
Q4122	Dermacell, per square centimeter	1419	G

Note: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2013.

3. Flublok (influenza virus vaccine)

Flublok (influenza virus vaccine) was approved by the FDA on January 16, 2013. For the July 2013 update, the HCPCS workgroup established HCPCS code Q2033 to describe Flublok. CMS is assigning the OPPS status indicator "L" (influenza vaccine; pneumococcal pneumonia vaccine) to HCPCS code Q2033 effective July 1, 2013. Prior to July 1, 2013, the appropriate code to report for Flublok would be an unlisted CPT/HCPCS vaccine code. Table 5, below, provides the descriptors and OPPS status indicator for HCPCS code Q2033.

Table 5– Flublok influenza vaccine OPPS status indicator

HCPCS code	Short descriptor	Long descriptor	APC	Status indicator effective 07/01/13
Q2033	Influenza Vaccine, (Flublok)	Influenza Vaccine, Recombinant Himagglutinin Antigens, for Intramuscular Use (Flublok)	N/A	L

4. Fluarix quadrivalent (influenza virus vaccine)

Fluarix quadrivalent (influenza virus vaccine) was approved by the FDA on December 14, 2012, and is described by *CPT®* code *90686*. Because of the timing of FDA approval, CMS was unable to assign *CPT®* code *90686* to a separately payable status. For the July 2013 update, CMS is revising the OPPS status indicator *CPT®* code *90686* from "E" (not covered by Medicare) to "L" (influenza vaccine; pneumococcal pneumonia vaccine) effective January 1, 2013. Prior to January 1, 2013, the appropriate code to report Fluarix quadrivalent would be an unlisted *CPT®*/HCPCS vaccine code. Table 6 provides the descriptors and OPPS status indicator for *CPT®* code *90686*.

Table 6– Fluarix quadrivalent (influenza virus vaccine) effective January 1, 2013

HCPCS code	Short descriptor	Long descriptor	APC	Status indicator effective 01/01/13
90686	Flu vac no prsv 4 val 3 yrs+	*Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use*	N/A	L

5. New HCPCS codes effective July 1, 2013 for certain drugs and biologicals

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 4 above) in the hospital outpatient setting for July 1, 2013. These codes are listed in Table 7, below, and are effective for services furnished on or after July 1, 2013.

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Outpatient *(continued)*

Table 7 – New HCPCS codes for certain drugs and biologicals effective July 1, 2013

HCPCS code	Long descriptor	APC	Status indicator effective 7/1/13
Q2050*	Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10 mg	7046	K
Q2051**	Injection, Zoledronic Acid, Not Otherwise Specified, 1 mg	1356	K

**HCPCS code J9002 (Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10 mg) will be replaced with HCPCS code Q2050 effective July 1, 2013. The status indicator for HCPCS code J9002 will change to E, "Not Payable by Medicare," effective July 1, 2013.*

*** HCPCS code J3487 (Injection, Zoledronic Acid (Zometa), 1 mg) and HCPCS code J3488 (Injection, Zoledronic Acid (Reclast), 1 mg) will be replaced with HCPCS code Q2051 effective July 1, 2013. The status indicators for HCPCS codes J3487 and J3488 will change to E, "Not Payable by Medicare," effective July 1, 2013.*

6. Revised status indicator for HCPCS codes Q4126 and Q4134 effective July 1, 2013

Effective July 1, 2013, the status indicators for HCPCS code Q4126 (Memoderm, dermaspan, tranzgraft or integuply, per square centimeter) and HCPCS code Q4134 (Hmatrix, per square centimeter) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (paid under OPPS; separate APC payment). For the remainder of CY 2013, HCPCS code Q4126 and HCPCS code Q4134 will be separately paid and the prices for these codes will be updated on a quarterly basis. These codes are listed in Table 8, below, and are effective for services furnished on or after July 1, 2013.

Table 8 – Drugs and biologicals with revised status indicators effective July 1, 2013

HCPCS code	Long descriptor	APC	Status indicator effective 7/1/13
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter	1452	K
Q4134	Hmatrix, per square centimeter	1453	K

7. Updated payment rates for certain HCPCS codes effective April 1, 2013, through June 30, 2013

The payment rates for two HCPCS codes were incorrect in the April 2013 OPPS pricer. The corrected payment rates are listed in Table 9, below, and have been installed in the July 2013 OPPS pricer, effective for services furnished on April 1, 2013, through June 30, 2013.

