Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

July 2013

In this issue

How does First Coast rate with you?

Register now for your chance to rate your satisfaction with us

As your Medicare administrative contractor (MAC), improving the quality of service we provide to you is our top priority, but we can't do it alone. Teamwork is the key. The comments and suggestions you share through our provider feedback forums help us know not only what we are doing right but also what we can do better.

We invite you and the other valued members of our provider community to rate your satisfaction with our performance in a brand-new way.

Introducing the MAC Satisfaction Indicator

The MAC Satisfaction Indicator (MSI) is an important new tool that allows the Centers for Medicare & Medicaid Services (CMS) to measure provider satisfaction within each contractor's jurisdiction. Each year, CMS will randomly select its MSI administration sample from a list of providers who have registered to become participants.

Your MSI participation will help us improve Medicare

The primary goals of the MSI are to help CMS evaluate providers' experiences with their assigned contractors and identify key drivers of customer satisfaction among the provider community. In addition, CMS plans to use the results from the MSI to monitor trends, improve oversight, and increase the efficiency of the Medicare program.

Most importantly, the MSI empowers providers by giving them an active voice in the Medicare program and helping CMS and contractors understand what is most important to the communities they serve. If you are a Medicare fee for service provider or represent a Medicare FFS provider, you are eligible to be selected to participate in this important new CMS initiative.

Registration required

CMS opened registration for the MSI July 8 -- but only for a limited time. So, please don't delay. It will only take a few minutes to complete the *MSI Participant Registration Information form*, and registration is required to participate. If selected, you'll have the opportunity to share your comments, suggestions, and feedback about your experiences with First Coast.

Your opinion matters. Let your voice be heard: *Register today*.

Contents

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.

Innovative providers use PDS reports to improve billing practices

Each year over 32,000 people rely on Escambia County Emergency Medical Services (EMS) for transport to health care providers. Like many public agencies around the United States, the county's EMS faces funding pressures to continue to serve their community at the level Pensacola area residents have come to expect.

Joe Scialdone, who manages Medicare billing for Escambia County EMS, says billing accuracy and timeliness are important to the agency's ability to provide life-saving services for its residents. "Escambia County EMS does not receive an operating subsidy from the county, so it is critical that we accurately bill for our EMS services on our initial invoice," Scialdone said.

> ***"Getting to the reports is very easy. It [PDS report] provides a snapshot of the quality of the claims we are filing."***
>
> - Joe Scialdone, Escambia County EMS

To stay on top of trends, Scialdone uses *provider data summary (PDS) reports* from First Coast Service Options Inc (First Coast). The PDS is a comprehensive billing report designed to help providers identify potential Medicare billing issues. The report gives a detailed analysis of personal billing patterns in comparison with those of similar providers.

Each quarter, he reviews PDS reports which show recent Medicare billing trends for the county as well as nearby agencies. "Getting to the reports is very easy," Scialdone says. "It [PDS report] provides a snapshot of the quality of the claims we are filing," he said.

Improving the bottom line

Scialdone points to two improvement initiatives where PDS reports helped the agency improve its processes and ultimately, the organization's bottom line.

"We had a team goal to reduce the number of days between providing a transport service and filing a claim with Medicare. We wanted to make sure the quality of our claims did not suffer. The data from the PDS report helped us track the information to make sure we were not just pushing more claims into the system quicker," Scialdone said. Ultimately, the team reduced the time from 13 days to three without an increase in the claim denial rates.

The second initiative grew from an increase in Medicare billing denials, which Scialdone spotted through his regular review of PDS reports. "We put together a hospice task team to review our procedures when we saw a spike in hospice claim denials. From our standpoint, it is not always evident that we were transporting a hospice patient. We would arrive at the hospital and later find the patient was in hospice care. Using the trends spotted with the PDS report, we changed our process to improve our claims."

"Now when we make the transport, we ask the hospice provider to sign a form that states the nature of the transport is related to end of life care," Scialdone said. "We make the determination up front before the claim is filed and know whether to bill the provider if the transport is related to the hospice care or the Medicare Part B program if the reason for the transport is unrelated to the patient's terminal diagnosis."

Other online tools

In addition to PDS reports, First Coast offers providers *other online tools* for providers to improve their billing practices. *Comparative billing reports (CBR)* and the *evaluation and management (E/M) interactive worksheet* are effective tools in reducing billing errors.

Providers may request different types of CBRs based on different criteria such as type of bill, provider-specific E/M distribution, or service specific distribution. The interactive E/M worksheet helps providers accurately bill E/M services provided to Medicare beneficiaries.

First Coast recommends providers use these tools to design and implement a compliance program to improve Medicare billing practices. For more information, First Coast *offers tips for providers* on how to develop a compliance program.

How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at *http://medicare.fcso.com/PDS/index.asp.*

Check out the new First Coast University

Experience the redesigned *First Coast University*, where you will have fast and easy access to what's new, what's coming, and what's happening now with Medicare provider education.

Best of all, you won't need to sign into your *First Coast University* account to explore educational opportunities available to providers within our jurisdiction.

If you have been thinking about establishing your free *First Coast University* account, or if you already have an account and have never had the opportunity to explore all that First Coast has to offer you and your staff, come explore the new redesigned First Coast University and find out what you've been missing.

First Coast University: Your Gateway to Medicare Knowledge

Come explore our redesigned site, where you will be able to:

- Explore First Coast's Medicare educational events calendar and register for classes and seminars that will help you learn more about the Medicare program and find ways to improve the accuracy and efficiency of your Medicare billing process
- Learn how to launch a webcast and get the most out of your interactive learning experience
- Download recordings of past First Coast webcasts
- Learn about upcoming Medifest events
- View all the classes offered by session without having to log in

- Take online training in preparation for Medifest
- Explore our online course catalog and register for informative courses
- Train when and where it is most convenient for you
- Access online training resources 24/7
  - Access useful links
  - Find help when you need it:
  - Call or email First Coast University's dedicated staff
  - Find answers in our FAQs section
  - Share your feedback

Our redesigned *First Coast University* is coming soon, and we can't wait to share this exciting new gateway to Medicare knowledge with you.

Rate your satisfaction with your MAC

Your opinion counts

The Centers for Medicare & Medicaid Services (CMS) is launching a new instrument for 2013 called the Medicare Administrative contractor satisfaction indicator (MSI). The MSI is a tool that measures your satisfaction with Medicare claims administrative contractors (MACs) that serve you. This measuring tool will provide the best opportunity for you to rate your satisfaction with your MAC. Your input will help your MAC to improve the services that they offer you. Participation is voluntary, but you must register if you would like to take the MSI. A random sample will be drawn from the registry.

If you are a Medicare fee-for-service (FFS) provider or you represent a Medicare FFS provider and are interested in participating, take a moment to register your contact information by completing the application at *https://adobeformscentral.com/?f=eMRKPqaWpqMxNOmTQpSKDA* . It will take about one minute to complete.

For more information visit the CMS MSI website at *http://www.cms.gov/Medicare/Medicare-Contracting/MSI*.

Let your voice be heard.

Cataract removal, Part B

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and providers who bill Medicare contractors for cataract removal services performed for Medicare beneficiaries.

What you need to know

Recovery auditors conduct claim reviews of cataract removal billing codes. The Centers for Medicare & Medicaid Services (CMS) policy dictates that cataract removal can only occur once per eye. Remember that *Current Procedural Terminology* (*CPT*®) codes for cataract removal are mutually exclusive and they can only be used one time for each eye.

Background

CMS is publishing this article to remind providers of the correct billing for cataract removal. Only one unit per eye can be billed. Cataract removal can only occur once per eye. CMS recovery auditors have identified overpayments associated to outpatient hospital providers billing more than one unit of cataract removal for the same eye for the same date of service.

According to the *National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services*, Chapter 8, Section D #3, cataract removal codes are mutually exclusive of each other and can only be billed once for the same eye. Because *CPT*® codes describing cataract extraction (*66830-66984*) are mutually exclusive of one another, providers may not report multiple codes for the same eye even if more than one technique is used or more than one code could be applicable. Only one code from this *CPT*® code range may be reported for an eye.

Codes involved with definition of each code:

CPT® code	Definition of *CPT*® code
66830	*Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)*
66840	*Removal of lens material; aspiration technique, 1 or more stages*
66850	*Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration*
66852	*Removal of lens material; pars plana approach, with or without vitrectomy*
66920	*Removal of lens material; intracapsular*
66930	*Removal of lens material; intracapsular, for dislocated lens*
66940	*Removal of lens material; extracapsular (other than 66840, 66850, 66852)*
66982	*Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)*
66983	*Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)*
66984	*Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)*

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Cataract *(continued)*

Case Studies

Recovery auditors presented the following examples to illustrate this policy:

Example 1: For date of service (DOS) 10/20/09 the provider billed and received reimbursement for code *66852* LT modifier and also *66984* LT modifier. Since these codes are mutually exclusive of one another only one code should have been reimbursed. Per the *NCCI Policy Manual CPT*® codes describing cataract extraction (*66830-66984*) are mutually exclusive of one another. Only one code from this *CPT*® code range may be reported for an eye. Therefore Medicare recovered payment for *CPT*® code *66984*.

Example 2: For DOS 11/23/10 the provider billed and received reimbursement for 2 units of code *66984* RT modifier. Since cataract removal can only occur once per eye for the same date of service this would be an overpayment. Medicare would adjust the units down to 1 unit for this claim line.

