Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers August 2013

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A nation united with a shared goal. All MACs join forces.

Part A/B Medicare administrative contractors (MACs) share a common goal to reduce the Medicare national payment error rate as measured by the Comprehensive Error Rate Testing (CERT) program. Recently, the MACs joined forces to educate on issues of mutual concern regarding claim errors.

The partnership led to creation of the CERT A/B Contractor Task Force with the full support of the Centers for Medicare & Medicaid Services (CMS). This new partnership affords providers the benefit of a collaborative, consistent voice to reduce costly claim denials as well as the CERT error rate.

The CERT A/B Contractor Task Force will serve to enhance, not replace, the ongoing educational activities by CMS, the Medicare Learning Network (MLN), and the MACs within their jurisdictions. Providers can identify educational efforts of the CERT A/B Contractor Task Force by the clear identity of its logo, which represents the task force's united vision:

Educational strategy

The A/B CERT Contractor Task Force will select one to four national CERT "hot topics" each year. The topics may focus on multiple provider types, or focus on certain specialties or facility types. The group will then periodically publish scenario-driven articles with tips focused on avoiding specific errors. Each contractor will also highlight the scenarios in any of their individual educational activities.

Each contractor hosts a dedicated page on their website for the CERT A/B Contractor Task Force and its communications. Providers will be able to access all communications for the task force on this page. Providers with First Coast Service Options can access their page at: *http://medicare.fcso.com/Landing/203608.asp*.

Stay tuned

Over the next few months, the CERT A/B Contractor Task Force will conduct a campaign to inform hospitals, home health, hospice, physician billing and compliance staff, and practitioners within all jurisdictions on this new initiative.

The campaign kicked off with the first national CERT A/B Contractor Task Force open door teleconference on August 20, 2013. The event was recorded and transcribed.

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

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Medicare Publications
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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.

The 'Extended Service Line' enhances customer service options for Florida Part A providers – new hours effective August 1

At First Coast Service Options Inc. (First Coast), providing the highest quality customer service is always our top priority.

We continuously looking for new ways to enhance the service we furnish to our providers, and we have learned that the best source for ideas is our provider community.

We gather valuable feedback not only from calls to the provider contact center but also through a variety of other sources including First Coast's Medifest, the Medicare Executive Council, POE-AG meetings, telephone surveys, and the *Feedback* page on our provider website.

ESL provides direct access to Medicare customer service team

The purpose of the extended service line (ESL) is to help resolve non-general inquiries more efficiently by offering providers direct access to our Medicare customer service operations team.

Since the start-up of the ESL in July 2010, more than 13,400 complex inquiries have been resolved.

Effective August 1, 2013, the ESL is available Tuesday, Wednesday, and Friday from 8:30 a.m.- noon.

If a provider calls the provider contact center and the representative cannot fully resolve their issue, the customer will be given a special confirmation number and will be asked to call the special extended service line directly.

What providers must have ready when calling the ESL

- Providers must have their confirmation number;
- Providers must have the document control number (DCN) number of the claim at issue;
- Providers should have their direct data entry (DDE) file pulled up;
- Providers should have any applicable policy references available if they are calling to question a claim and they are referencing a particular policy.

If this information is not available for the representative, providers will be asked to hang-up and callback when this information is available.

Because representatives on the ESL will be handling more complex issues than is currently handled, the wait time may be longer than our normal toll free service line.

CERT *(continued)*

First Coast will send a communication to providers when the recording is available on its provider education website.

The CERT A/B Contractor Task Force will collaborate for error-free Medicare claims and documentation with providers, associations and societies across the nation.

Participating MACS include:

Cahaba Government Benefit Administrators, LLC/J10

CGS Administrators, LLC/J15

First Coast Service Options, Inc./J9

National Government Services, Inc./J6 & JK

NHIC, Corp/J14

Noridian Healthcare Solutions, LLC/JF

Novitas Solutions, Inc./JL & JH

Palmetto GBA/J1 & J11

Wisconsin Physicians Service Insurance Corporation/J5, J8, & T18

Mobile apps for the open payments program

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) announced July 17, 2013, the availability of two new mobile applications (mobile apps) for the open payments program (Physician Payments Sunshine Act), which are designed to assist in helping physicians, applicable manufacturers, and applicable group purchasing organizations (GPOs) track much of the data necessary for successful program reporting. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

The two new mobile apps track contact information of physicians and industry, share information between the physician and industry apps using mobile technology, and track payments and other transfers of value in real-time.

One app is targeted specifically to physicians (Open Payments Mobile for Physicians) and the other is for industry, including applicable manufacturers and applicable GPOs (Open Payments Mobile for Industry). A picture of the app icons is shown below.

Ultimately, the goal of these apps is to make tracking payment information easier and more convenient, and to improve the accuracy of payment information by tracking payments as they occur throughout the year. You and your staff should read more information about the apps in the *Background* section below.

Additional information

For more information about the open payments program, read the *MLN Matters*® special article SE1303, "Information on the National Physician Payment Transparency Program: Open Payments," available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf*.

More information about open payments is available at *http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html*.

Background

Why are these apps needed?

The new open payments mobile applications will assist physicians and the industry in tracking financial relationships.

The two free mobile apps will help physicians and health care industry users to track their payments and other financial transfers that the industry will report under the open payments program (Physician Payments Sunshine Act). Created by a provision of the Affordable Care Act, open payments creates greater public transparency about the financial transactions between doctors, teaching hospitals, drug and device manufacturers, and other health care businesses.

CMS has made these apps available to facilitate accurate reporting of required information, which will be available to the public and will be published annually on the open payments website.

CMS's goal is about providing user-friendly tools for doctors, manufacturers, and others in the health care industry to use in working with CMS to implement the law in a smart way. These two apps are innovative options for doctors and the industry to accurately and securely track their financial ties and other transfers of values as required under this important transparency program.

To support the "open payments" program, CMS designed the mobile applications (one each for physicians and health care industry users), merging this proven and efficient format with real-time 24-hour tracking technology.

The apps offer on-the-go convenience for users to track financial data. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

What are the reporting requirements of open payments?

August 2013 marked the beginning of pharmaceutical and device manufacturers and group purchasing organizations (GPOs) collecting and preparing to report payments and other transfers of value made to physicians and teaching hospitals, as well as certain ownership and investment interests, as required by the open payments program.

Physicians are not required to report any information to CMS, though they may wish to use this app to help validate reports submitted by manufacturers to

(continued on next page)

Open *(continued)*

CMS about payments they have received. (Reporting requirements do not apply to physician claims payments.)

Financial information entered into the apps will help health care industry entities meet the timely reporting requirements of the open payments program.

Financial data loaded into the apps does not interact with CMS systems and cannot be used for direct data reporting to CMS or its contractors.

In addition, CMS will not validate the accuracy of data stored in the apps, nor will it be responsible for protecting data stored in the apps.

For physician users, the Open Payments for Physicians mobile app will help them assure that industry information reported about them is accurate by:

- Tracking payments and other transfers of value received from their health care industry affiliations in real-time, as they occur;
- Transferring user profile and high level information associated with the event or situation in which the "transfer of value" occurred between physicians and industry; and
- Storing personal contact information.

Industry app users hold the responsibility for accuracy and completeness of their official reports. For industry users, the open payments mobile for Industry mobile app will facilitate their reporting by:

- Tracking their payments and other transfers of value assigned to physicians and teaching hospitals, in real-time;
- Transferring user profile and high level information associated with the event or situation in which the "transfer of value" occurred between physicians and industry;
- Helping to ensure greater accuracy of information about financial relationships with physicians; and
- Collecting physician user profile information.

What is a mobile app?

A mobile application (or mobile app) is a software application designed to run on smartphones and other mobile devices.

Is use of the apps completely voluntary?

The use of the apps is voluntary. The apps are available for the user's own information collection and to serve as a personal storage depository only.

How can I obtain the mobile apps?

You can download the mobile apps directly from your app store (e.g., iOS Apple™ or GooglePlay™); search for either Open Payments Mobile for Physicians or Open Payments Mobile for Industry, depending on which app you are downloading and follow your normal downloading instructions.

What if I have questions about the functions and uses of the apps?

For more information on functionality and usage of the apps, visit the frequently asked questions for Open Payments Mobile for Physicians & Open Payments Mobile for Industry document, available at *http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Mobile-App-Public-FAQs.pdf*.

You can also view a demonstration of the app during the upcoming national provider call on August 8, 2013. To register, visit MLN Connects upcoming calls at *https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html*.

For help with the apps you can contact the open payments helpdesk at *openpayments@cms.hhs.gov*. Please also send any comments or suggestions regarding the apps' functionality to our help desk, as we are continuing to explore opportunities to leverage technology solutions that will help enable successful program implementation.

MLN Matters® Number: SE1329
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

Open payments training modules for providers

Two continuing medical education activities are available

Continuing medical education (CME) activities are available for physicians to learn more about Open Payments (Physician Payments Sunshine Act). Two such activities are available and accessible via Medscape; both are accredited by the Accreditation Council for Continuing Medical Education:

- *"Are You Ready for the National Physician Payment Transparency Program?"*: Physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70 percent on the post-test. Through the activity, participants will learn more about Open Payments, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify physician information in advance of website publication.
- *"The Physician Payment Transparency Program and Your Practice"*: Physicians can receive a maximum of 0.25 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70 percent on the post-test. Through this activity, participants will be able to identify opportunities for physicians to review transfers of value attributed to them and differentiate types of transfers of value that will or will not be reported under Open Payments.