Table 9 – Updated payment rates for certain HCPCS codes effective April 1, 2013, through June 30, 2013

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
C9297	G	9297	Omacetaxine mepesuccinate	$2.53	$0.51
C9298	G	9298	Injection, ocriplasmin	$1,046.75	$209.35

8. Updated guidance: billing and payment for new drugs, biologicals, or radiopharmaceuticals approved by the FDA but before assignment of a product-specific HCPCS code

Hospital outpatient departments are allowed to bill for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the "unclassified" drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under the OPPS unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, should be billed with the appropriate "A" NOC code as follows:

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Outpatient *(continued)*

a. Diagnostic radiopharmaceuticals – All new diagnostic radiopharmaceuticals are assigned HCPCS code A4641 (Radiopharmaceutical, diagnostic, not otherwise classified). HCPCS code A4641 should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS code A4641 is assigned status indicator "N" and, therefore, the payment for a diagnostic radiopharmaceutical assigned to HCPCS code A4641 is packaged into the payment for the associated service.

b. Contrast agents – All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator "N" and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.

Coverage determinations

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

Revisions to the *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (including inpatient Hospital Part B and OPPS))

CR 8338 updates the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)) by revising the table of contents and Section 61; 4.1 (Billing for Brachytherapy Sources), and by adding new Section 61.4.5 (Payment for New Brachytherapy Sources). The updated Chapter 4 is included as an attachment to CR 8338, and the new Section 61.4.5 (Payment for New Brachytherapy Sources) is as follows:

61.4.5-Payment for new brachytherapy sources

"Not otherwise specified (NOS) brachytherapy source codes are available for payment of new Brachytherapy sources for which source codes have not yet been established: C2698 (Brachytherapy source, stranded, not otherwise specified, per source), and C2699 (Brachytherapy source, non-stranded, not otherwise specified, per source).

The payment rates for these NOS codes are based on a rate equal to the lowest stranded or non-stranded payment rate for such sources, respectively, on a per source basis (as opposed, for example, to per mCi). Once CMS establishes a new HCPCS code for a new source, the new code will be assigned to its own APC, with the payment rate set based on consideration of external data and other relevant information, until claims data are available for the standard OPPS rate making methodology."

Additional information

The official instruction, CR 8338 issued to your FIs, RHHIs, and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2718CP.pdf*.

If you have any questions, please contact your FIs, RHHIs, or A/B MACs 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*.

MLN Matters® Number: MM8338
Related Change Request (CR) #: CR 8338
Related CR Release Date: June 7, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2718CP
Implementation Date: July 1, 2013

Pass-through payments for certified registered nurse anesthetist services

Provider types affected

This *MLN Matters*® article is intended for rural hospitals and critical access hospitals (CAHs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for certified registered nurse anesthetist (CRNA) services.

Provider action needed

This article is based on change request (CR) 7896, which clarifies that effective January 1, 2013, in addition to anesthesia services, qualifying CAHs and rural hospitals can receive CRNA pass-through payments for services the CRNA is legally authorized to perform in the state in which the services are furnished Make sure that your billing staffs are aware of this update.

Background

The Centers for Medicare & Medicaid Services (CMS) has received questions concerning whether, in addition to anesthesia, other CRNA service are eligible for pass-through payments.

CR 7896 applies to rural hospitals and to CAHs that are eligible for CRNA pass-through payments and provides clarification concerning which services are eligible for pass-through payments consistent with the regulatory change made in the 2013 physician fee schedule final rule. In that rule, the definition of "Anesthesia and related care" was added to the regulations at 42 CFR 410.69(b). The regulation change is discussed in the November 16, 2012 *Federal Register* page 69005 (77 FR 69005).

The Social Security Act, Section 1861(bb), defines the term "services of a certified registered nurse anesthetist" to mean "anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the state in which the services are furnished."

In the 2013 physician fee schedule final rule, CMS amended the regulations at 42 CFR 410.69(b) by adding a definition of "Anesthesia and related care," which reads "Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished." Therefore, CMS is clarifying that effective January 1, 2013, in addition to anesthesia services, qualifying CAHs and rural hospitals can receive CRNA pass-through payments for services the CRNA is legally authorized to perform in the state in which the services are furnished.