Additional information

The most recent *NCCI Manual* is available in the *Downloads* section of *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

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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Pre-admission diagnostic testing review

Provider types affected

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

Provider action needed

Stop – impact to you

This article is to inform you that the recovery auditors have identified pre-admission diagnostic testing services being reimbursed in addition to reimbursement of the inpatient prospective payment system (IPPS) hospital for services provided during the defined temporal window as a source of overpayments.

Caution – what you need to know

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage.

The technical portion of all services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and therefore, must be included on the bill for the inpatient stay.

The technical portion of outpatient services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the first, second, and the third calendar days (1 calendar day for a non-subsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless these services are unrelated to the inpatient hospital claim (that is, these preadmission services are clinically distinct or independent from the reason for the beneficiary's inpatient admission).

Go – what you need to do

Make sure that your billing staffs are aware of these billing requirements in order to avoid billing errors that may lead to overpayments.

(continued on next page)

Admissions *(continued)*

Background

Medicare Policy

Section 102(a)(1) of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) provides that, for outpatient services furnished on or after June 25, 2010, the technical portion of all services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and thus, must be included on the bill for the inpatient stay.

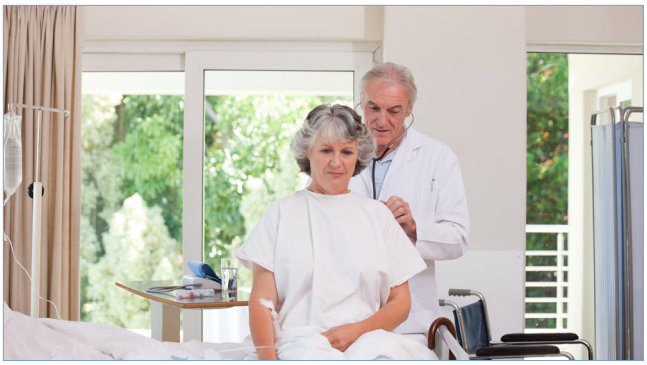
Also, the technical portion of outpatient services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the first, second, and the third calendar days (1 calendar day for a non-subsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless these services are unrelated to the inpatient hospital claim (that is, these preadmission services are clinically distinct or independent from the reason for the beneficiary's inpatient admission).

Claims examples

Example 1: An outpatient claim was submitted for *CPT*® codes *36415* - Routine Venipuncture; *80053* - *Comprehensive metabolic panel*; *86304* - Immunoassay, tumor, CA 125; *83725* - Assay of magnesium; and *85025* - Complete CBC w/auto diff WBC for date of service (DOS) 2/18/2011. The patient was also admitted to inpatient with the same DOS, 2/18/2011. The admitting diagnostic codes were 183.0 malignant neoplasm ovary and V58.11 Antineoplastic chemotherapy and immunotherapy.

Finding: Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

Example 2: An outpatient claim was submitted for *CPT*® codes *36415* - Routine venipuncture; *80053* - *Comprehensive metabolic panel*; *83615* - Lactate (LD) (LDH) enzyme; *85025* - Complete CBC w/auto diff WBC; *86850* - RBC antibody screen; *86900* - *Blood typing ABO*; *86901* - *Blood typing Rd* (D); and *86923* -



Compatibility test for DOS 3/15/2011. The patient was admitted to inpatient on the following day, 3/16/2011. The admitting diagnostic codes were 285.9 Anemia NOS and 162.8 Malignant neoplasm bronchus or lung NEC.

Finding: When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and FIs apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and are included in the Part A payment.

Where to read about this policy

The *Medicare Claims Processing Manual*, Chapter 3 - Inpatient Hospital Billing, Section 40.3 - Outpatient Services Treated as Inpatient Services, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf*, states:

"Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment."

"This provision does not apply to ambulance services and maintenance renal dialysis services (see the *Medicare Benefit Policy Manual*, Chapters 10 and 11,

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Admissions *(continued)*

respectively). Additionally, Part A services furnished by skilled nursing facilities (SNFs), home health agencies (HHAs), and hospices are excluded from the payment window provisions."

"For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children's hospitals; and cancer hospitals."

"Critical access hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window."

"An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facilities routine operations), regardless of whether it also has the authority to make the policies."

Additional information

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

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Customer service inquiries on Part A appeals

First Coast customer service often receives inquiries on the status of Part A appeals. To provide better service to our customers, we are providing some additional information and tips which we hope will help you when you file an appeal of your claim.

- You should always allow at minimum 60 days for us to process your appeal request.
- If you call or write prior to 60 days and your appeal has not yet finalized, we can only tell you if we have received your request.
- If your claim originally denied because medical documentation was not received timely and we subsequently receive an appeal, we are required to refer your appeal to our program integrity department. When an appeal is sent to Program Integrity, it can take an additional 60 days to process the appeal request.

The requirement to send appeal request to program integrity is outlined under the Internet-only manual 100-04 Chapter 34 Section 10.3. You may wish to review this information in totality by accessing the following link:*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf*.

As a result of increasing requirements to reduce the Medicare paid claims error rate, there is an increase in the need to review records. You may avoid the need to appeal denials related to documentation request and the associated processing delays, by enhancing office procedures related to responding timely to documentation request.

If a referral is made to the zone program integrity contractor (ZPIC) the timeframes for resolution starts from the date that they receive the request.

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Update to Chapter 15 of the *Program Integrity Manual*

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) 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) 8341, which incorporates certain provider enrollment policy and operational clarifications into Chapter 15 of the *Program Integrity Manual* (PIM).

Background

The key clarifications/updates of interest to providers are as follows:

- If a contractor returns an enrollment revalidation application, the contractor shall – unless an existing Centers for Medicare & Medicaid Services (CMS) instruction or directive dictates otherwise – deactivate the provider's Medicare billing privileges under 42 CFR 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.
- If a contractor returns a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires – unless the provider has resubmitted the revalidation application.

  If the provider resubmits the revalidation application and the contractor returns it again, rejects it, or denies it, the contractor shall – unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.
- If the contractor rejects or denies a revalidation application, the contractor shall – unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's Medicare billing privileges under 42 CFR 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.
- If the contractor rejects or denies a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires, unless the provider has resubmitted the revalidation application. If the provider resubmits the revalidation application and the contractor rejects it again, returns it, or denies it, the contractor shall – unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.

- Absent a CMS instruction or directive to the contrary, the contractor shall send a denial letter to the provider or supplier (1) no later than five business days after the contractor concludes that the provider or supplier's application should be denied, or (2) if the denial requires prior CMS authorization, no later than five business days after CMS notifies the contractor of such authorization.

Additional information

The official instruction, CR 8341 issued to your Medicare contractor may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R474PI.pdf*.

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

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National coverage determination for transcatheter aortic valve replacement – mandatory reporting of clinical trial number

Note: This article was revised July 12, 2013, to reflect revised change request (CR) 8255 issued July 11. The article has been updated to clarify that the addition of "CT" with the registry number is only for paper claims.

Also, Web addresses for the articles related to CRs 7897 and 8168 are now in this article. The CR release date, transmittal number and the Web address for accessing CR 8255 are revised. The article was previously published in the May 2013 edition of *Medicare A Connection*, Pages 13-14. All other content remains the same.

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (A/B MACs)) for transcatheter aortic valve replacement (TAVR) services provided to Medicare beneficiaries.

Provider action needed

CR 8255 is being issued to require that claims for TAVR carry an approved clinical trial number, effective for claims processed on or after July 1, 2013.

Given that TAVR is covered only under coverage with evidence development (CED), the Centers for Medicare & Medicaid Services (CMS) has ensured that the approved clinical trials and approved registry have obtained valid numbers from *http://www.clinicaltrials.gov* and that those numbers are maintained at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html*.

See the *Background* and *Additional information* sections of this article for further details regarding these changes. Please make sure that your billing staffs are aware of these changes.

Background

On May 1, 2012, CMS issued a national coverage determination (NCD) covering TAVR with CED. The TAVR NCD is available at *http://www.cms.gov/medicare-coverage-database/details/ncddetails.aspx?NCDId=355*.

TAVR (also known as TAVI or transcatheter aortic valve implantation) is a new technology for use in treating aortic stenosis. A bioprosthetic valve is inserted percutaneously using a catheter and implanted in the orifice of the native aortic valve.

The procedure is performed in a cardiac catheterization lab or a hybrid operating room/cardiac catheterization lab with advanced quality imaging and with the ability to safely accommodate complicated cases that may require conversion to an open surgical procedure.

The interventional cardiologist and cardiac surgeon jointly participate in the intra-operative technical aspects of TAVR. CR 8255 requires that claims for TAVR carry an approved clinical trial number. Specific claims processing instructions are as follows:

- For professional claims processed on or after July 1, 2013, Medicare expects this numeric, 8-digit clinical trial (CT) registry number to be preceded by the alpha characters of "CT" in Field 19 of paper Form CMS-1500 claims or entered similarly BUT WITHOUT THE "CT" prefix in the electronic 837P in Loop 2300 REF01 (REF01=P4).
- Professional claim lines for *0256T, 0257T, 0258T, 0259T, 33361, 33362, 33363, 33364, 33365*, and *0318T* must have the CT registry number, a Q0 modifier, and a secondary diagnosis code of V70.7 (ICD-10=Z00.6). Such claims lines will be returned as unprocessable if the CT registry number, the modifier Q0, or the V70.7 (ICD-10=Z00.6) is not present.
- Claims for TAVR submitted without the CT registry number will be returned as unprocessable with the following messages:
- Claims adjustment remarks code (CARC) 16: "Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)";
- Remittance advice remarks code (RARC) MA50: "Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.";
- RARC MA130: "Your claim contains incomplete

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NCD *(continued)*

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."; and

- Group code-contractual obligation (CO).