Accredited by the Accreditation Council for Continuing Medical Education, physicians or health care professionals can earn one credit of continuing medical education for the first module and 0.25 credits for the second module. Medscape accounts are free and users do not have to be health care professionals to register. Registration can be found on the *Medscape* website.

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

Implementation of the hospice quality reporting required by the Affordable Care Act Section 3004

Provider types affected

This *MLN Matters*® article is intended for hospices submitting claims to Medicare contractors (regional home health intermediaries (RHHIs) and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8241 that implements the payment reduction required for hospice agencies that fail to report quality data as specified in Section 3004 of the Affordable Care Act.

Background

The Affordable Care Act, Section 3004, requires each hospice to collect data on quality measures specified by the Secretary, Department of Health and Human Services (HHS), and submit the data timely to the Center for Medicare & Medicaid Services (CMS).

For fiscal year 2014, and each subsequent year, failure of hospices to submit required quality data will result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.

Additional information

The official instruction, CR 8241 issued to your RHHI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2696CP.pdf*.

For more information about the data requirements, review *MLN Matters*® special article SE1301, entitled *Hospice Quality Data Reporting Reminders*, available at *http://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1301.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*.

MLN Matters® Number: MM8241
Related Change Request (CR) #: CR 8241
Related CR Release Date: May 3, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2696CP
Implementation Date: October 7, 2013

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Additional data reporting requirements for hospice claims

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8358 which requires claim data reporting for hospices to support hospice payment reform as authorized by Section 3132(a) of the Affordable Care Act.

Additional data reporting includes visit reporting for general inpatient care (GIP), reporting the service facility national provider identifier (NPI) where the service was performed when the service is not performed at the same location as the billing hospice's location, and reporting of infusion pumps and prescription drugs.

Specifically, hospices shall report line-item visit data for hospice staff providing GIP to hospice patients in skilled nursing facilities or in hospitals for claims with dates of service on or after April 1, 2014. Hospices may voluntarily begin this reporting as of January 1, 2014. This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length reported as is done for the home levels of care.

Background

Over the past several years the Medicare Payment Advisory Commission (MedPAC), the Government Accountability Office (GAO), and the Office of the Inspector General (OIG) all recommended that the Centers for Medicare & Medicaid Services (CMS) collect more comprehensive data to better evaluate trends in utilization of the Medicare hospice benefit.

CMS began collecting additional data on hospice claims beginning in January 2007. Then CMS required reporting of a Healthcare Common Procedure Code System (HCPCS) code on the claim to describe the location where services were provided. (See *MLN Matters*® article MM5245 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5245.pdf*.)

CMS continued the data collection effort with CR 5567 which required Medicare hospices to, beginning in July 2008, provide detail on their claims about the number of physician, nurse, aide, and social worker visits provided to beneficiaries. (See the *MLN Matters*® article MM5567 corresponding to CR 5567 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5567.pdf*),

In January 2010, CMS required line item reporting on hospice claims, including visit time reporting, and added therapists and social work phone calls to the data collected with CR 6440. (See MM6440 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6440.pdf*.)

Effective in October 2010, CR 6905 added an additional HCPCS site of service code (Q5010, for hospice home care provided in a hospice facility), to supplement those implemented in 2007 with CR 5245. (See the *MLN Matters*® article MM6905 corresponding to CR 6905 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM6905.pdf*.)

On several occasions, industry representatives communicated to CMS that the required claims information was not comprehensive enough to accurately reflect hospice care. Industry stakeholders commented that to understand hospice costs, CMS should consider non-labor costs, as these 1) can be significant, and 2) are largely comprised of data on drugs, durable medical equipment (DME), and medical supplies.

Finally, the Affordable Care Act, Section 3132(a) gives CMS the authority to collect additional data as needed to revise payments for hospice care. This claims data collection will support hospice payment reform. See *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf* to view the Affordable Care Act.

CR 8358 instructs that Medicare hospices will report line-item visit data for hospice staff providing GIP to hospice patients in skilled nursing facilities or in hospitals. This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length reported as is done for the home levels of care. It also includes certain calls by hospice social workers (as described in CR 6440, transmittal 1738, dated May 15, 2009), on a line-item basis, with call and call length reported as is done for the home levels of care.

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Hospice *(continued)*

CMS is not changing the existing GIP visit reporting requirements when the site of service is a hospice inpatient unit. For all visit/call reporting, only report visits/calls by the paid hospice staff; do not report visits by non-hospice staff.

See the *MLN Matters*® article MM6440 corresponding to CR 6440 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6440.pdf*.

Note: CMS is not making any changes to the existing claims requirements for physician services reported on the hospice claim.

Coding for New Required Hospice Claims Reporting:

Coding for GIP reporting: Revenue code *0656* + HCPCS for the discipline + Units of 15 minute increments, when site of service = Q5004, Q5005, Q5007, or Q5008

Coding for NPI reporting: Other provider location loop 2310 E (Only required on the 5010 electronic claim)

- The NPI of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving services, regardless of the level of care provided, when the site of service is not the billing hospice.

In compliance with the 837i requirements, the billing hospice must report the name, address, and NPI of the service facility where the service is being performed when the service is not performed at the same location as the billing hospice's location. When the patient has received care in more than one facility during the billing month, the hospice reports the NPI of the facility where the patient was last treated.

Effective for claims with dates of service on or after April 1, 2014, Medicare will return hospice claims that do not report this new required information in 2310E when the claims have a HCPCS of Q5003, Q5004, Q5005, Q5007, or Q5008.

Coding for post-mortem visits: Code appropriate revenue code + HCPCS for the discipline + PM Modifier + Units of 15 minute increments. The following modifier is required reporting for claims with dates of service on or after April 1, 2014:

- PM – Post-mortem visits.

Hospices shall report visits and length of visits (rounded to the nearest 15 minute increment), for nurses, aides, social workers, and therapists who are employed by the hospice, that occur on the date of death, after the patient has passed away. Post mortem visits occurring on a date subsequent to the date of death are not to be reported. The reporting of post-mortem visits, on the date of death, should occur regardless of the patient's level of care or site of service.

Coding for injectable drugs: Report on a line-item basis per fill, using revenue code 0636 and the appropriate HCPCS code, with units representing the amount filled (i.e. if Q1234 drug 100mg is supplied and the fill was for 200 mg, units reported = 2).

Coding for non-injectable prescriptions: Report on a line-item basis per fill, using revenue code 0250 and the national drug code (NDC). The NDC qualifier represents the quantity of the drug filled, and should be reported as the unit measure.

Coding for infusion pumps: Report on the claim on a line-item basis per pump order and per medication refill, using revenue code 029x for the equipment and *0294* for the drugs along with the appropriate HCPCS.

Additional information

The official instruction, CR 8358 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2747CP.pdf* on the CMS website.

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

MLN Matters® Number: MM8358
Related Change Request (CR) #: CR 8358
Related CR Release Date: July 26, 2013
Effective Date:
Voluntary Reporting Effective January 1, 2014
Mandatory Reporting Effective April 1, 2014
Related CR Transmittal #: R2747CP
Implementation Date: January 6, 2014

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Outpatient therapy functional reporting requirements

Provider types affected

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

Functional reporting applies to all claims for therapy services furnished under the Medicare Part B outpatient therapy benefit and to physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services furnished under the comprehensive outpatient rehabilitation facility (CORF) benefit. Specifically, functional reporting is required of the following:

- Hospitals, including beneficiaries in outpatient and emergency departments, and inpatients paid under Medicare Part B;
- Critical access hospitals;
- Skilled nursing facilities;
- Comprehensive outpatient rehabilitation facilities;
- Rehabilitation agencies;
- Home health agencies (for beneficiaries who are not under a home health plan of care, are not homebound, and whose therapy or other services are not paid under the home health prospective payment system);
- Therapists in private practice: physical therapists, occupational therapists, and speech language pathologists;
- Physicians: medical doctors, doctors of osteopathy, doctors of podiatric medicine, and doctors of optometry; and
- Non-physician practitioners: nurse practitioners, clinical nurse specialists, and physician assistants.

Provider action needed

This article describes the reporting requirements for functional reporting using 42 G-codes and seven severity/complexity modifiers.

The functional reporting data collection system is effective for therapy services with a date of service (DOS) on or after January 1, 2013. However, a testing period was in effect from January 1, 2013, through June 30, 2013, to allow providers to use the new coding requirements without penalty while they assured that their systems worked. During this period, claims were processed with or without the required G-codes and modifiers.

Background and purpose of functional reporting

The Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012 required the Centers for Medicare & Medicaid Services (CMS) to implement a claims-based data collection strategy for outpatient therapy services. CMS developed this collection strategy known as "functional reporting" in the 2013 physician fee schedule final rule (77 Federal Regulation (FR) 68958). Functional reporting collects data on patient function during the therapy episode of care to understand beneficiary functional limitations and outcomes.

Effective January 1, 2013, claims for outpatient therapy services are required to include non-payable G-codes and modifiers, which describe a beneficiary's functional limitation and severity level, at specified intervals during the therapy episode of care.