Additional information

The official instruction, CR 7896, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2719CP.pdf* on the CMS website.

If you have questions, please contact your Medicare contractor at the toll-free number found at *http://www.cms.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7896
Related Change Request (CR) #: CR 7896
Related CR Release Date: June 7, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2719CP
Implementation Date: September 9, 2013

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Ambulance payment reduction for non-emergency basic life support transports to and from renal dialysis facilities

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8269 which informs Medicare contractors about changes to the ambulance fee schedule (AFS). Effective for claims with dates of service on and after October 1, 2013, payment for non-emergency basic life support (BLS) transports of individuals with end-stage renal disease (ESRD) to and from renal dialysis treatment facilities will be reduced by 10 percent.

The reduced rate will be calculated and applied to Healthcare Common Procedure Code System (HCPCS) code A0428 when billed with destination modifier code "G" or "J", and the associated mileage, represented by HCPCS code A0425. A claim adjustment reason code of 45 (charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement) and group code "CO" (contractual obligation) will be on the remittance advice notice for claims for which a Medicare contractor has applied the reduced AFS methodology. Make sure that your billing staffs are aware of these changes.

Background

Section 637 of the American Taxpayer Relief Act of 2012 requires that, effective for transports occurring on and after October 1, 2013, fee schedule payments for non-emergency BLS transports of individuals with ESRD to and from renal dialysis treatment be reduced by 10 percent. The payment reduction affects transports to and from both hospital-based and freestanding renal dialysis treatment facilities for dialysis services provided on a non-emergency basis. Non-emergency BLS ground transports are identified by HCPCS code A0428. Ambulance transports to and from renal dialysis treatment are identified by origin/ destination modifier codes "G" (hospital-based ESRD) and "J" (freestanding ESRD facility) in either the origin or destination position of an ambulance modifier.

Payment for ambulance transports, including items and services furnished in association with such transports, are based on the AFS and includes a base rate payment plus a separate payment for mileage. The payment reduction for non-emergency BLS transports to and from renal dialysis treatment applies to both the base rate and the mileage reimbursement. The payment reduction will be applied to HCPCS code A0425 when billed with HCPCS code A0428 and origin/destination modifier code "G" or "J" is present.

For ambulance services, suppliers and hospital-based ambulance providers must report an accurate origin and destination modifier for each ambulance trip provided. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates a modifier. The first position alpha code equals origin; the second position alpha code equals destination. The reduction will be applied on claim lines containing HCPCS code A0428 with modifier code "G" or "J" in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code and HCPCS code A0425, which reflects the mileage associated with the transport.

Additional information

The official instruction, CR 8269 issued to your FI, carrier, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2703CP.pdf*.

If you have any questions, please contact your FI, carrier, or 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*.

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July 2013 update to Medicare physician fee schedule database

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services that are paid under the MPFS.

What you need to know

This article is based on change request (CR) 8291 and instructs Medicare contractors to download and implement a new MPFSDB.

Payment files were issued to your contractor(s) based upon the 2013 MPFS final rule (published in the *Federal Register* on November 16, 2012) as modified by 1) the American Taxpayer Relief Act of 2012 (applicable January 1, 2013), and 2) the final rule correction notice (published in the *Federal Register* in April 2013). This article details changes included in the July quarterly update to those payment files.

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 your contractor(s) based upon the 2013 Medicare physician fee schedule (MPFS) final rule (published in the *Federal Register* on November 16, 2012) as modified by the American Taxpayer Relief Act of 2012 (applicable January 1, 2013; see *http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf*), and the final rule correction notice (published in the *Federal Register*, April, 2013).

For more information and access to the 2013 final rule, see the "Physician Fee Schedule" Web page available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*.

Summary of changes in the July 2013 update (Unless otherwise specified, the effective date is the date of service.)

- Effective January 1, 2013, HCPCS codes *37211*, *37212,* and *92071* will have their bilateral indicators are being corrected to "1" = 150 percent payment adjustment applies if billed with modifier 50.
- Effective January 1, 2013, the TC component of the nerve conduction test (*95937*) will have its physician supervision of diagnostic procedures indicator changed to "7A" = "Supervision standards for level 77 apply.