TAVR claims submitted without the Q0 modifier will be returned as unprocessable with the following messages:

- CARC 4: "The procedure code is inconsistent with the modifier used or a required modifier is missing.

  Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.";
- RARC N29: "Missing documentation/orders/notes/ summary/report/chart.";
- 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."; and
- Group code-contractual obligation (CO).
- For claims processed on or after July 1, 2013, the claim lines for *0256T, 0257T, 0258T, 0259T, 33361, 33362, 33363, 33364, 33365* & *0318T* will be returned as unprocessable when billed without secondary diagnosis code V70.7 (ICD-10=Z00.6) with the following messages:
- CARC 16: "Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either NCPDP reject reason code, or Remittance Advice Remark Code that is not an ALERT.)";
- RARC M76: "Missing incomplete/invalid diagnosis or condition.";
- 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."; and
- Group code-contractual obligation (CO).

Medicare also requires the CT registry number on hospital claims for TAVR for inpatient hospital discharges on or after July 1, 2013. Claims for TAVR for inpatient discharges on or after July 1, 2013, that do not have the registry number will be rejected. Medicare is ensuring the presence of the procedure codes and associated diagnosis and condition codes per CR 7897/TR 2552, issued September 24, 2012.

Additional information

The official instruction, CR 8255 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2737CP.pdf*.

Note: CR 8255 does not eliminate the previous instructions contained in CRs 7897 and 8168 that were not formally replaced/revised. Links to the related articles for these CRs may be found below.

For more information regarding the Medicare approved registry and the Medicare approved clinical trials which have been reviewed and determined to meet the requirements of coverage go to *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html*.

You may also want to review two related TAVR articles MM8168 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8168.pdf*) and MM7897 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7897.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 CR Transmittal #: R2737CP
Implementation Date: October 7, 2013

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Additional/subsequent procedures performed during the 90 day global period for major surgeries

Provider types affected

This *MLN Matters*® special edition article is intended or physicians who perform and bill for surgery on Medicare beneficiaries. This article may also be of interest to hospitals, multispecialty clinics, and accountable care organizations.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is publishing this article to remind providers of the global surgery period and to educate providers on how to correctly bill for additional/subsequent procedures performed in the 90-day global period.

You and your billing staff should review and be familiar with the payment guidelines for evaluation and management (E/M) services provided during the global surgery period.

Background

CMS is reminding providers of the global surgical package (GSP) and the services which are included.

Recovery auditor reviews have determined that providers are incorrectly billing E/M services provided by the surgeon the day before major surgery, the day of minor surgery, 0-10 days after minor surgery, and up to 90 days after major surgery. The GSP was established by CMS to ensure that all components of surgery (including pre- and post-operative services) were bundled into one payment.

Under Medicare physician fee schedule rules, most surgical procedures include pre- and postoperative E/M services.

Physicians can indicate that E/M services rendered during the global period are not included in the GSP by submitting modifiers 24 (Unrelated E/M service by same physician during postoperative period), 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service), and 57 (Decision for surgery made within global surgical period) with the E/M service.

In addition, where appropriate, modifier 79 (Unrelated procedure or service by the same physician during the postoperative period) may be used.

CMS established modifier 79 to simplify billing for services provided to a patient by the same physician during the postoperative period that were unrelated to the original surgical procedure and not included in the payment for the surgical procedure.

Make certain you and/or your billing staff are NOT billing for E/M services that are already included in the payment for global surgery.

Your staff may want to review the payment guidelines for E/M services provided during the global period of surgery. These instructions can be found in the *Medicare Claims Processing Manual*, Chapter 12, Section 40, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf*.

Additional information

For more information on the global surgical package, refer to "Global Surgery Fact Sheet" which provides an overview of global surgery, available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.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 CR Transmittal #: N/A
Implementation Date: N/A

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Incorrect number of units billed for rituximab (HCPCS J9310) and bevacizumab (HCPCS C9257 and J9035) – dose versus units billed

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and nonphysician practitioners who bill Medicare for rituximab (Rituxan®) and bevacizumab (Avastin®). The purpose of the article is to remind providers to properly compute the units of rituximab and bevacizumab billed to Medicare.

What you need to know

This article informs you that the recovery auditors conducted complex reviews of claims billed for rituximab and bevacizumab. According to the Healthcare Common Procedure Coding System (HCPCS), rituximab is coded as J9310 and bevacizumab is coded as C9257 or J9035.

Recovery auditors reviewed medical records to verify the exact number of milligrams (mg) administered and identify the correct number of units that should have been billed to Medicare.

To accurately bill for rituximab and bevacizumab, it is very important that providers instruct their billing staff to verify the milligrams given, convert to the proper units for billing, and ensure the quantity administered is consistent with the units billed. Providers should differentiate between unit billing versus milligram billing on these high cost drugs.

The following are key points to remember when billing Medicare for rituximab (J9310):

- J9310 is defined in the HCPCS manual as: Injection, rituximab, 100 milligrams (mg)
- One (1) unit represents 100 mg of rituximab ordered/administered per patient
- Rituximab should be billed based on units, not the total number of milligrams.
- For example, if the quantity administered is 200 mg and the description of the drug code is 100 mg, the units billed should be two (2).

The following are key points to remember when billing Medicare for bevacizumab (J9035):

- C9257 is defined in the HCPCS manual as: Injection, bevacizumab, 0.25 mg
- J9035 is defined in the HCPCS manual as: Injection, bevacizumab, 10 mg
- One (1) unit represents 10 mg of (J9035) or 0.25 mg (C9257) of bevacizumab ordered/administered per patient
- Bevacizumab should be billed based on units
  - For example, if the quantity administered is 300 mg and the description of the drug code is 10 mg, the units billed should be thirty (30), not the total number of milligrams.

Examples of findings

Rituximab

1. For date of service 10/27/2009, the provider billed J9310 for 71 units. Since J9310 has 1 unit equal to 100 mg, this would mean that the patient received 7,100 mg of rituximab for that date of service. This seemed abnormal and, therefore, a chart was requested. The medical record showed that the patient only received 710 mg and the provider billed an incorrect number of units. The correct units should be 7.1 units; however, this would be rounded up to 8 units for billing purposes.

2. For date of service 04/29/2010, the provider billed J9310 for 100 units. Since J9310 has 1 unit equal to 100 mg, this would mean that the patient received 10,000 mg of rituximab for that date of service. This seemed abnormal and, therefore, a chart was requested. The medical record showed that the patient only received 1,000 mg and the provider billed an incorrect number of units. The units were adjusted down to 10 units to reflect the proper dosage amount given.

Bevacizumab

1. A provider billed code J9035 for 1,300 units. Since J9035 has 1 unit equal to 10 mg, this would mean that the patient received 13,000 mg of bevacizumab for that date of service. It is unlikely a patient would receive 13,000 mg of bevacizumab in one day. The medical record showed that the patient only received 1,300 mg and the provider billed an incorrect number of units. Therefore, the correct number of units that should have been billed is 130 units.

2. For date of service 10/6/2010, the provider billed code J9035 for 1,600 units. Since J9035 has 1 unit equal to 10 mg, this would mean that the patient received 16,000 mg of bevacizumab for

(continued on next page)

Rituximab *(continued)*

that date of service. It is unlikely a patient would receive 16,000 mg of bevacizumab in one day. The medical record showed that the patient only received 1,600 mg and the provider billed an incorrect number of units. Therefore, the correct number of units that should have been billed is 160 units.

Additional information

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

Links to additional resources:

National coverage determination (NCD) for bevacizumab

- *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*
  - Document ID: 110.17

Supplementary *MLN Matters*® articles:

- *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3419.pdf*
- *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3742.pdf*

Alpha-Numeric HCPCS codes:

http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

Medicare manual references:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

2013 Medicare Part B drug average sales price: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2013ASPFiles.html*

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Billing social work and psychological services in comprehensive outpatient rehabilitation facilities

Note: This article was revised on July 1, 2013, to reflect the revised change request (CR) 8257 issued on June 28. In this article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. The article was previously published in the May 2013 edition of *Medicare A Connection*, Page 31. All other information remains the same.

Provider types affected

This *MLN Matters*® article is intended for comprehensive outpatient rehabilitation facilities (CORFs) 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 CR 8257, which updates the list of Healthcare Procedure Coding System (HCPCS) codes billable in a CORF. It also manualizes billing instructions for a national coverage determination (NCD) related to CORFs that was previously omitted from the *Medicare Claims Processing Manua*l. CR 8257 contains no new policy. It updates Medicare system edits and billing instructions to more accurately reflect current policy.