Functional reporting requirements

Definitions

A reporting episode is similar to the therapy episode of care. A reporting episode is defined as the period of time, based upon DOS, from the first reporting of functional codes for the functional limitation being treated by one therapy discipline (PT, OT, or SLP) until the date of discharge (if one occurs) from the therapy episode. Within a reporting episode, there can be multiple reporting periods as defined below.

A **reporting period** covers the same period as progress reporting. A clinician (therapist, physician, or NPP) is required to report once every 10 treatment days. A reporting period is defined as the period from the first reporting of functional codes until reporting at the 10th treatment day. For subsequent reporting periods, the first visit is the treatment date following the 10th treatment date. Clinicians are permitted to report functional information prior to the 10th treatment day. Please note that a submission of G-codes and modifiers restarts the 10 day count towards the progress reporting period.

(continued on next page)

Outpatient *(continued)*

Note: A reporting episode links a beneficiary to a specific therapy billing provider NPI. For the purpose of tracking beneficiary's functional limitations, Functional reporting data is reported **per beneficiary**, **per therapy discipline**, and **per billing provider NPI** on specified therapy claims for certain DOS.

Required reporting of functional codes

Functional reporting, using the G-codes and modifiers, is required on therapy claims for certain DOS as described below:

- At the outset of a therapy episode of care, i.e., on the DOS for the initial therapy service;
- At every progress reporting period, which occurs at least once every 10 treatment days;
- At the DOS that an evaluative or re-evaluative procedure code is submitted on the claim; and
- At the time of discharge from the therapy episode of care, unless discharge data is unavailable, e.g., when the beneficiary discontinues therapy unexpectedly.

Note: Once one functional limitation is discharged and further therapy is medically necessary, reporting of the subsequent functional limitation begins on the next treatment DOS.

Discharge reporting

Discharge reporting is required at the end of the reporting episode or to end reporting on one functional limitation prior to reporting on another medically necessary functional limitation.

The exception is in cases where the beneficiary discontinues therapy expectantly. When the beneficiary discontinues therapy expectantly, we encourage clinicians to include discharge reporting whenever possible on the claim for the final services of the therapy episode.

When a beneficiary discontinues therapy without notice, and returns less than 60 calendar days from the last recorded DOS to receive treatment for:

- the **same functional limitation**, the clinician must resume reporting following the reporting requirements outlined in the "Required Reporting of Functional Codes" subsection; or
- a **different functional limitation**, the clinician must discharge the functional limitation that was previously reported and begin reporting on a different functional limitation at the next treatment DOS.

Note: A reporting episode will automatically be discharged when it has been 60 or more calendar days since the last recorded DOS.

Functional reporting example

In Table A below, the self-care G-code set (G8987-G8989) is used to illustrate the required reporting of functional G-codes and severity modifiers at specified reporting intervals. See the "functional reporting codes" section for a complete list of G-codes and modifiers used in functional reporting.

If further therapy is medically necessary once reporting for the self-care functional limitation has ended,

Table A - Self-care G-code set (G8987-G8989)

	At the outset of the therapy episode of care	At the end of each progress reporting period	At the time of discharge from the therapy episode of care
G8987 current status + corresponding modifier	X	X	
G8988 goal status + corresponding modifier	X	X	X
G8989 discharge status + corresponding modifier			X

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Outpatient *(continued)*

the clinician may begin reporting on a subsequent functional limitation using the appropriate G- code set on the next treatment DOS.

Unique functional reporting scenarios

When functional reporting is required at specified intervals for a treatment DOS, generally two G-codes are required. The following exceptions exist:

1. **One-time therapy visit**. When a beneficiary is seen for a one-time visit and future therapy services are either not medically indicated or are going to be furnished by a different provider, the clinician reports as a one-time visit. The clinician reports on the claim for the DOS of the visit, all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.

2. **Reporting evaluative procedures for multiple POCs for the same therapy discipline**. The clinician should report the evaluative procedure furnished under a separate/ different POC for a functional limitation that is not subject to reporting as a one-time visit by reporting all three G-codes and corresponding severity modifiers for the functional limitation that most closely matches the evaluative procedure that was furnished.

3. **Therapy services from more than one therapy discipline**. Claims will contain more than two non- payable functional G-codes in cases where a beneficiary receives therapy services on the same treatment DOS from more than one therapy discipline (PT, OT, and/or SLP) from the same therapy provider.

Note: In unique scenario two, the DOS that functional codes are reported as a one-time visit alongside separately payable procedure code(s), including evaluative/re-evaluative services, does not count as a treatment day for the progress reporting period of the functional limitation subject to reporting.

Claims requirements

Claims containing any of these functional G-codes must also contain:

- another separately payable (non-bundled) service;
- functional severity modifier in the range CH – CN;
- therapy modifier indicating the discipline of the plan of care (POC) – GP, GO or GN – for PT, OT, and SLP services, respectively;
- date of the corresponding payable service;
- nominal charge, e.g., a penny;
- completion of the units field with “1” unit of service; and
- all other currently required claims data elements as described in the claims processing manuals.

Out of sequence claims

An out of sequence therapy claim has a DOS earlier than the last DOS recorded by the claims processing system. To avoid claims being returned or rejected, we encourage clinicians to submit claims in order by treatment DOS.

An out of sequence claim that does not meet the functional reporting requirements outlined above may be returned or rejected and providers will need to resubmit the out of sequence claim, and possibly other claims, to correct the information.

Other requirements

Evaluative Procedures

As described in the “Required Reporting of Functional Codes” subsection, functional reporting is always required when a HCPCS/ *CPT*® evaluation or re-evaluation code is reported on a DOS. These HCPCS/*CPT*® codes are listed below:

Evaluation/re-evaluation codes

92597	*92607*	*92608*	*92610*
92612	*92614*	*92616*	*96105*
97001	*97002*	*97003*	*97004*

Note: Clinicians are not required to furnish an evaluative or re-evaluative procedure every time G-codes and modifiers are reported. An evaluation or re-evaluation should be furnished when it is medically necessary and not solely for reporting at the required intervals.

Tracking and documentation

The clinician furnishing the therapy services must report the functional information on the therapy claim, and must also track and document the G-codes and modifiers in the beneficiary’s medical record of therapy services.

Transitioning from the testing period

For beneficiaries whose therapy episode of care and functional reporting began prior to July 1, 2013, clinicians do not need to restart functional reporting on the first DOS on or after July 1, 2013. Simply, report at the next required reporting interval that occurs on or

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Outpatient *(continued)*

after July 1, 2013.

For beneficiaries whose therapy episode of care began prior to July 1, 2013, but for whom functional reporting information has not been submitted prior to July 1, 2013, clinicians must report on the first claim with a treatment DOS on or after July 1, 2013, and document the beneficiary's functional status for that DOS in a progress report.

Functional reporting codes

G-codes are used to report a beneficiary's functional limitation being treated and note whether the report is on the beneficiary's current status, projected goal status, or discharge status.

Modifiers are used to indicate the severity/complexity level of the functional limitation being reported. By reporting G-codes and modifiers on a periodic basis, a beneficiary's functional limitation is tracked throughout the therapy episode of care.

The functional reporting G-codes:

- have a status code indicator of Q =Therapy functional information code, used for required reporting purposes only;
- have no payment amounts or relative value units; and
- are "always therapy" codes, which requires the use of a therapy modifier (GP, GO, or GN).

  A separate article (see *MLN Matters*® article MM8126 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/Downloads/MM8126.pdf*) was issued to alert providers/suppliers and contractors that these non-payable functional G-codes are "always therapy" codes on the therapy code list.

Functional reporting G-codes — short descriptors

The following Healthcare Common Procedure Coding System (HCPCS) G-codes are used to report the status of a beneficiary's functional limitations:

Mobility G-code set:

- G8978 mobility status
- G8979 mobility goal status
- G8980 mobility D/C status

Changing & maintaining body position G-code set:

- G8981 body pos current status
- G8982 body pos goal status
- G8983 body pos D/C status

Carrying, moving & handling objects G-code set:

- G8984 carry current status
- G8985 carry goal status

- G8986 carry D/C status

Self-care G-code set:

- G8987 self-care current status
- G8988 self-care goal status
- G8989 self-care D/C status

Other PT/OT primary G-code set:

- G8990 other PT/OT current status
- G8991 other PT/OT goal status
- G8992 other PT/OT D/C status

Other PT/OT subsequent G-code set:

- G8993 sub PT/OT current status
- G8994 sub PT/OT goal status
- G8995 sub PT/OT D/C status

Swallowing G-code set:

- G8996 swallow current status
- G8997 swallow goal status
- G8998 swallow D/C status

Motor speech G-code set: (Note: Codes in this set are not sequentially numbered)

- G8999 motor speech current status
- G9186 motor speech goal status
- G9158 motor speech D/C status

Spoken language comprehension G-code set:

- G9159 lang comp current status
- G9160 lang comp goal status
- G9161 lang comp D/C status

Spoken language expressive G-code set:

- G9162 lang express current status
- G9163 lang express goal status

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Outpatient *(continued)*

- G9164 lang express D/C status

Attention G-code set:

- G9165 atten current status
- G9166 atten goal status
- G9167 atten D/C status

Memory G-code set:

- G9168 memory current status
- G9169 memory goal status
- G9170 memory D/C status

Voice G-code set:

- G9171 voice current status
- G9172 voice goal status
- G9173 voice D/C status

Other speech language pathology G-code set:

- G9174 speech lang current status
- G9175 speech lang goal status
- G9176 speech lang D/C status

Severity/complexity modifiers

For each non-payable G-code, a modifier must be used to report the severity level for that functional limitation. The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the clinician furnishing the therapy services.