  In addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill." ("77" = "Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under general supervision of a physician (TC only; PC always physician)"). (This change reflects the policy of Transmittal B-01-28, its effective date for the PT with ABPTS certification was July 1, 2001).
- Effective July 1, 2013, HCPCS codes J3487, J3488, and J9002 will have their PROCSTAT indicators changed from "E" to "I" = "Not valid for Medicare purposes."
- Effective July 1, 2103, HCPCS codes Q0090, Q2033, Q2051, Q2050, *0329T, 0330T, 0331T, 0332T, 0333T*, and *0334T* will be added to the fee schedule.
- Effective January 1, 2013, HCPCS codes G0460, "Autologous PRP for ulcers", will be added to the fee schedule. (For more information, please reference *MLN Matters*® article MM8213 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8213.pdf*)
- The following tables reflect additional changes made with their effective dates.

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Physician *(continued)*

HCPCS Code	*0329T*	*0330T*	*0331T*	*0332T*	*0333T*	*0334T*
Procedure status	C	C	C	C	C	C
Short descriptor	Mntr io press 24hrs/> uni/bi	Tear film img uni/bi w/i&r	Heart symp image plnr	Heart symp image plnr spect	Visual ep acuity screen auto	Perq stablj sacroiliac joint
Effective date	07/01/2013	07/01/2013	07/01/2013	07/01/2013	07/01/2013	07/01/2013
Work RVU	0.00	0.00	0.00	0.00	0.00	0.00
Full non-facility PE RVU	0.00	0.00	0.00	0.00	0.00	0.00
Full facility PE RVU	0.00	0.00	0.00	0.00	0.00	0.00
Malpractice RVU	0.00	0.00	0.00	0.00	0.00	0.00
Multiple procedure indicator	9	9	9	9	9	9
Bilateral surgery indicator	9	9	9	9	9	9
Assistant surgery indicator	9	9	9	9	9	9
Co-surgery indicator	9	9	9	9	9	9
Team surgery indicator	9	9	9	9	9	9
PC/TC	9	9	9	9	9	9
Site of service	9	9	9	9	9	9
Global surgery	YYY	YYY	YYY	YYY	YYY	YYY
Pre	0.00	0.00	0.00	0.00	0.00	0.00
Intra	0.00	0.00	0.00	0.00	0.00	0.00
Post	0.00	0.00	0.00	0.00	0.00	0.00
Physician supervision diagnostic indicator	09	09	09	09	09	09

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Physician *(continued)*

HCPCS code	*0329T*	*0330T*	*0331T*	*0332T*	*0333T*	*0334T*
Diagnostic family imaging indicator	99	99	99	99	99	99
Non-facility PE used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00	0.00
Facility PE used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00	0.00
MP used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00	0.00
Procedure status	C	C	C	C	C	C
Type of service	1	4	4	4	1	1
Long descriptor	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	Tear film imaging, unilateral or bilateral, with interpretation and report	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	Visual evoked potential, screening of visual acuity, automated	Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (eg, CT or fluoroscopic)

HCPCS code	**G0460**	**Q0090**	**Q2033**	**Q2051**	**Q2050**
Procedure status	**C**	**N**	**X**	**E**	**E**
Short descriptor	Autologous PRP for ulcers	Skyla 13.5mg	Influenza Vaccine, (Flublok)	Zoledronic acid 1mg	Doxorubicin inj 10mg
Effective date	01/01/2013	07/01/2013	07/01/2013	07/01/2013	07/01/2013
Work RVU	0.00	0.00	0.00	0.00	0.00
Full non-facility PE RVU	0.00	0.00	0.00	0.00	0.00