Background

In 2008, the Centers for Medicare & Medicaid Services (CMS) issued CR 5898, entitled "Comprehensive Outpatient Rehabilitation Facility (CORF) Billing Requirement Updates for fiscal year (FY) 2008." That CR established a number of edits in Medicare claims processing systems that ensure the correct *Current Procedural Terminology*® (*CPT*®)/HCPCS code and revenue code combinations are billed on CORF claims (type of bill (TOB) 75x). One of these edits required that *CPT*® code *96152* was the only code that could be billed with medical social services or behavioral health revenue codes on CORF claims.

In September 2009, Medicare issued CR 6005, entitled "Comprehensive Outpatient Rehabilitation Facility (CORF) Services." CR 6005 created a new HCPCS code, G0409, for billing of social work and psychological services in the CORF setting. At that time, Medicare did not update the claims processing system to replace *CPT*® code *96152* with HCPCS code G0409 in the edit created by CR 5898. CR 8257 corrects this oversight. On TOB 75x, G0409 can only be billed with revenue codes *0569* or *0911*. Also, note that Medicare only allows revenue codes *0270*, *0274*, *0279*, *029x*, *0410*, *0412*, *0419*, *042x*, *043x*, *044x*, *0550*, *0559*, *0569*, *0636*, *0771*, *0911*, and *0942* to be billed on TOB 75x.

With CR 8257, Medicare is also correcting another oversight in the therapy chapter of the *Medicare Claims Processing Manual*. In 2001, Medicare issued CR 1535, which implemented an NCD regarding biofeedback training for the treatment of urinary incontinence. CR 1535 established CORF claims (type of bill 75x) as a valid type of bill for payment of biofeedback training as defined by the NCD.

Additional information

The official instruction, CR 8257 issued to your FI or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2736CP.pdf*.

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: MM8257
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Related CR Release Date: June 28, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2736CP
Implementation Date: October 7, 2013

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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

Revisions to LCDs

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

Bone mineral density studies – revision to the Part A LCD (addition of diagnosis)

LCD ID number: L28766 (Florida)

LCD ID number: L28767 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was most recently revised July 2, 2013.

Since that time, the LCD has been revised to add diagnosis code V58.65 (Long-term [current] use of steroids) under the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after August 7, 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*.

Bone mineral density studies – revision to the Part A LCD (addition of therapeutic agent)

LCD ID number: L28766 (Florida)

LCD ID number: L28767 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was most recently revised January 1, 2012.

Since that time, the LCD has been revised to add rIsedronate sodium (Atelvia) under 'Frequency Standards' in the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD and under the 'Utilization Guidelines' section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after July 2, 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*.

Myocardial imaging positron emission tomography scan – revision to Part A LCD

LCD ID number: L28933 (Florida)

LCD ID number: L28954 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for myocardial imaging, positron emission tomography (PET) scan was most recently revised June 4, 2013.

Since that time, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add ICD-9-CM diagnosis codes 413.0 (Angina decubitus) and 413.9 (Other unspecified angina pectoris).

Effective date

This LCD revision is effective for services rendered **on or after July 26, 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

Ocular photodynamic therapy with verteporfin – revision to Part A LCD

LCD ID number: L28939 (Florida)

LCD ID number: L28960 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ocular photodynamic therapy (OPT) with verteporfin was most recently revised April 18, 2012.

Since that time, based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8292, transmittals 155 and 2728, dated June 14, 2013, the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the LCD were updated to add verbiage to allow subsequent follow-up visits with either fluorescein angiogram (FA) (*CPT*® code *92235*) or optical coherence tomography (OCT) (*CPT*® code *92133* or *92134*) prior to treatment.

Effective date

This LCD revision is effective for claims processed **on or after July 16, 2013**, for services rendered **on or after April 3, 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*.

Troponin – revision to the Part A LCD

LCD ID number: L29000 (Florida)

LCD ID number: L29032 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for troponin was most recently revised February 22, 2012. Since that time, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add ICD-9-CM diagnosis codes 428.21 (Acute systolic heart failure), 428.23 (Acute on chronic systolic heart failure), 428.41 (Acute combined systolic and diastolic heart failure) and 428.43 (Acute on chronic combined systolic and diastolic heart failure).

Effective date

This LCD revision is effective for services rendered **on or after July 24, 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

Issues completing the PWK fax/mail coversheet

First Coast Service Options' (First Coast's) claims department is receiving a high volume of invalid or unnecessary PWK (5010 paperwork segment) fax/mail coversheets. If a coversheet is received containing inaccurate, incomplete, or invalid information, the coversheet will be either faxed or mailed back to the originating source, but without the documentation. Coversheets returned in this manner should not be resent; instead, the provider should await an additional documentation request (ADR) before submitting the documentation again to First Coast.

Pwk issues

In other cases, the coversheets and additional documentation are not able to be appropriately attached to a claim due to several reasons. The following list has been developed to assist you in avoiding these situations.

1. PWK coversheet is received, completed accurately with documentation, but the claim was submitted without the indicators in the PWK loop. This will not allow us to assign the documentation in the system to the appropriate claim. If the claim requires documentation, an ADR letter will be sent and providers will need to respond to the letter.
2. PWK coversheet is received with the related documentation attached and a copy of our additional documentation request (ADR) letter. Again, the PWK loop indicators are not on the claim. There are two issues here: 1) without the PWK loop completed, the claim will not suspend to look for any anticipated documentation. Most importantly 2) the claim has already suspended for additional documentation; therefore, providers only need to respond to the ADR letter with appropriate documentation.
3. PWK coversheet is received with a request for an appeal/redetermination in the information box. The PWK process may only be used on initial claim submission. PWK cannot be used to bypass the standard appeals process. Please use the appropriate level of the appeals process if your claim has been denied or you need to make adjustments/corrections. Appeal requests submitted via the PWK fax/mail process will not be acknowledged.
4. In all of these instances, since the PWK fax/mail coversheet and/or claim is not being submitted correctly or with the correct information, the supporting documentation submitted to us is not being utilized to adjudicate the claim. Also, since in most cases this is outside of the standards for PWK, providers affected by these scenarios will not receive a response concerning the outcome or lack thereof.
5. Our internal claims area is being negatively impacted as well as our electronic storage capacity is being overwhelmed by unneeded, unusable documentation. Providers affected by this will more than likely never receive any indication of the negative impacts this is having on their claims.

Reminders

Here are some items to verify before faxing or mailing your form:

- Verify you have indicated the ACN (attachment control number [submitted in the PWK06 segment]), DCN (document control number [Part A]), ICN (internal control number [Part B]), the beneficiary's health insurance claim number (HICN)/Medicare number, billing provider's name and NPI (national provider identifier) on the fax/mail coversheet.
- Include an address to mail the coversheet to, in case we are unable to fax it back to the originating number.
- Fax users: ensure to send your PWK fax coversheet and documentation to the appropriate locality fax line. Example: claims for providers in Puerto Rico should be faxed to the Puerto Rico fax line; claims for Florida providers to the Florida fax line; etc. If a coversheet is received into the incorrect faxination account, we will be unable to locate the claim.
- Do not send in documentation without the completed fax/mail coversheet.
- Do not use the PWK coversheet for any reason other than the PWK process.

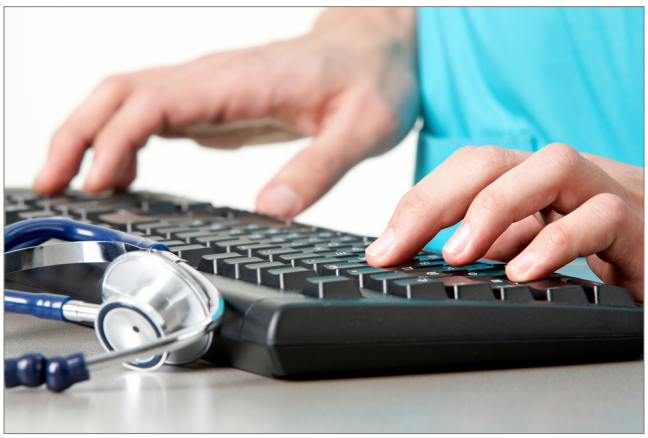
Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's 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.

Appropriate assignment of disposition codes

Incorrect discharge status codes have been identified by Connolly Healthcare the recovery auditor (RA) contractor as an underpayment for inpatient providers. Data analysis has identified occurrences in which no matching facility claim was found.

There could be times where this can legitimately occur after; it also means the hospital transferring the patient is being underpaid. It is important for the hospitals to follow up on the patient's discharge, especially when the following patient discharge status codes are utilized.



The patient discharge status codes that should be taken into consideration are: acute care inpatient facility (02), skilled nursing facility (03), home health (06), inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65).

The prior patient discharge status codes in combination with 275 transfer diagnosis related group (DRGs) listed in *Table 5 of the FY 2013 Inpatient Prospective Payment System (IPPS)* triggers the post-acute care transfer (PCAT) policy. Specific transfer cases qualify for payment under alternative methodology.

There are instances when the patient is discharged home and decides he or she wants to receive post-acute care at a facility; the opposite can occur where the patient was discharged to a post-acute care facility and the patient or the family decides they do not need that type of care. Then, the patient discharged status code is incorrect the hospital would be underpaid and it would be an error.

For the patient discharge status code home health (06) the service would have to begin within three days after the date of discharge and the service is related to the previous hospital admission. If this does not occur, condition code 42 (continuing care not related to inpatient admission) or 43 (continuing care not provided within prescribed post discharge window) should be utilized.