Therefore, the beneficiary's current status, projected goal status, and discharge status are reported via the appropriate severity modifiers. The following table includes the seven modifier's definitions.

Modifier	Impairment limitation restriction
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

Other information

Remittance advice messages

Medicare will return a claim adjustment reason code 246 (This non-payable code is for required reporting only.) and a group code of CO (contractual obligation) assigning financial liability to the provider. In addition, beneficiaries will be informed via Medicare summary notice 36.7 that they are not responsible for any charge amount associated with one of these G-codes.

Additional resources

There are related *MLN Matters*® articles that you may want to review:

- MM8126 - "2013 Annual Update to the Therapy Code List," discusses the 42 "Always Therapy" Codes, which are non-payable and for use only in functional reporting, and is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8126.pdf*.
- MM8166 - "Outpatient Therapy Functional Reporting Non-Compliance Alerts" inform providers of alert messaging that conveys supplemental information regarding your claims for outpatient therapy during the 6-month functional reporting testing period of January 1, 2013, to June 30, 2013, to allow you to use the new G-codes to assure that your systems work. It is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8166.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*.

You are encouraged to go to the therapy services page at *http://www.cms.gov/Medicare/Billing/TherapyServices/index.html* for more information and links related to this article.

MLN Matters® Number: SE1307 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

Pacific Rim facilities added to ESRD prospective payment system

Provider types affected

This *MLN Matters*® article is intended for end-stage renal disease (ESRD) facilities who submit claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for ESRD services provided to Medicare beneficiaries at ESRD facilities located in the Pacific Rim.

Provider action needed

This article is based on change request (CR) 8368 which provides the requirement that Pacific Rim ESRD facilities are to be paid under the ESRD prospective payment system (PPS) effective January 1, 2014. Make sure that your billing staff is aware of these changes.

Background

The ESRD facilities located in the United States Territories of Guam, American Samoa, and the Northern Mariana Islands (Pacific Rim) are subject to the ESRD prospective payment system (PPS) in accordance with the Medicare Improvement for Patients and Providers Act (MIPPA; Section 153b) and existing ESRD instructions provided in the *Medicare Claims Processing Manual* (Chapter 8; see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf*)). You can find the MIPPA; Section 153b, at *http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf*.

The ESRD facilities located in the Pacific Rim were removed from the initial implementation of the ESRD PPS because these facilities were previously not paid under the basic case-mix adjusted composite rate payment system.

However, by statute, all ESRD facilities are required to be paid fully under the ESRD PPS by January 1, 2014. Therefore, ESRD facilities located in the Pacific Rim have been advised and educated by their Medicare contractor that their PPS payments will begin January 1, 2014, and full PPS payment implementation will be required for claims with dates of service on or after January 1, 2014.

The 2014 wage index file provided with the annual update instructions will include a core-based statistical area (CBSA) with a corresponding wage index value for each of these areas.

Note: No new ESRD PPS payment policy is being implemented with CR 8368.

Additional information

You can find the ESRD payment Web page at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html*.

The ESRD PPS facility FAQs Web page is located at *http://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/ESRDpayment/FAQs.html*. This Web page contains responses to questions that CMS has received concerning the ESRD PPS.

You can review the *MLN Matters*® article MM7064, titled 'ESRD PPS and Consolidated Billing for Limited Part B Services,' at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7064.pdf*.

The official instruction, CR 8368 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1264OTN.pdf*.

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

MLN Matters® Number: MM8368
Related Change Request (CR) #: CR 8368
Related CR Release Date: July 26, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R12640TN
Implementation Date: January 6, 2014

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Incorrect number of units billed for Rituximab and Bevacizumab

Note: This article was revised on August 1, 2013, to add the section on "Supplemental Information on Reporting Drugs" that begins on page 3. It was previously published in the July 2013 edition of *Medicare A Connection*, Pages 13-14.

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 how to properly compute the units of rituximab and bevacizumab that should be 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 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 300mg 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.

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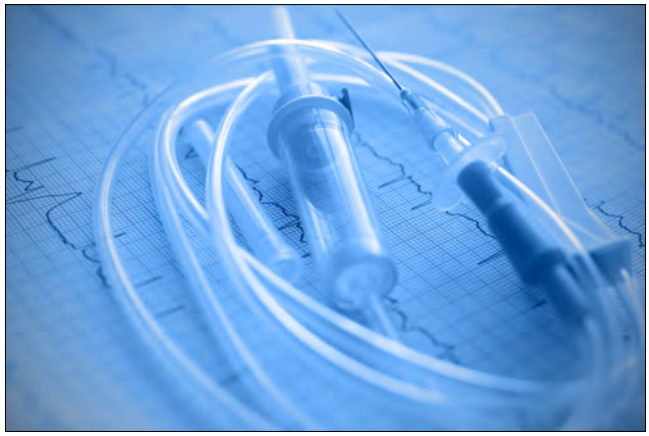
Rituximab *(continued)*

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 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.

Supplemental information related to reporting drugs

The following serves to clarify billing guidelines and provide examples of proper billing with a single-dose vial and discarded drug billing:

- Providers and hospitals are reminded to ensure that amounts of drugs administered to patients are accurately reported in terms of the dosage specified in the long descriptors for the applicable HCPCS codes. This is because the short descriptors are limited to 28 characters so they do not always capture the complete description of the drug.



- When submitting Medicare claims, units should be reported in multiples of the dosage included in the long HCPCS descriptor. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the number as a multiple.
- If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Medicare may cover the amount of the drug discarded along with the amount administered. The following elements must be followed in order for the discarded amount to be covered.
- The vial must be a single-use vial. Multi-use vials are not subject to payment for any discarded amounts of the drug.
- The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
- The left-over amount must actually be discarded and may not be used for another patient regardless of whether or not that other patient has Medicare.
- Please clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain. This kind of detailed documentation helps benefit your practice by justifying your billing in the event a medical review should occur.
- If your Medicare contractor requires discarded drugs to be reported with the JW modifier on a separate line, the total number of discarded units reported should not include amounts of the drug also included on the administered line due to the rounding up of units (see examples below).
- Please remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Hypothetical examples:

Rituximab (Rituxan®)

- Rituxan® is supplied as 100 mg/10 mL and 500 mg/50 mL solution in single-use vials.
- The physician administers 80 mg of rituximab to a patient. The smallest-sized vial available for this dose is 100 mg. The physician uses the 100 mg vial to administer 80 mg. The physician discards the remaining 20 mg in the vial.
- Since the J9310 long descriptor for rituximab (Rituxan®) shows that 1 billing unit represents 100 mg ordered/administered per patient, the correct calculation of units would be 0.8 units (80/100). However, for billing purposes, this would be rounded up to 1 unit.
- In this example, billing for 100 units would be an error. Since J9310 is defined as 1 unit being equal to 100 mg, this would mean that the patient received an unlikely dosage of 10,000 mg of rituximab for that date of service.
- Due to the single-use vial type, the provider may bill for the amount administered as well as the amount appropriately discarded. The discarded amount is reported with the JW modifier. The JW

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Rituximab *(continued)*

modifier is only applied to the amount of drug or biological that is discarded. A situation in which the JW modifier is not permitted is when the actual dose of the drug or biological administered is less than the billing unit. (See the *Medicare Claims Processing Manual*, Chapter 17, Section 40 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf*.)

For example, one billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7 mg dose is administered to a patient while 3mg of the remaining drug is discarded. The 7 mg dose is billed using one billing unit that represents 10mg on a single line item.

The single line item of 1 unit would be processed for payment of the total 10mg of drug administered and discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.

Bevacizumab (Avastin®)

Avastin® is supplied as 100 mg/4 mL and 400 mg/16 mL solution in single-use vials.

- The physician administers 395 mg of bevacizumab to a patient. The smallest-sized vial available for this dose is 400 mg. The physician uses the 400 mg vial to administer 395 mg. The physician discards the remaining 5 mg in the vial.
- Since the J9035 long descriptor for bevacizumab (Avastin®) shows that 1 billing unit represents 10 mg ordered/administered per patient, the correct calculation of units would be 39.5 units (395/10). However, for billing purposes, this would be rounded up to 40 units.
- In this example, billing for 395 units would be an error. Since J9035 is defined as 1 unit being equal to 10 mg, this would mean that the patient received 3,950 mg of bevacizumab for that date of service. This would be a billing error.
- Due to the single-use vial type, the provider may bill for the amount administered as well as the amount appropriately discarded.

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*

MLN Matters® Number: SE1316 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

Mandatory reporting of an 8-digit clinical trial number on claims

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8401, which informs you that, effective January 1, 2014, it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the *Medicare National Coverage Determination (NCD) Manual*, Section 310.1.

The clinical trial number to be reported is the same number that has been reported voluntarily since the implementation of CR 5790, dated January 18, 2008. That is the number assigned by the National Library of Medicine (NLM) *http://clinicaltrials.gov/* website when a new study appears in the NLM clinical trials data base.

Make sure that your billing staffs are aware of this requirement.

Background

CR 5790, transmittal 310, dated January 18, 2008, titled "Requirements for including an 8-Digit Clinical Trial Number on Claims" is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R310OTN.pdf*.

The *MLN Matters*® article for CR 5790 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5790.pdf*.