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Physician *(continued)*

HCPCS code	G0460	Q0090	Q2033	Q2051	Q2050
Procedure status	**C**	**N**	**X**	**E**	**E**
Full facility PE RVU	0.00	0.00	0.00	0.00	0.00
Malpractice RVU	0.00	0.00	0.00	0.00	0.00
Multiple procedure indicator	0	9	9	9	9
Bilateral surgery indicator	0	9	9	9	9
Assistant surgery indicator	9	9	9	9	9
Co-surgery indicator	0	9	9	9	9
Team surgery indicator	0	9	9	9	9
PC/TC	0	9	9	9	9
Site of service	9	9	9	9	9
Global surgery	000	XXX	XXX	XXX	XXX
Pre	0.00	0.00	0.00	0.00	0.00
Intra	0.00	0.00	0.00	0.00	0.00
Post	0.00	0.00	0.00	0.00	0.00
Physician supervision diagnostic indicator	09	09	09	09	09
Diagnostic family imaging indicator	99	99	99	99	99
Non-facility PE used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00
Facility PE used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00
MP Used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00
Type of service	1	9	V	1,9	1,9
Long descriptor	Autologous platelet rich plasma for chronic wounds/ ulcers, including phlebotomy,	Levonorgest rel- Releasing Intrauterine Contraceptive System (SKYLA), 13.5 mg	Influenza Vaccine,	Injection, Zoledronic Acid, not otherwise specified, 1mg	Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg

(continued on next page)

Physician *(continued)*

Your Medicare contractor(s) will, in accordance with the *Medicare Claims Processing Manual* (Pub 100-4, Chapter 23, Section 30.1; see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf*) give you 30 days notice before implementing the changes identified in CR 8291.

Note: Your Medicare contractor(s) will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, your Medicare contractor(s) will adjust claims brought to their attention.

Additional information

The official instruction, CR 8291 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2708CP.pdf*.

If you have any questions, please contact your Medicare contractor 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*.

MLN Matters® Number: MM8291
Related Change Request (CR) #: CR 8291
Related CR Release Date: May 17, 2013
Effective Date: January 1, 2013 and July 1, 2013
Related CR Transmittal #: R2708CP
Implementation Date: July 1, 2013

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2013, must be paid before the end of business on March 31, 2013.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *http://fms.treas.gov/prompt/rates.html* for the correct rate.

The new rate of 1.75 percent is in effect through December 31, 2013. Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

Medicare Benefit Policy Manual, updated with the implementation of the ESRD prospective payment system

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare contractors, fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for end stage renal disease (ESRD) services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8261 which updates the *Medicare Benefit Policy Manual* to reflect implementation of the ESRD prospective payment system. This system has been covered in prior articles and publications and the Centers for Medicare & Medicaid Services (CMS) is now updating their official manual to reflect this implementation.

Background

Effective January 1, 2011, CMS implemented the ESRD PPS, which provides a single payment to ESRD facilities, including hospital-based and independent facilities.

The payment includes all items and services used in furnishing outpatient dialysis services including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services.

CR 8261 updates the *Medicare Benefit Policy Manual*, Chapter 11- End Stage Renal Disease (ESRD) to reflect implementation of the ESRD PPS. A copy of the revised Chapter 11-End Stage Renal Disease (ESRD) is included as an attachment to CR 8261.

Additional information

The official instruction, CR 8261 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R171BP.pdf* on the CMS website.

See the ESRD payment page at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html* on the CMS website for specific ESRD PPS downloads and related links.

MLN Matters® article MM7064 "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services", explains PPS reimbursement for Part B ESRD services.

The article is at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7064.pdf*.

If you have any questions, please contact your Medicare contractor 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*.

MLN Matters® Number: MM8261
Related Change Request (CR) #: CR 8261
Related CR Release Date: June 7, 2013
Effective Date: January 1, 2011
Related CR Transmittal #: R171BP
Implementation Date: September 9, 2013

Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Take the time to 'chat' with the website team

Save valuable time by asking your website-related questions online – with First Coast's new Live Chat service.
Monday - Friday, 10 a.m. - 2 p.m. EDT

Educational Events

Provider outreach and educational events – July/August 2013

Medicare Part A/B: Internet-based PECOS

When: Thursday, July 18
Time: 8:00 a.m. – noon ET **Delivery language:** English
Type of Event: Jacksonville, FL **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Medifest 2013 - Tallahassee

When: July 24-25
Location: Four Points By Sheraton Tallahassee Downtown
Time: All Day **Delivery language:** English
Type of Event: Educational Seminar **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

1. **Online** – Visit *www.fcsouniversity.com*, logon to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time user?** Set up an account by completing "Request a New Account" online. Providers with no national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.
2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 904-791-8103. Class materials will be faxed to you the day of the event.

Please note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking the *Education* section of our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit *medicare.fcso.com*, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. Our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Explore our catalog of online courses and learn more at *www.fcsouniversity.com*.