Providers are encouraged to review the following: Centers for Medicare & Medicaid Services (CMS) *Internet-only manual, Publication 100-04 Medicare Claims Processing Manual, Section 20.1.2.4, Transfers and Section 40.2.4 IPPS Transfers Between Hospitals*.

For additional information see *MLN Matters® SE1317*.

New fax coversheet to precede all EDI enrollment forms

To streamline the submission process, improve office workflow, and enhance efficiency, First Coast Service Options Inc. (First Coast) has implemented a new receipt process for EDI (electronic data interchange) forms. First Coast's EDI department has introduced a new electronic fax image interface process.

This process will require all EDI forms to be preceded with the required fax cover sheet effective immediately. This includes enrollment and DDE (data direct entry) forms and ASCA (Administrative Simplification Compliance Act) information.

The fax cover sheet provides detailed information about the fax transmission and provides routing and linking of documentation received depending on the information on the cover sheet.

You will not be able to create your own coversheet. You will need to use the interactive fax coversheet from our website. Simply type the requested information into the interactive fields on the form, print it, and fax it along with your EDI form(s).

Note: The fax coversheet may not be altered in any way except entering information into the appropriate fields.

The EDI department will process all accurate and complete EDI forms in the order in which they are received. Once processed, notification will be sent to the provider containing the information on how the form was processed and the details regarding the status.

Additionally, to ensure timely notification your email address will be required on the original EDI enrollment form(s) and DDE form(s) received so we can email this information to you. Any EDI form that is incomplete or unable to be processed for any reason will be returned to the provider indicated on the form.

Click here to access the EDI fax coversheet.

Add-on HCPCS/*CPT*® codes without primary codes

Provider types affected

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

Provider action needed

An add-on code is a Health Care Common Procedure System (HCPCS) code or *Current Procedural Terminology*® (*CPT*®) code that describes a service that, with one exception (see *Background* section below), is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner on the same date of service.

The Centers for Medicare & Medicaid Services (CMS) has learned from recovery auditor reports that some providers are billing only add-on HCPCS/*CPT*® codes without their respective primary codes resulting in overpayments.

This *MLN Matters*® special edition article provides an overview of billing for HCPCS/*CPT*® add-on codes, and it is based on CMS manuals and publications including the *Medicare Claims Processing Manual*, (Chapter 12, Sections 30(D) and 30.6.12(I). Change request (CR) 7501 (Transmittal 2636 dated January 16, 2013) titled "National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION.".

Background

An add-on code is a HCPCS/*CPT*® code that describes a service that is always performed in conjunction with the primary service. An add-on code is eligible for payment only if it is reported with the appropriate primary procedure performed by the same practitioner.

The *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.12(I) requires a provider to report *CPT*® code *99292* (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)), without its primary code *CPT*® code *99291* (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes). If two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service.

For the same date of service only one physician of the same specialty in the group practice may report *CPT*® code *99291* with or without *CPT*® code *99292*, and the other physician(s) must report their critical care services with *CPT*® code *99292*.

See CR 7501 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf* for current information regarding add-on codes in addition to the manual section mentioned above. The following shows an example of this issue:

Example:

- A provider submitted a claim with *CPT*® code *26863* for one unit for date of service May 5, 2010, without billing for the primary *CPT*® code *26862*. Add-on codes billed without their primary codes are considered an overpayment. Overpayment for add-on *CPT*® code *26863* was retracted as a billing error.
- Add-on *CPT*® code *26863* Description: Fuse/Graft added joint – Arthrodesis, interphalangeal joint with or without internal fixation; with autograft, each additional joint. List separately in addition to code for primary procedure.
- Primary *CPT*® code *26862* Description: Fusion/graft of finger – Arthrodesis, interphalangeal joint, without internal fixation; with autograft. This is a parent *CPT*® code and can be reported with add-on *CPT*® code *26863*.

Additional information

You can find CR 7501 (Transmittal 2636 dated January 16, 2013) titled "National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION" at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf*.

You can review the *Medicare Claims Processing Manual* (Chapter 12, Section 30.6.12(I) Critical Care Services Provided by Physicians in Group Practice(s)) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.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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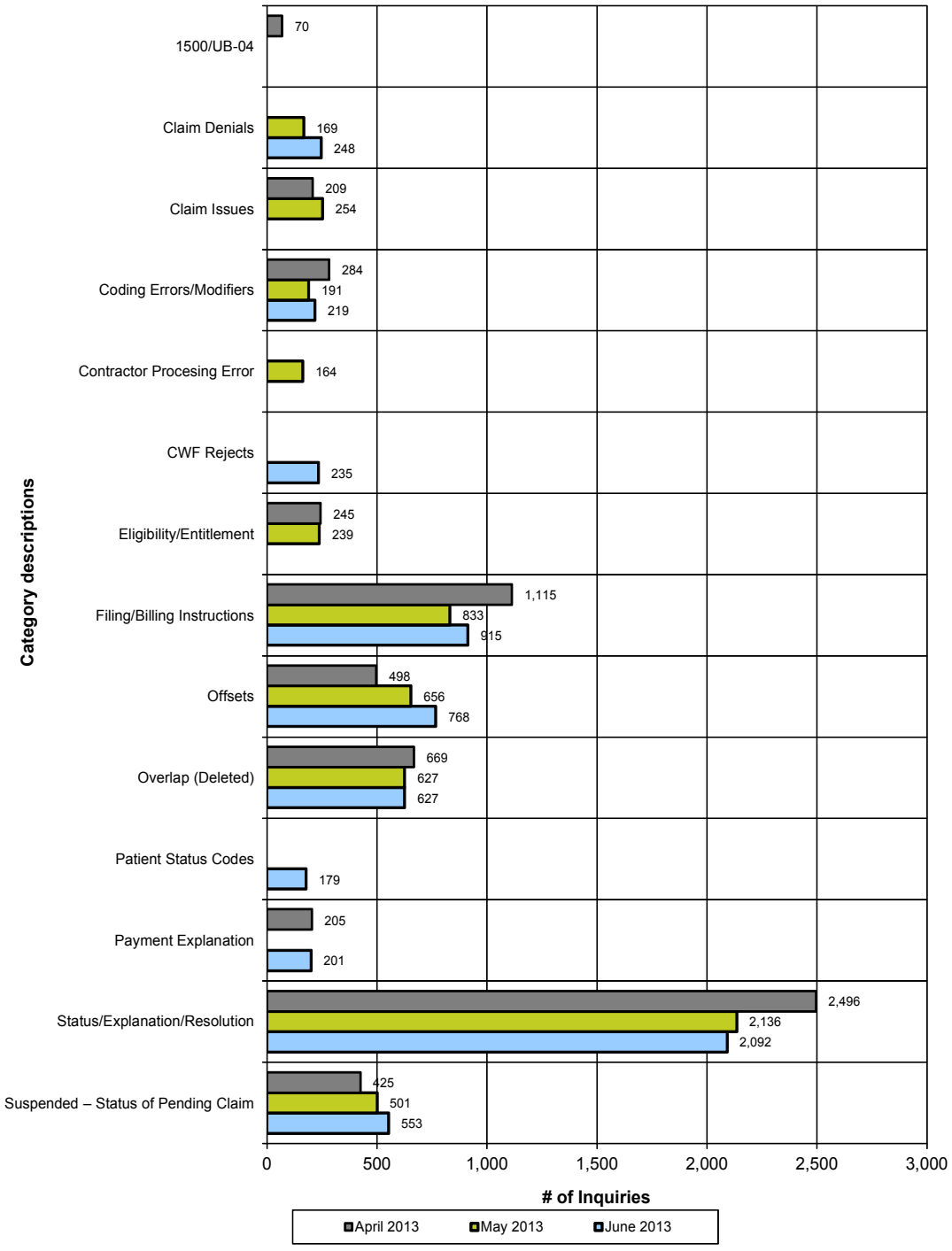
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Top inquiries, rejects, and return to provider claims April 2013 through June 2013