This number is listed prominently on each specific study's page and is always preceded by the letters 'NCT'.

The Centers for Medicare & Medicaid Services (CMS) uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry. Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by consulting CMS's clinical trials/registry website at *http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html*.

For institutional paper or direct data entry (DDE) claims, the 8-digit clinical trial number is to be placed in the value amount for paper only value code D4/DDE claim UB-04 (For Locators 39-41) when a clinical trial claim includes:

- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For institutional claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For professional claims, the 8-digit clinical trial number preceded by the two alpha characters of CT must be placed in Filed 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) when a clinical trial claim includes:

- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an 8-digit clinical trial number will be returned as not processable to the provider for inclusion of the trial number using the messages listed below.

- Claim adjustment reason 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 National Council for Prescription Drug Programs (NCPDP) reject reason code, or remittance advice remark

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Clinical *(continued)*

code (RARC) that is not an ALERT.)"

- RARC MA50: "Missing/incomplete/invalid Investigational Device Exemption number for FDA- approved clinical trial services."
- RARC MA130: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is not processable. Please submit a new claim with the complete/correct information."
- Group code-contractual obligation (CO).

Note: This is a reminder/clarification that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

Additional information

The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2758CP.pdf*.

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

MLN Matters® Number: MM8401
Related Change Request (CR) #: CR 8401
Related CR Release Date: August 9, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2758CP
Implementation Date: January 6, 2014

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Positron emission tomography (PET)

Provider types affected

This *MLN Matters*® article is intended is intended for physicians, other providers, and suppliers 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.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 8381 which announces that on July 11, 2012, the Centers for Medicare & Medicaid Services (CMS) opened a reconsideration of the *Medicare National Coverage Determinations (NCD) Manual* (Publication (Pub) 100-03, Section 220.6 (positron emission tomography (PET) Scans -Effective April 6, 2009)), to review coverage of PET for oncologic imaging. The new policy appears below.

Caution – what you need to know

CMS has determined that (unless there is a specific NCD to the contrary) local MACs may determine coverage or non-coverage for PET (within their respective jurisdictions) using new, proprietary radiopharmaceuticals for their Food and Drug Administration (FDA)-approved labeled indications for oncologic imaging only. This is effective for dates of service on or after March 7, 2013, and includes those radiopharmaceuticals that may be approved by the FDA in the future.

This decision does not change coverage for any uses of PET using the following four radiopharmaceuticals: FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)); NaF-18 (fluorine-18 labeled sodium fluoride); ammonia N-13; or rubidium-82 (Rb-82)). In addition, this decision does not prevent CMS from determining national coverage for any uses of any radiopharmaceuticals in the future, and if such determinations are made, a future determination would supersede local MAC determination(s).

Go – what you need to do

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

Background

PET is a minimally-invasive diagnostic imaging procedure used to evaluate normal tissue as well as in diseased tissues in conditions such as cancer, ischemic heart disease, and some neurologic disorders.

On July 11, 2012, CMS opened a reconsideration of the *NCD Manual*" Pub 100-03, Section 220.6 PET Scans, to review coverage of PET for oncologic conditions. See *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf*.

The Medicare NCD section 220.6 currently identifies the following radiopharmaceuticals as the only nationally covered radiopharmaceuticals (also known

(continued on next page)

PET *(continued)*

as radioisotopes or tracers) for certain defined uses in PET.

1. FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)),
2. NaF-18 (fluorine-18 labeled sodium fluoride),
3. Ammonia N-13, and,
4. Rubidium-82 (Rb-82)

All remaining uses of PET are nationally non-covered.

Effective March 7, 2013, CMS subsequently decided that (unless there is a specific NCD to the contrary) local MACs may determine coverage or non-coverage for PET (within their respective jurisdictions) using new, proprietary radiopharmaceuticals for their FDA-approved labeled indications for oncologic imaging only, and includes those radiopharmaceuticals that may be approved by the FDA in the future. This decision does not:

Change coverage for any uses of PET using the four radiopharmaceuticals listed above (i.e., FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)), NaF-18 (fluorine-18 labeled sodium fluoride), Ammonia N-13, or Rubidium-82 (Rb-82)); or

Prevent CMS from determining national coverage for any uses of any radiopharmaceuticals in the future, and if such determinations are made, a future determination would supersede local contractor determination.

For claims with dates of service on or after March 7, 2013, Medicare contractors will not search their files, but contractors will adjust claims brought to their attention.

CR 8381 revised the *Medicare NCD Manual*, Pub 100-03, Section 220.6 (Positron Emission Tomography (PET) Scans (Effective April 6, 2009)) as follows:

We emphasize each of the following points:

1. Changing the 'restrictive' language of prior PET decisions will not by itself suffice to expand Medicare coverage to new PET radiopharmaceuticals.
2. The scope of this change extends only to FDA-approved indications for oncologic uses of PET tracers.
3. This change does not include screening uses of PET scanning.

CR 8381 also revises the *Medicare Claims Processing Manual*, Chapter 13, Radiology Services and Other Diagnostic Procedures, and adds Section 60.19 (Local Coverage Determination for PET Using New, Proprietary Radiopharmaceuticals for their FDA-Approved Labeled Indications for Oncologic Imaging Only) as follows:

- Effective for dates of service on or after March 7, 2013, MACs may determine coverage within their respective jurisdictions for PET using radiopharmaceuticals for their FDA- approved labeled indications for oncologic imaging. When the local MAC determines that a claim is non-covered, the following messages apply:
    1. Claim adjustment reason code (CARC) 167: This (these) diagnosis(es) is(are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
    2. If an advance beneficiary notice (ABN) is provided with a GA modifier indicating there is a signed ABN on file, the liability falls to the beneficiary. However, if an ABN is provided with a GZ modifier indicating no ABN was provided, the liability falls to the provider.

Additional information

The official instruction, CR 8381, issued to your Medicare contractor regarding contained two transmittals. The first updates the *Medicare Claims Processing Manual* and is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2750CP.pdf*.

The second updates the *NCD Manual* and is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R156NCD.pdf*.

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*.

MLN Matters® Number: MM8381
Related Change Request (CR) #: CR 8381
Related CR Release Date: August 2, 2013
Effective Date: March 7, 2013
Related CR Transmittal #: R2750CP, R156NCD
Implementation Date: September 3, 2013

Prescribing specific brands under the DMEPOS competitive bidding

Do you order or refer Medicare beneficiaries for items included in the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program?

If so, this is a reminder to you that the requirement for suppliers to furnish items in accordance with the prescription continues to apply under the program.

In addition, the program includes a special beneficiary safeguard to ensure that beneficiaries have access to specific brands or modes of delivery of competitively bid items when needed to avoid an adverse medical outcome. This safeguard, which is sometimes called the physician authorization process, allows a physician (including a podiatric physician) or treating practitioner (i.e., a physician assistant, clinical nurse specialist, or nurse practitioner) to prescribe a specific brand or mode of delivery to avoid an adverse medical outcome. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome.

If a physician or treating practitioner prescribes a particular brand or mode of delivery for a beneficiary to avoid an adverse medical outcome, the contract supplier must, as a term of its contract, ensure that the beneficiary receives the needed item.

If the contract supplier does not ordinarily furnish the specific brand or mode of delivery and cannot obtain a revised prescription or locate another contract supplier that will furnish the needed item, the contract supplier must furnish the item as prescribed. Medicare will pay the single payment amount for covered competitively bid items furnished through the physician authorization process.

For more information about the Physician Authorization Process, please see the *Referral Agents Fact Sheet* on the CMS website.

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

CMS issues update on incarcerated beneficiary claims

The Centers for Medicare & Medicaid Services (CMS) has posted frequently asked questions (FAQs) about incarcerated beneficiary claims denials on the *All-Fee-For-Service-Providers* page on the CMS website.

Source: *PERL 201308-01*

Evaluate your Medicare administrative contractor

The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring a quality experience for health care providers who participate in the Medicare program. We can't do this without input from you.

If you are a Medicare fee-for-service (FFS) provider, practice manager or work on behalf of a Medicare FFS provider (such as a billing agency), please *register now* for an opportunity to tell CMS about the level of services that your MAC provides.

You'll need your national provider identifier (NPI) and provider transaction access number (PTAN) to sign up. If you work for a medical practice, you can list a group NPI and PTAN. MAC services to be rated include, but are not limited to, claims processing, Medicare enrollment, and responsiveness to inquiries.

It's quick and easy. Those selected to participate will be emailed a link to an online survey. All information collected will be kept confidential and used solely for this survey. Yes, I'd like to *sign up*.

Source: CMS PERL 201308-05

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.

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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.**

New LCDs

Molecular pathology procedures for human leukocyte antigens typing – new LCD

LCD ID number: L33732 (Florida/Puerto Rico/U.S. Virgin Islands)

Effective for services rendered on or after January 1, 2013, Medicare implemented the use of the *Current Procedural Terminology* (*CPT*®) molecular pathology codes. *CPT*® codes *83890* through *83914*, which were a component of the stacking method of coding molecular pathology testing, have been deleted for 2013.

The American Medical Association (AMA) in the 2012 and 2013 *CPT*® categorizes molecular pathology codes as either tier one (*CPT*® codes *81200-81383*) or tier two (*CPT*® codes *81400-81479*). Molecular diagnostic testing is a rapidly evolving science in which the significance of detecting specific mutations has yet to be clarified.