Other Educational Resources

CMS Medicare Provider e-News

The Centers for Medicare & Medicaid Services (CMS) Medicare Provider e-News is an official *Medicare Learning Network*® (*MLN*)-branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate.

To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to the latest e-News:

- 'CMS Medicare FFS Provider e-News': May 30, 2013, – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-30-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': June 6, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-06-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': June 13, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-13Enews.pdf*
- 'CMS Medicare FFS Provider e-News': June 20, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-20Enews.pdf*

Source: CMS PERL 201305-05, 201306-03, 201306-04, 201306-05

Register for free, hands-on Internet-based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment.

Click on the date for any of the following sessions: July 18, or August 15, 2013.

Addresses

First Coast Service Options

American Diabetes Association certificates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

Claims/correspondence
Florida:
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

U.S. Virgin Islands:
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

Electronic claim filing
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

Fraud and abuse
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests
(relative to cost reports and audits)

Provider Audit and Reimbursement (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

Local coverage determinations
Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)
General information, conditional payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital protocols, admission questionnaires, audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, automobile accident cases, settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections
Repayment plans, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, interim rate determinations, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Post-pay medical review
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

Redetermination
Florida:
Medicare Part A Redetermination and Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Special delivery mail and courier services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

Durable medical equipment regional carrier (DMERC)
DME, orthotic and prosthetic device, take-home supply, and oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare
Palmetto Government Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health and hospice intermediary
Palmetto Government Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Phone numbers

Customer service/IVR
Providers:
888-664-4112
Speech and hearing impaired
877-660-1759

Beneficiaries:
800-MEDICARE (800-633-4227)
Speech and hearing impaired
800-754-7820

Credit balance report
Debt recovery
904-791-6281
Fax
904-361-0359

Electronic data interchange
888-670-0940

Option 1 – Transaction support

Option 2 – PC-ACE support

Option 3 – Direct data entry (DDE)

Option 4 – Enrollment support

Option 5 – 5010 testing

Option 6 – Automated response line

Provider audit and reimbursement
904-791-8430

Provider education and outreach
Seminar registration hotline
904-791-8103
Seminar registration fax
904-361-0407

Provider enrollment
877-602-8816

Websites

First Coast Service Options Inc. (Florida and U.S. Virgin Islands Medicare contractor)
medicare.fcso.com

Centers for Medicare & Medicaid Services
Providers:
www.cms.gov

Beneficiaries:
www.medicare.gov

Puerto Rico Contact Information

Addresses

Claims

Additional documentation
General mailing
Congressmen mailing
First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Redeterminations

Redeterminations on overpayments
First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Debt recovery (except for MSP)

First Coast Service Options Inc.
P.O. Box 45096
Jacksonville, FL 32232-5096

Post-payment medical exams

First Coast Service Options Inc.
P.O. Box 44159
Jacksonville, FL 32231-4159

Freedom of Information Act (FOIA*) related requests

First Coast Service Options Inc.
Attn: FOIA PARD 16T
P.O. Box 45268
Jacksonville, FL 32232-5268

Medicare fraud and abuse

First Coast Service Options Inc.
P.O. Box 45087
Jacksonville, FL 32232-5087

Provider enrollment

First Coast Service Options Inc.
Provider Enrollment
Post Office Box 44021
Jacksonville, FL 32231-4021

Electronic Data Interchange (EDI*)

First Coast Service Options Inc.
Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

MSPRC DPP debt collection – Part A

First Coast Service Options Inc.
P.O. Box 44179
Jacksonville, FL 32231-4179

Credit balance
First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

Audit and reimbursement department

Reporte de costo, auditoría, apelación de reporte de costo, porcentaje tentativo, rama de PS &R
First Coast Service Options Inc.
P.O. Box 45268
Jacksonville, FL 32231-0048

Overnight mail and other special handling postal services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)
CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Phone Numbers

Providers

Customer service – free of charge
Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-908-8433

For the hearing and speech impaired (TDD)
1-888-216-8261

Interactive voice response (IVR)
1-877-602-8816

Beneficiary

Customer service – free of charge
1-800-MEDICARE
1-800-633-4227

For the hearing and speech impaired (TDD)
1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number
1-904-361-0407

Audit And Reimbursement Department

Fax number
1-904-361-0407

Websites

Providers

First Coast – MAC J9
medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services
www.medicare.gov