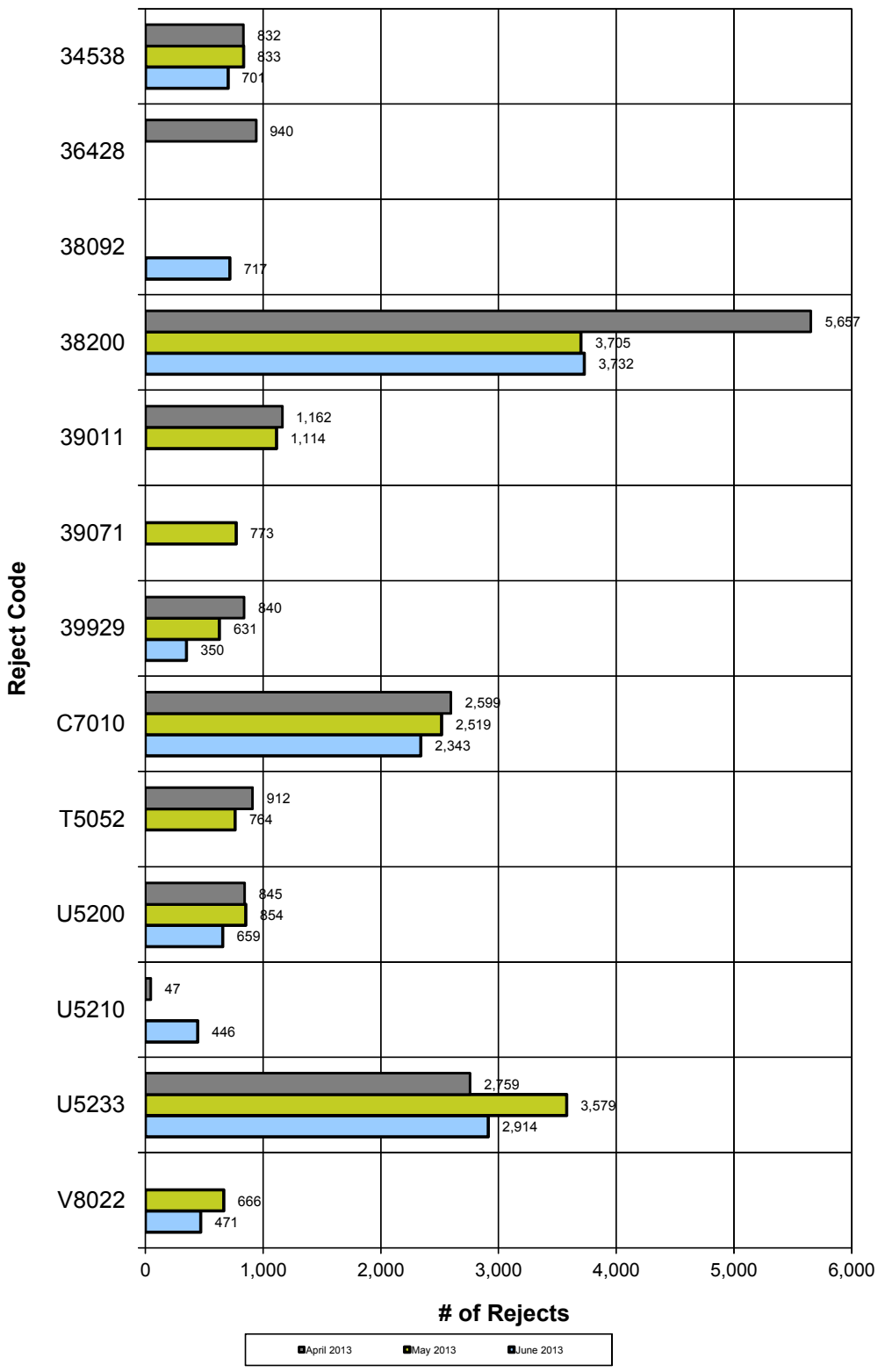
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during April 2013 through June 2013.

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 April-June 2013

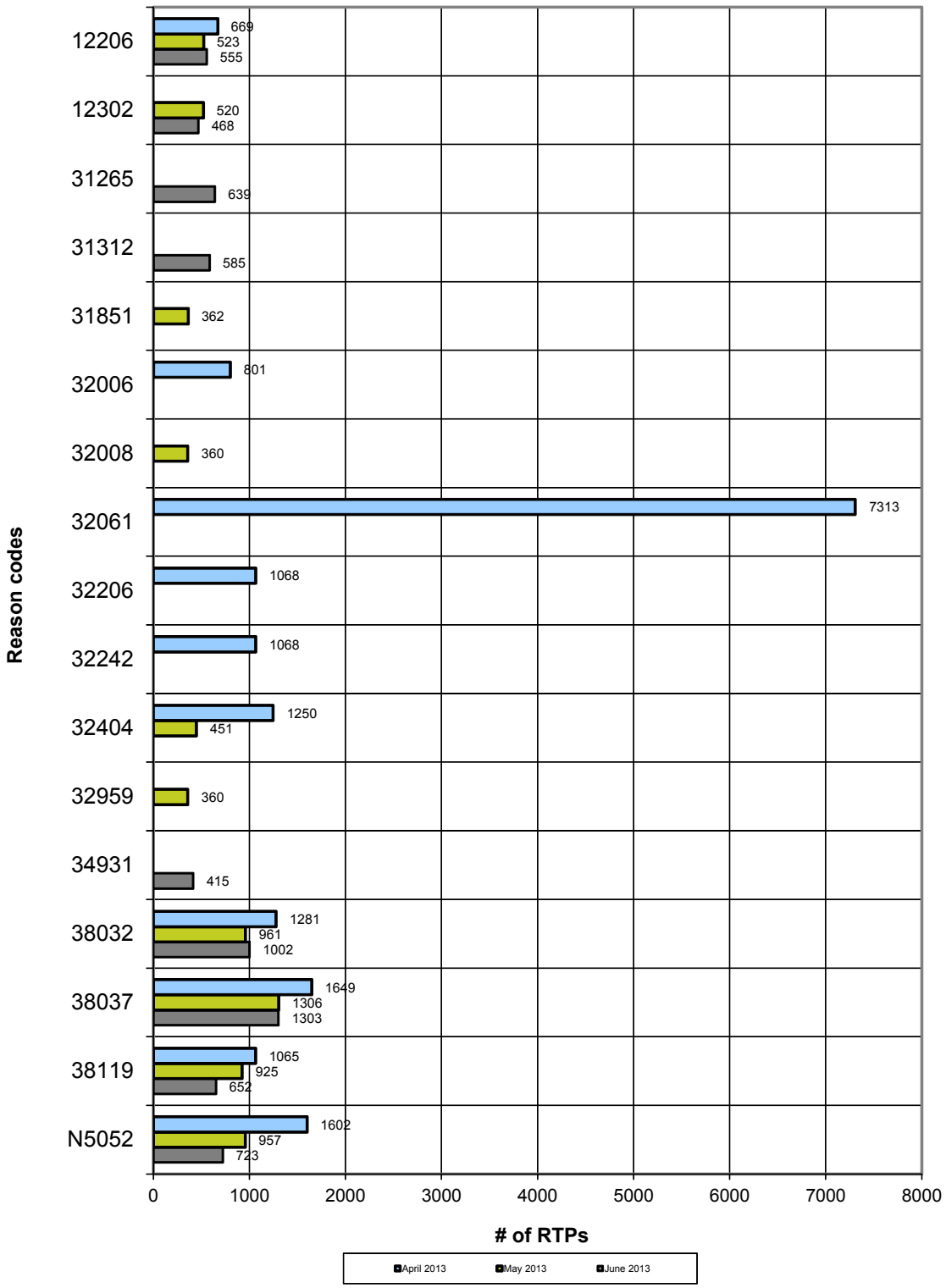


Part A top rejects for April 2013 through June 2013



Part A top return to providers (RTPs) for April 2013 through June 2013

Top RTPs for April-June 2013



Medicare enrollment for 'mass immunizers'

The following information has been excerpted from the Centers for Medicare & Medicaid Services (CMS) Internet-only manual (IOM), Publication 100-08, *Medicare Program Integrity Manual*, Chapter 15, Section 15.4.6.2 – Mass Immunizers Who Roster Bill.

An entity or individual who wishes to furnish mass immunization services -- but may not otherwise qualify as a Medicare provider -- may be eligible to enroll as a "mass immunizer" via the Form CMS-855I (individuals) or the Form CMS-855B (entities).

Providers may expedite their enrollment process by completing and submitting their application online through the *Internet-based Provider Enrollment Chain and Ownership System (PECOS). Click here to find out more.*

Such suppliers must meet the following requirements:

- They may not bill Medicare for any services other than pneumococcal pneumonia vaccines (PPVs), influenza virus vaccines, and their administration.
- They must submit claims through the roster billing process.
- All personnel who administer the shots must meet all applicable state and local licensure or certification requirements.

The roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by public health clinics and other organizations.

Note: The following information regarding the enrollment of mass immunizers:

- The effective date provision in 42 CFR § 424.520(d) does not apply to the enrollment of mass immunizers. This is because the individual/entity is not enrolling as a physician, non-physician practitioner, physician group or non-physician practitioner group.

- In section 4 of the Form CMS-855, the supplier need not list each off-site location (e.g., county fair, shopping mall) at which it furnishes services. It need only list its base of operations (e.g., county health department headquarters, drug store location).
- For more information on mass immunization roster billing, refer to:
- Publication 100-02, *Benefit Policy Manual*, *Chapter 15, section 50.4.4.2*
- Publication 100-04, *Claims Processing Manual*, *Chapter 18, sections 10 through 10.3.2.3*
  Note: Section 10.3.1 outlines the requirements for submitting roster bills.

New providers must first obtain a national provider identifier (NPI) prior to enrollment. Visit *https://nppes.cms.hhs.gov/NPPES/Welcome.do* for NPI enrollment information.

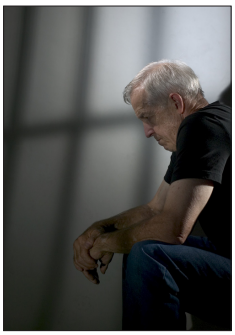
Source: *IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 15 - Medicare Enrollment*

Demand letters issued for service provided to incarcerated beneficiaries

Recently, the Centers for Medicare & Medicaid Services (CMS) initiated recoveries from providers and suppliers based on data that indicated a beneficiary was incarcerated on the date of service.

Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated when the items and services were furnished.