The focus of this local coverage determination (LCD) is tier 1 *CPT*® codes (*81370-81383*) for molecular pathology procedures for human leukocyte antigen typing, also known as HLA, which are a group of proteins present on the surface of white blood cells and other nucleated cells. These proteins help the body's immune system to identify its own cells and to distinguish between "self" and "non-self."

This new LCD has been developed to include indications and limitation of coverage, documentation requirements, utilization guidelines, and procedure and diagnosis codes that support medical necessity.

For HLA-B*27 testing for the diagnosis of symptomatic patients with presumed ankylosing spondylitis (ICD-9 code 720.0), the contractor will request documentation supporting the medical necessity for the test from the physician in all cases where ankylosing spondylitis is indicated as the reason for the test.

Providers are required to code to specificity however, if *CPT*® code *81479* (*Unlisted molecular pathology procedure*) is used the documentation must clearly identify the unique molecular pathology procedure performed. When multiple procedure codes are submitted on a claim (unique and/or unlisted) the documentation supporting each code should be easily identifiable. If on review the contractor cannot link a billed code to the documentation, these service will be denied based on Title XVIII of the Social Security Act, §1833(e).

Effective date

This new LCD is effective for services rendered **on or after October 07, 2013**. First Coast LCDs are available through the CMS Medicare coverage databases 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*.

Transcranial magnetic stimulation for major depressive disorder – new LCD

LCD ID number: L33676 (Florida/Puerto Rico/U.S. Virgin Islands)

Transcranial magnetic stimulation (TMS) is a non-invasive, non-systemic treatment modality that uses magnetic resonance imaging (MRI)-strength, pulsed and magnetic fields to induce an electric current in a localized region of the cerebral cortex.

This local coverage determination (LCD) has been developed to provide access to care of TMS as a treatment option for the management of major depressive disorder.

Currently, the *Current Procedural Terminology* (*CPT*®) codes that describe TMS (*CPT*® codes *90867, 90868*, and *90869*) listed in this LCD are included in the Noncovered Services LCD, and will be removed upon finalization of this LCD.

This LCD has been developed to include indications and limitations of coverage and/or medical necessity, documentation requirements, utilization guidelines, procedure codes, and ICD-9-CM diagnosis codes that support medical necessity.

Effective date

This new LCD is effective for services rendered **on or after October 07, 2013**. First Coast LCDs are available through the CMS Medicare coverage databases 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*.

New LCDs

Molecular pathology procedures – new LCD

LCD ID number: L33703 (Florida/Puerto Rico/U.S. Virgin Islands)

Molecular pathology procedures are medical laboratory procedures involving the analyses of nucleic acid to detect variants in genes that may be indicative of germline (e.g., constitutional disorders) or somatic (e.g., neoplasia) conditions, or to test for histocompatibility antigens (e.g., HLA).

Given the elimination of the stacking procedure codes (*83890-83914*) in the American Medical Association (AMA) 2013 *Current Procedural Terminology* (*CPT®*) manual and the array based evaluation procedure codes (*88384-88386*), molecular pathology codes now include all analytical services performed in the test (e.g., cell lysis, nucleic acid stabilization, extraction, digestion, amplification, and detection).

The molecular pathology procedure codes are categorized by two tiers. The Tier 1 molecular pathology codes (*81200–81383*) are applicable to specific biomarkers that represent gene-specific and genomic procedures. The Tier 2 molecular pathology codes (*81400–81408*) represent multiple biomarkers and are arranged by level of technical resources and interpretive work by the physician or other qualified healthcare professional. Tier 2 procedures are performed in lower volumes than Tier 1 procedures (e.g., the incidence of disease being tested is rare).

The focus of this local coverage determination (LCD) is to provide general guidance to the medically reasonable and necessary applications of the molecular pathology procedures described in *CPT®* code range *81200-81479* (with the exception of HLA

testing *CPT®* code range *81370-81373* addressed in the LCD for Molecular Pathology for Human Leukocyte Antigen). This new LCD has been developed to outline indications and limitations of coverage and/or medical necessity, documentation requirements, and utilization guidelines for molecular pathology procedures.

Effective date

This new LCD is effective for services rendered **on or after October 07, 2013**. First Coast LCDs are available through the CMS Medicare coverage databases 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.

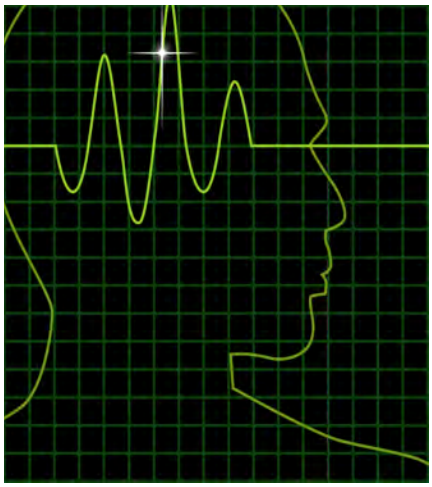
Not every procedure code is covered by an LCD. *Click here* **to look up current LCDs**

New LCDs

Special EEG tests – new LCD

LCD ID number: L33699 (Florida/Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) has been developed based on data analysis and claims review which resulted in the identification of aberrancies in Florida for the following *Current Procedural Terminology (CPT®)* codes: *95951* (*Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (e.g., for pre-surgical localization), each 24 hours*), *95953* (*Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended*), and *95957* (*Digital analysis of electroencephalogram (EEG) (e.g., for epileptic spike analysis*).



Data analysis also identified that ambulatory-EEGs were consistently billed by certain providers prior to a resting EEG as required by national coverage determination (NCD) 160.22-ambulatory EEG Monitoring.

Additionally, it was determined that *CPT®* code *95957*-EEG digital spike analysis was consistently billed by certain providers as included in an initial package of care and 1-2 months later this EEG test was repeated with a different package of care, and generally, a routine EEG was not billed prior to the billing of *CPT®* codes *95951*, *95953*, and *95957*.

This new LCD was developed to address the indications and limitations of coverage and/or medical necessity, procedure and diagnosis codes, documentation requirements, and utilization guidelines for ambulatory EEG tests.

Effective date

This new LCD is effective for services rendered **on or after October 07, 2013**. First Coast LCDs are available through the CMS Medicare coverage databases 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

Erythropoietin stimulating agents – revision to Part A LCD

LCD ID number: L28836 (Florida)

LCD ID number: L28869 (Puerto Rico/U.S. Virgin Islands)

The "Coding Guidelines" attachment of the local coverage determination (LCD) for erythropoiesis stimulating agents (ESA) was most recently revised April 1, 2013.

Since that time, the LCD "Coding Guidelines" attachment has been updated based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8256, transmittal 2688. Per this CR providers must identify when a drug is administered via dialysate by appending modifier JE (administered via dialysate).

Also, per the *CMS Manual System*, Pub 100-04, Chapter 8, Section 60.4.2 effective for services rendered on or after January 1, 2012, all facilities billing for injections of ESA for end stage renal disease (ESRD) beneficiaries must include modifier JA on the claim to indicate an intravenous administration or modifier JB to indicate a subcutaneous administration.

Effective date

This revision to the LCD "Coding Guidelines" attachment is effective for services rendered **on or after January 1, 2012**, for modifiers JA and JB and for services rendered **on or after July 1, 2013**, for modifier JE. First Coast Service Options, Inc. (First Coast) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Revision to LCDs

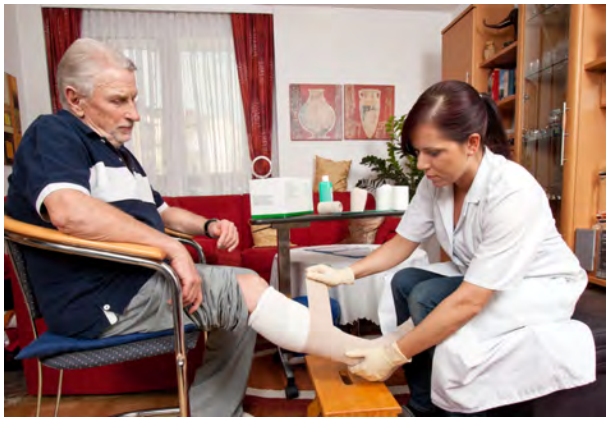
Noncovered services – revision to the Part A LCD

LCD ID number: L28991 (Florida)
LCD ID number: L29023 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for non-covered services was most recently revised July 1, 2013.

Since that time, the LCD has been revised to remove HCPCS codes G0456 (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds (s) surface area less than or equal to 50 square centimeters) and G0457 (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds (s) surface area greater than 50 square centimeters) under the heading "Devices" in the "*CPT*®/HCPCS Codes" section of the LCD.

For all claims submitted with HCPCS codes G0456 or G0457 medical record documentation will be requested and reviewed on an individual consideration basis. Of note, when an item or service is removed from the noncovered services LCD, it does not imply a positive coverage statement and coverage by Medicare. Therefore, claims billed for HCPCS codes G0456 and G0457 (assuming all other requirements of the program are met) would always need to meet the medically reasonable and necessary threshold for coverage in a prepayment or post payment audit of the official record.



Any time there is a question whether Medicare's medical reasonableness and necessity criteria would be met, we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed HCPCS codes. For further details about the Centers for Medicare & Medicaid Services (CMS') Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*. Please note that services leading up to or associated with non-covered services are also not covered.

Effective date

This LCD revision is effective for services rendered **on or after August 14, 2013**. First Coast LCDs are available through the CMS Medicare coverage databases at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

LCD ID number: L29004 (Florida)
LCD ID number: L29036 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for vinorelbine tartrate (Navelbine®) was most recently revised June 18, 2013. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to add the off-labeled indication of soft tissue sarcoma (retroperitoneal/intra-abdominal).

Also, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add diagnosis codes 158.0, 171.5, and 171.9 and descriptors.

In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after August 21, 2013**. First Coast LCDs are available through the CMS Medicare coverage databases 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*.

Healthcare provider taxonomy codes update, October 2013

Provider types affected

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

What you need to know

Change request (CR) 8417, from which this article is taken, instructs Medicare contractors to obtain the most recent healthcare provider taxonomy codes (HPTC) set and use it to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law when electronically transmitting certain health care transactions. These standards contain implementation guides that dictate when and how data must be sent, and specify the code sets that must be used.

Both the current ASC x12 837 institutional and professional claims require that the National Uniform Claim Committee (NUCC) HPTC set be used to identify provider specialty information on a health care claim. However, the standards do not mandate that a HPTC be on every claim, nor for every provider to be identified by specialty there.

They state that this information is:

- "Required when the payer's adjudication is known to be impacted by the provider taxonomy code" and
- "If not required by this implementation guide, do not send." In addition, please note that Medicare does not use HPTCs to adjudicate its claims, and would not expect to see these codes on a Medicare claim. However, it does currently validate any HPTC that a provider happens to supply against the NUCC HPTC code set.

As the HPTC code set maintainer, the NUCC updates the code set twice a year (effective April 1 and October 1), and CR 8417 implements the NUCC HPTC code set that is effective on October 1, 2013. CR 8417 instructs Medicare contractors and maintainers to obtain the October 2013 HPTC set, and to update the current HPTC tables with this updated list. It further instructs the contractors and maintainers that: 1) Have the capability to implement the updated October 2013 HPTC set, to update the HPTC table so that claims received on and after October 1, 2013, can be validated against this updated set; or 2) Lack this capability, to implement the October 2013 HPTC update as soon as they can after October 1, 2013, but not beyond January 6, 2014.

The HPTC set is available for view or for download at *http://www.wpc-edi.com/reference/* on the Washington Publishing Company (WPC) website. When reviewing the HPTC set online, revisions made since the last release can be identified by the color code: 1) New items are green; 2) Modified items are orange; and 3) Inactive items are red.

Additional information

The official instruction, CR 8417, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2762CP.pdf*.

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

MLN Matters® Number: MM8417
Related Change Request (CR) #: CR 8417
Related CR Release Date: August 9, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2762
Implementation Date: January 6, 2014

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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.

Update to the claims processing Internet-only manual to add the national uniform billing committee payer-only codes

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A Medicare administrative contractors (MACs), regional home health intermediaries (RHHIs), or home health & hospice Medicare administrative contractors (HH&H MACs), for services to Medicare beneficiaries.

What you need to know

Change request (CR) 8413, from which this article is taken, adds the National Uniform Billing Committee (NUBC) payer-only codes to the *Medicare Claims Processing Manual*, Chapter 1 (General Billing Requirements), Section 190 (payer-only codes utilized by Medicare) which you can find as an attachment to CR 8413. Please note that you do not submit these codes on your claim forms. Rather Medicare systems apply them to the claim systematically.

Background

The NUBC designates various series within the condition, occurrence, occurrence span and value codes as payer only codes. CR 8413 adds a new section to the *Medicare Claims Processing Manual* that identifies current definitions for codes designated by the NUBC to be assigned by payers only.

The following tables summarize the new manual section and contain the listing, and definitions, of the payer only codes. Providers shall not submit these codes on their claim forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

Table 1 - Condition codes

Condition codes*	Code definitions
12-14	Not currently used by Medicare
15	Clean claim is delayed in CMS processing system
16	SNF transition exception
60	Operating cost day outlier
61	Operating cost outlier
62	PIP bill
63	Bypass CWF edits for incarcerated beneficiaries. Indicates services rendered to a prisoner or a patient in state or local custody meets the requirement of 42 CFR 411.4(b) for payment
64	Other than clean claim
65	Non-PPS bill
98	Data associated with drg 468 has been validated
EY	Lung reduction study demonstration claims
M0	All-inclusive rate for outpatient - used by a critical access hospital electing to be paid an all-inclusive rate for outpatient services
M1	Roster billed influenza virus vaccine or pneumococcal pneumonia vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.
M2	Allows home health claims to process if provider reimbursement > $150,000.00. HHA payment significantly exceeds total charges. Used when payment to an HHA is significantly in excess of covered billed charges.
M3 – M9	Not used by Medicare
MA	GI bleed
MB	Pneumonia
MC	Pericarditis
MD	Myelodysplastic syndrome
ME	Hereditary hemolytic and sickle cell anemia
MF	Monoclonal gammopathy
MG-MZ	Not currently used by Medicare
UU	Not currently used by Medicare

*UB-04 Form Locators (FLs) 18-28

Table 2 - Occurrence codes

Occurrence codes*	Code definitions
23	Date of cancellation of hospice election period
48-49	Not currently used by Medicare

* FLs 31-34

(continued on next page)

Codes *(continued)*

Table 3 - Occurrence span codes

Occurrence span code*	Code definition
79	Verified non-covered stay dates for which the provider is liable

* FLs 35-36

Table 4 - Value codes

Value codes*	Code definitions
17	Operating outlier amount – The FI or A/B MAC reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry
18	Operating disproportionate share amount – The FI or A/B MAC reports the operating disproportionate shares amount applicable. It uses the amount provided by the disproportionate share field in pricer. It does not include any PPS capital IME adjustment entry
19	Operating indirect medical education amount – The FI or A/B MAC reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in pricer. It does not include any PPS capital IME adjustment in this entry
20	Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount
62	HH Visits - Part A - The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812(a)(3) of the Social Security Act
63	HH visits – Part B - The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812(a)(3) of the Social Security Act
64	HH reimbursement – Part A - The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812(a) (3) of the Social Security Act

Value codes*	Code definitions
65	HH reimbursement – Part B - The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812(a)(3) of the Social Security Act
70	Interest amount - The contractor reports the amount of interest applied to this Medicare claim
71	Funding of ESRD networks - The FI or A/B MAC reports the amount the Medicare payment was reduced to help fund ESRD networks
72	Flat rate surgery charge - The standard charge for outpatient surgery where the provider has such a charging structure
73	Sequestration adjustment amount
74	Not currently used by Medicare
75	Prior covered days for an interrupted stay
76	Provider's interim rate – Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00
77	Medicare new technology add-on payment - Code indicates the amount of Medicare additional payment for new technology

(continued on next page)

Codes *(continued)*

Value codes*	Code definitions
78	Payer only value code. When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 12x, 13x, 14x, 22x, 23x, 34x, 72x, 74x, 75x, 81x, 82x, and 85x. The zip code is associated with this value and is used to price MPFS HCPCS and anesthesia services for CAH Method II
79	Not currently used by Medicare
Q0	Accountable Care Organization reduction
Q1 – Q9	Not used by Medicare

*FLs 39-41

Additional information

The official instruction, CR 8413, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2759CP.pdf*.

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

MLN Matters® Number: MM8413
Related Change Request (CR) #: CR 8413
Related CR Release Date: August 9, 2013
Effective Date: November 12, 2013
Related CR Transmittal #: R2759CP
Implementation Date: November 12, 2013

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Requesting a duplicate remittance advice

First Coast sometimes receives requests for duplicate Medicare remittance notices (MRNs), also known as Medicare summary notices (MSNs).

Trading partners who are directly submitting through the electronic data interchange (EDI) gateway using their own submitter number and receive electronic remittance advices (ERAs) may use the *Remittance reload request for X12 v5010*.

Providers who are sending/receiving files through a clearinghouse should contact the clearinghouse for any reload requests. Providers may also download free software to retrieve ERAs.

How do I get the free software?

For Part A providers, download *PC-Print Software*.

For Part B providers, download *MREP software*.

What if I receive paper remittance notices?

Medicare contractors do not routinely provide duplicate paper remits (standard paper remittance or SPR). Providers who receive SPR may contact customer service for duplicates if the originals were never received or were lost due to natural disaster.

Note: Customer service can only send the duplicates to the address printed on the SPR. In addition, Part A requests must be made within 30 days of the remit date; otherwise, there is a $25 fee for duplicates.

We recommend using ERA. *Click here* for answers to concerns you may have regarding ERA, or *click here* to view ERA FAQs.

Update on processing issue with Medicare secondary payer claims

This is an update on the processing issue related to Medicare secondary payer (MSP) claims rejecting with reason code 39071, 39072, or 39073.

First Coast Service Options Inc. (First Coast) has successfully released the majority of held claims.

However, there is still a small amount of claims that are not processing through to completion.

First Coast is working closely with the Centers for Medicare & Medicaid Services and system maintainers to resolve this issue. A system fix is being worked and scheduled for October 7.

Source: Change request 7605

October 2013 integrated outpatient code editor specifications version 14.3

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8419 which informs FIs, A/B MACs, RHHIs and the fiscal intermediary shared system (FISS) that the I/OCE was updated for October 1, 2013. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis. The full list of I/OCE specifications can now be found at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html*.