A beneficiary may be "incarcerated" even when the individual is not confined within a penal facility, such as a beneficiary who is on a supervised release, on medical furlough, residing in a halfway house, or other similar situation.



Medicare identified previously paid claims that contain a date of service partially or fully overlapping a period when a beneficiary was apparently incarcerated based on information CMS receives from the Social Security Administration (SSA).

As a result, a large number of overpayments were identified, demand letters released, and, in many cases, automatic recoupment of overpayments made. CMS has since learned that the information related to these periods of incarcerations was, in some cases, incomplete for CMS purposes.

(continued on next page)

Demand *(continued)*

CMS is actively reviewing these data and will be taking action to improve the process used to identify periods of incarceration.

As part of this effort, CMS is working to quickly identify claims that resulted in our recent recovery actions and take steps, as appropriate, to correct any inappropriate overpayment recoveries.

CMS will continue to issue messages about this topic, including timeframes for resolution, to keep the provider and supplier community informed. Information will also be posted on the *All Fee For Service Providers* page.

Revised actions required for providers and beneficiaries

In the interim, providers and suppliers should no longer encourage beneficiaries to contact their local Social Security office in order to have their records updated as a result of this recent issue. Providers also should no longer fax information to their local CMS regional offices as CMS is currently working to develop processes to resolve this issue.

Source: PERL 201307-05

Requests to override timeliness due to discharge status change

First Coast Service Options Inc. (First Coast) frequently receives requests to override timeliness on Part A claims when the reason is a patient discharge status change.

When submitting requests, Medicare providers must include a detailed explanation that shows why the patient status is being changed.

The reason of "patient status" or "discharge status change" by itself is not justification enough to provide approval of a claim for claims filing timeliness.

Claims filing timeliness requests will not be approved if a detailed explanation is not provided that substantiates why a claim could not have been filed timely, even for the reason of a correction to change the patient discharge status.

Are you ready to transition to ICD-10?

The Centers for Medicare & Medicaid Services (CMS) will host a presentation on the conversion to the International Classification of Diseases, Tenth Revision (ICD-10) by Sue Bowman from the American Health Information Management Association (AHIMA), Thursday, August 22, 1:30-3 p.m. EDT.

The webinar will include information on the benefits of ICD-10, an implementation update by CMS, training needs and timelines, resources for coding and training and a question and answer session will follow the presentation. Other topics covered include:

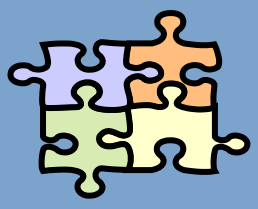
- similarities and differences from ICD-9
- coding
- basics of finding a diagnosis code
- external cause of injury codes
- type of encounter

For more information about the presentation, *click here*.

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

Puzzled about your enrollment status?

Put the pieces together using the enrollment status lookup. View all active applications, specific applications, and confirm if you have been sent a revalidation request at *http://medicare.fcso.com/Enrollment/PEStatus.asp*



Medicare Part A skilled nursing facility prospective payment system pricer update FY 2014

Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or Part A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries paid under the SNF prospective payment system (PPS).

Provider action needed

This article is based on CR 8329 which describes the updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2013, as required by statute. Be sure that your billing staff is aware of these changes.

Background

Annual updates to the prospective payment system (PPS) rates are required by the Social Security Act (Section 1888(e)), as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

Each July, the Centers for Medicare & Medicaid Services (CMS) publishes the skilled nursing facility (SNF) payment rates for the upcoming fiscal year (that is, beginning October 1, 2013 through September 30, 2014) in the *Federal Register*, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html*.

The update methodology is identical to that used in the previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds 0.5 percentage point. The statute mandates an update to the federal rates using the latest SNF full market basket adjusted for productivity. The payment rates will be effective October 1, 2013.

Additional information

The official instruction, CR 8329 issued to your Medicare FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2731CP.pdf*.

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

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Related CR Release Date: June 21, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2731CP
Implementation Date: October 7, 2013

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How to avoid filing duplicate outpatient claims

Provider types affected

This *MLN Matters*® special edition article is intended for providers submitting claims to Medicare contractors for services to Medicare beneficiaries.

What you need to know

Recovery auditors continue to conduct automated reviews of claims to identify duplicate services billed and reimbursed under Medicare. Specific codes are listed in the *Background* section of this article.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is publishing this article to alert providers to include the appropriate modifier when billing for multiple diagnostic services on the same day. Providers, coders, and billing staff should review the claims submitted, and verify that appropriate modifiers are used for claims that are submitted for the same beneficiary, for the same date of service, with the same codes, but are verified to be unique.

Background

An issue may exist when duplicate services are billed and reimbursed under Medicare. Outpatient claims submitted by a facility for the same service to a

(continued on next page)

Claims *(continued)*

particular individual on a specified date of service that was included in a previously submitted claim will be audited for duplicate payments.

Exact duplicate data fields submitted for outpatient facility claims including same beneficiary, same provider, same dates of service, same types of services, same place of service, same procedure codes, and same billed amount will be audited for duplicate payments.

The following Healthcare Common Procedure Coding System (HCPCS) and *Current Procedural Terminology*® (*CPT*®) codes were involved in this audit:

- HCPCS – A codes – Ambulance/transportation services;
- HCPCS – B&C codes – Enteral and parenteral therapy;
- HCPCS – D codes – Dental procedures;
- HCPCS – E codes – Durable medical equipment;
- HCPCS – G&H codes – Temporary procedures and professional services and mental health;
- HCPCS codes – J codes – drugs administered other than oral method;
- HCPCS codes – L codes – Orthotic procedures;
- HCPCS codes – M-P codes – medical services & pathology/laboratory;
- HCPCS codes – Q-R-S codes – Temporary codes;
- HCPCS codes – V codes – Vision codes;
- *CPT*® codes – Anesthesia – *00100* to *01999*;
- *CPT*® codes – Medicine – *90281* to *99607* (excluding E/M *99201* to *99499*);
- *CPT*® codes – Path & Lab – *80047* to *89356*;
- *CPT*® codes – Radiology – *70010* to *79999*; and
- *CPT*® codes – Surgery –*10021* to *69990*.

Case Studies

Example 1: A provider received duplicate payments of $87.45 on 4/13/12 and 5/5/12 for *CPT*® *71020* (Chest x-ray) with billed date of service of 3/29/12. Both claims were billed for same patient, same provider, and same date of service, same charge, same *CPT*® code, and same units, without a modifier. The duplicate billing increased the subscriber's liability by $53.00.

Resolution: Billing of modifier 76 (repeat procedure or service by the same physician or other qualified health care professional) or 77 (repeat procedure or service by another physician or other qualified

health care professional) should be used to report the performance of multiple diagnostic services on the same day if these were not actually duplicate claims.

Example 2: A provider received duplicate payments of $64.19 on 2/22/12 and 4/20/12 for *CPT*® *77080* Dual-energy X-ray absorptiometry (DXA), bone density axial) with billed date of service of 1/31/12. Both claims were billed for the same patient, same provider, and same date of service, same charge, same *CPT*® code, and same units, without a modifier.

Resolution: Billing of modifier 76 or 77 should be used to report the performance of multiple diagnostic services on the same day if these were not actually duplicate claims.

Additional information

The most current *MLN Matters*® *article* MM8121 about the "Clarification of Detection of Duplicate Claims Section of the CMS Internet Only Manual" is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8121.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 CR Transmittal #: N/A
Implementation Date: N/A

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Post-acute care transfer - underpayments

Provider types affected

This *MLN Matters*® special edition article is intended for inpatient hospitals 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 informs you that Medicare's recovery auditors conducted an automated review of inpatient claims with qualifying diagnosis-related groups (DRGs) that were identified with discharge disposition to an acute care inpatient facility (02), skilled nursing facility (03), home health (06), inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65).

These inpatient claims fall under the post-acute care transfer (PACT) policy and are reimbursed on a per diem rate, up to full Medicare severity diagnosis related group (MS-DRG) code reimbursement.

Specifically, the recovery auditors examined hospital claims that indicated the patient was discharged to another facility as noted in the preceding paragraph. However, in a number of cases, the auditors did not find a claim from a separate facility showing these patients were received by another facility.

There are instances where this can legitimately occur, such as the patient dies en route to the other facility or the other facility is a non-Medicare participating facility. In such situations, Medicare may not receive a subsequent claim, but the transfer to another facility coding could be correct.

The key point is that a claim coded to show transfer to another facility is paid differently from a claim where no discharge to another facility occurs. If the discharge disposition is miscoded, the miscoded claim may be paid incorrectly. To avoid payment errors, please remind staff to code claims as transfers only if the beneficiary is discharged to another facility.

Background

The *Medicare Claims Processing Manual*, Chapter 3, Sections 20.1.2.4 and 40.2.4, present necessary information for proper claims submissions as they relate to patient transfers. This manual chapter is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf*.

PACT rules are found in the *Code of Federal Regulations* (CFR) at 42 CFR Section 412.4 .The *Code of Federal Regulations* (CFR) at 42 CFR Sections 405.980 (b) and (c), and Section 405.986, states that a Medicare contractor may reopen an initial determination made on a claim between one year and

four years from the date of the initial determination when good cause exists. If a contractor performs data analysis on claims and finds potential claims errors that may constitute new and material evidence, as it relates to good cause for reopening the claims. Justification for reopening these claims was due to improper payments found in the results of the data analysis.

When Medicare reopens such claims and the resulting analysis shows an error occurred, Medicare will adjust the initial claim accordingly. To avoid this situation, providers should strive to ensure accuracy in submitting inpatient claims with discharge disposition to an acute care inpatient facility (02), skilled nursing facility (03), home health (06), inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65).

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*.

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Related CR Transmittal #: N/A
Implementation Date: N/A

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Guidance to reduce Mohs surgery reimbursement issues

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and hospitals submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for providing Mohs micrographic surgical (MMS) services to Medicare beneficiaries.

What you need to know

Medicare will only reimburse for MMS services when the Mohs surgeon acts as both surgeon and pathologist. You may not bill Medicare for these procedures if preparation or interpretation of pathology slides is performed by a physician other than the Mohs surgeon.

Background

MMS is a precise, tissue-sparing, microscopically controlled surgical technique used to treat selected skin cancers. It is an approach that aims to achieve the highest possible cure rates, and minimize wound size and consequent distortions at critical sites such as the eyes, ears, nose, and lips.

MMS is a two-step process in which: 1) The tumor is removed in stages, followed by immediate histologic evaluation of the margins of the specimen(s); and 2) Additional excision and evaluation is performed until all margins are clear.

Further, the physician performing MMS serves both as surgeon and pathologist; performing not only the excision but also the histologic evaluation of the specimen(s). Specifically, the descriptions for these Mohs-specific *Current Procedural Terminology*® (*CPT*®) codes are:

CPT® code *17311* - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to five tissue blocks.

CPT® code *17312* - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to five tissue blocks (list separately in addition to code for primary procedure).

CPT® code *17313* - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to five tissue blocks.

CPT® code 17314 - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to five tissue blocks (list separately in addition to code for primary procedure).

CPT® code 17315 - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), each additional block after the first five tissue blocks, any stage (list separately in addition to code for primary procedure).

Identified coding problems

During an audit of the *CPT*® codes associated with MMS across several states in a region, Medicare recovery auditors found instances in which the preparation and/or interpretation of the slides of tissue removed during the procedures was performed by someone other than the surgeon (or his/her employee). Examples of findings from this audit follow:

Example 1: A physician billed *CPT*® code *17311* (Mohs Micrographic Surgery), while on the same date of service *CPT*® code *88305* (Surgical Pathology, gross and microscopic examination) for the preparation and interpretation of the slides taken during the procedure, was separately billed for a specimen examination by

Mohs *(continued)*

a different practitioner without a modifier. *CPT*® code *17311* was, therefore, an overpaid claim.

Example 2: A physician billed *CPT*® code *17313* (Mohs micrographic surgery) while on the same date of service *CPT*® code *88305* (*Surgical pathology, gross and microscopic examination*) for the preparation and interpretation of the slides during the procedure was separately billed for a specimen examination by a different practitioner without a modifier. *CPT*® code *17313* was, therefore an overpaid claim.

Coding and documentation guidance to help prevent reimbursement problems

The majority of skin cancers can be managed by simple excision or destruction techniques. The medical record of a patient undergoing MMS should clearly show that this procedure was chosen because of the complexity (e.g. poorly defined clinical borders, possible deep invasion, prior irradiation), size or location (e.g. maximum conservation of tumor-free tissue is important).

> *"The medical record of a patient undergoing MMS should clearly show that this procedure was chosen because of the complexity (e.g. poorly defined clinical borders, possible deep invasion, prior irradiation), size or location (e.g. maximum conservation of tumor-free tissue is important)."*

Medicare will consider reimbursement for MMS for accepted diagnoses and indications, which you must document in the patient's medical record as being appropriate for MMS and that MMS is the most appropriate choice for the treatment of a particular lesion.

Additionally, you should be aware of Mohs Medicare coverage limitations: 1) Only physicians (MD/DO) may perform MMS; 2) The physician performing MMS must be specifically trained and highly skilled in MMS techniques and pathologic identification; and 3)

As mentioned above, if the surgeon performing the excision using MMS does not personally provide the histologic evaluation of the specimen(s), the *CPT*® codes for MMS cannot be used, rather the codes (*11600-11646*) for the standard excision of malignant lesions should be chosen.

If MMS on a single site cannot be completed on the same day because the patient could not tolerate further surgery and the additional stages were completed the following day, you must start with the primary code (*CPT*® code *17311*) on day two. Computer edits will reject claims where a secondary code (e.g., *CPT*® code *17312*) is billed without the primary code (e.g., *CPT*® code *17311*) also appearing on same date of service, and the same claim.

Your documentation in the patient's medical record should support the medical necessity of this procedure and of the number and locations of the specimens taken.

The operative notes and pathology documentation should clearly show that the procedure was performed using accepted MMS technique, in which you acted in two integrated, but distinct, capacities as surgeon and pathologist. The notes should also contain the location, number, and size of the lesion(s), the number of stages performed, and the number of specimens per stage.

You must describe the histology of the specimens taken in the first stage. That description should include depth of invasion, pathological pattern, cell morphology, and, if present, perineural invasion or presence of scar tissue.

For subsequent stages, you may note that the pattern and morphology of the tumor (if still seen) is as described for the first stage; or, if differences are found, note the changes. There is no need to repeat the detailed description documented for the first stage, presuming that the description would fit the tumor found on subsequent stages.

Additional information

There are a number of local coverage determinations and articles that address Mohs surgery in more detail. To access those LCDs, visit *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=mohs&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAAAAAA%3d%3d&&*.

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: SE1318 Revised
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

Billing for visits to patients in swing bed facilities

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) Comprehensive Error Rate Testing (CERT) program has identified a significant number of claims paid in error relating to evaluation and management (E/M) services provided in swing bed settings.

Background

Hospitals, as defined in the Social Security Act (Section 1861(e); see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*), or critical access hospitals (CAHs) with a Medicare provider agreement that includes CMS approval to furnish swing bed services, may use their beds as needed to furnish either acute or skilled nursing facility (SNF) levels of care.

Through the review of previous CERT reports, CMS has learned that there have been a high percentage of errors occurring in billing for E/M services rendered in swing bed facilities. Some providers are inappropriately billing hospital visit codes for E/M services rendered in swing bed facilities (with nursing facility levels of care) when they should be billing nursing facility visit E/M codes.

Physicians should bill hospital care codes when the facility is providing inpatient hospital care to the beneficiary and nursing facility care codes when the swing bed is being used to provide skilled nursing services.

The *Current Procedure Terminology*® (*CPT*®) codes involved include:

- *99221-99223* (Initial Hospital Care),
- *99231-99233* (Subsequent Hospital Care), and
- *99238-99239* (Hospital Discharge Day Management)

Example

A 92-year old female was admitted to a hospital with swing bed approval for nursing facility care on April 30, 2010, and was discharged on May 6, 2010. A physician billed *CPT*® code *99232* (Subsequent hospital care) for a date of service May 5, 2010, a day on which the facility was providing services at a skilled nursing level. The date of service (May 5, 2010), was during the stay for nursing facility care at a swing bed approved facility. Therefore, *CPT*® code *99232* was an overpaid claim.

Additional information

You can review the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.9) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*. This section of the manual provides details on proper coding of hospital visits and swing bed visits. If you have any questions, please contact your carriers, FIs, 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*.

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Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Medicare proposes updates for the ESRD prospective payment system

The Centers for Medicare & Medicaid Services (CMS) recently proposed a rule that updates Medicare policies and payment rates for end-stage renal disease (ESRD) facilities. The proposal also adds five new quality measures to the ESRD quality incentive program (QIP).

While CMS projects an inflation adjustment increase of 2.9 percent in 2014 under the ESRD bundled market basket, overall estimated payments to ESRD facilities will decrease by 9.4 percent due to a proposed drug utilization adjustment required by the American Taxpayer Relief Act of 2012. The rule provisions would affect payments for outpatient maintenance dialysis treatments furnished on or after January 1, 2014 under the bundled ESRD prospective payment system.

The rule also provides payment incentives to dialysis facilities to improve the quality of care under the ESRD quality incentive program. ESRD facilities that do not achieve certain quality standards will experience a reduction in reimbursement up to 2 percent. In addition, the rule introduces five new quality measures to the criteria used to evaluate quality of dialysis care.

For more information on the proposed rule, *click here*.

Information contained within this article was previously released in an edition of the weekly "*CMS MLN Connects ™ Provider e-News*."

Educational Events

Provider outreach and educational events – August/September 2013

Medicare Part A/B: Internet-based PECOS

When: Thursday, August 15
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

Medicare Part A: changes and regulations

When: Tuesday, September 17
Time: 11:30 AM-1:00 PM ET – Delivery language: English
Type of Event: Webcast

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 MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) MLN Connects™ Provider eNews 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 MLN Connects™ Provider eNews: June 27, 2013, – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-27Enews.pdf*
- CMS MLN Connects™ Provider eNews: July 4, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-04-Enews.pdf*
- CMS MLN Connects™ Provider eNews: July 11, 2013– *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-11-Enews.pdf*
- CMS MLN Connects™ Provider eNews: July 18, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-18Enews.pdf*

Source: CMS PERL 201306-06, 201307-01, 201307-02, 201307-04

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 to register 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

Back to Contents

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