There is a summary of the changes for October 2013 in Appendix M of Attachment A of CR 8419. That summary is captured in the following key points. Effective October 1, 2013, (except as noted below) Medicare will:

- Update Appendix N, list A, to add codes *90473* and *90474*. Effective January 1, 2007;
- Update Appendix N, list A, to add code G0010. Effective January 1, 2011.
- Implement mid-quarter US Food and Drug Administration (FDA) approval for code *90685*. Edit 67 is affected. Effective June 7, 2013.
- Add new modifier AO (Prov declined alt pmt method) to the list of valid modifiers. Edit 22 is affected.
- Remove ICD-9-CM diagnosis codes *7512* and *75161* from the pediatric only (0-17 yrs) age limitation. Edit 2 is affected.
- Update the program logic to assign the extended assessment & management composite ambulatory payment classification (APC) on a claim containing multiple service dates if the appropriate criteria for assignment are met after a gap in service dates. Effective January 1, 2008.
- Update Appendix N, list A (HCPCS codes for reporting antigens, vaccine administration, splints and casts), to add codes *90473* and *90474*, effective January 1, 2007.
- Update Appendix N, list A (HCPCS codes for reporting antigens, vaccine administration, splints and casts), to add code G0010, effective January 1, 2011.
- Make HCPCS/APC/status indicator (SI) changes as specified by the Centers for Medicare & Medicaid Services (data change files) effective July 1, 2013.
- Implement version 19.3 of the NCCI (as modified for applicable institutional providers). Edits 20 and 40 are affected.
- Update Appendix F to note deletion of bill type 33x.
- Update Appendix N, list A and List C to remove deleted code G9141.
- Correct the standard APC assigned for G0379 on page 40 to be APC 608.
- Implement new edit 86. Manifestation code not allowed as principal diagnosis (RTP). Criteria: A diagnosis code considered to be a manifestation code from the Medicare code editor (MCE) manifestation diagnosis list is reported as the principal diagnosis code on a hospice bill type claim (81x, 82x).

Additional information

The official instruction, CR 8419, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2763CP.pdf*.

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

MLN Matters® Number: MM8419
Related Change Request (CR) #: CR 8419
Related CR Release Date: August 9, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2763CP
Implementation Date: October 7, 2013

Common working file informational unsolicited response for hospital-to-hospital transfers

Provider types affected

This *MLN Matters*® article is intended for 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 is based on change request (CR) 8231, which will cause Medicare's common working file (CWF) to recognize situations where hospital A submits an inpatient prospective payment system (IPPS) claim which indicates that the patient was discharged to home, when in fact, the patient was transferred to hospital B. When hospital A's claim indicates that the patient is being discharged to home they will be paid at the full Medicare severity diagnosis related group (MS-DRG) rate, which results in an overpayment. This improvement to Medicare's claims processing system will ensure that payments to both hospitals accurately reflect the IPPS transfer policy. **There is no new policy in CR 8231.** The claims processing systems are being updated to ensure that the current policies are applied to claims.

Background

The Centers for Medicare & Medicaid Services (CMS) recovery auditor program is responsible for identifying and correcting improper payments in the Medicare fee-for-service (FFS) payment process. The contractor claim data identified inpatient claims that were improperly reported as a discharge to home rather than as a transfer to another hospital, resulting in an overpayment to the transferring hospital. When a transferring IPPS hospital indicates to Medicare that the patient is being discharged to home, the transferring hospital receives a full MS-DRG payment. In these cases, the transferring hospital should receive reimbursement per the CMS-defined per diem rate logic when transferring a patient to another acute care facility. An overpayment may exist when both hospitals (the transferring hospital and the final discharging hospital) receive full MS-DRG payments.

The *Medicare Claims Processing Manual*, Chapter 03, Section 20.1.2.4, states that for transfers between IPPS hospitals, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by a number equal to the length of stay for the case plus one day. The payment to the final discharging hospital is made at the full prospective payment rate.

The same manual, Chapter 03, Section 40.2.4, states that a discharge of a hospital inpatient is considered to be a transfer if the patient is admitted the same day to another hospital. A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred from the hospital where the patient was admitted to another hospital for additional treatment once the patient's condition has stabilized or a diagnosis established.

The relevant chapter of the *Medicare Claims Processing Manual* is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf*.

Additional information

The official instruction, CR 8231 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R12660TN.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*.

MLN Matters® Number: MM8231
Related Change Request (CR) #: CR 8231
Related CR Release Date: July 26, 2013
Effective Date: October 7, 2013
Related CR Transmittal #: R12660TN
Implementation Date: October 7, 2013

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Response for add-on codes billed without respective primary codes

Note: This article was revised on August 16, 2013, to add a reference to *MLN Matters*® article SE1320 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1320.pdf)* for further information about the rules for HCPCS/*CPT*® add-on codes. All other information remains the same.

Provider types affected

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

Provider action needed

Stop – Impact to you

This article is based on change request (CR) 8271 which informs Medicare contractors about changes to CWF IURs. Add-on codes are only payable when billed in addition to the code for the primary procedure. Generally, these are identified with the statement "list separately in addition to code for primary procedure" in parentheses, and other times the supplemental code is used only with certain primary codes, which are parenthetically identified. The reason for these *CPT*® codes is to enable physicians and others to separately identify a service that is performed in certain situations as an additional service.

Go – What you need to do

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

Background

The CMS recovery audit contractor (RAC) program is responsible for identifying and correcting improper payments in the Medicare fee-for-service payment process. The contractor claim data identified providers that were billing only the add-on codes without their respective primary codes resulting in overpayments. The Centers for Medicare & Medicaid Services (CMS) policy indicates:

"Add-on codes are always performed in addition to a primary service or procedure and must never be reported as a stand-alone code." These services are always done in conjunction with another procedure and are only payable when an appropriate service is also paid.

CR 8271 prompts your Medicare contractor to generate an IUR or reject for an add-on *CPT*® code on outpatient claims when there is no primary procedure *CPT*® code associated with the Add-On *CPT*® code or when primary procedure code associated with the add-on *CPT*® code is not covered.

Key points in CR 8271

Generate an IUR

- An IUR will be generated for paid outpatient claims from April 1, 2013, to April 6, 2014, for the billed Add-On *CPT*® code detail line when the following conditions exist:
  - The type of bill (TOB) = 13x, 14x, or 85x; and
  - There is a covered add-on *CPT*® code; and
  - There is no primary *CPT*® code associated with the add-on *CPT*® code on the same claim or separate claim for the same date of service (DOS); OR
  - There is a primary code associated with the add-on code that is non-covered on the same claim or separate claim for the same DOS; and
  - The reimbursement amount for the add-on *CPT*® code is greater than $10.00.
- Your contractor will issue an adjustment for the Medicare claim and will initiate recoupment procedures using automated processes currently in use for IURs.

Reject a claim

- The Medicare hospital outpatient claim will be rejected at the line level for the add-on *CPT*® code when the following conditions exist:
- The type of bill (TOB) = 13x, 14x or 85x; and
- There is a valid add-on *CPT*® code on the claim; and
- There is no primary *CPT*® code associated with the add-on *CPT*® code on the same claim or separate claim for the same DOS; OR
- There is a primary code associated with the add-on code that is non-covered on the same claim or separate claim for the same DOS.
- Your contractor will mark the detail line item for the add-on code as non-covered.

(continued on next page)

Codes *(continued)*

- Your contractor will have override capability for a claim upon first appeal when it is determined that the claim should have been paid.

The following codes will be used when creating an adjustment and a reject for the outpatient claim:

- Group code - CO;
- RARC N122 - Add-on code cannot be billed by itself; and
- CARC 107 - The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.

Additional information

In Attachment A of CR 8271, the primary *CPT*® codes are listed in column B of the table and the associated add-on codes are listed in column A of the table.

The official instruction, CR 8271 issued to your FI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1262OTN.pdf*.

You may want to review the *Medicare Claims Processing Manual*, Chapter 12, Section 30 (Correct Coding Policy) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.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: MM8271
Related Change Request (CR) #: CR 8271
Related CR Release Date: July 26, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R12620TN
Implementation Date: January 6, 2014

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New claim adjustment reason code (CARC) to identify sequestration cuts

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8378 which informs Medicare contractors about a new claim adjustment reason code (CARC) reported when payments are reduced due to sequestration. Make sure that billing staffs are aware of these changes.

Background

As required by law, President Obama issued a sequestration order on March 1, 2013. As a result, Medicare fee-for-service claims, with dates of service or dates of discharge on or after April 1, 2013, incur a 2 percent reduction in Medicare payment.

The Centers for Medicare & Medicaid services (CMS) previously assigned CARC 223 (Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created) to explain the adjustment in payment.

Effective June 3, 2013, a new CARC was created and will replace CARC 223 on all applicable claims. The new CARC is as follows:

- 253 - Sequestration - reduction in federal spending

Also, Medicare contractors will not take any action on claims processed prior to implementation of CR 8378.

Additional information

The official instruction, CR 8378 may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2739CP.pdf*.

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

MLN Matters® Number: MM8378
Related Change Request (CR) #: CR 8378
Related CR Release Date: July 25, 2013
Effective Date: June 3, 2013
Related CR Transmittal #: R2739CP
Implementation Date: January 6, 2014

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Redaction of claim numbers in Medicare redetermination notices

Provider types affected

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

What you need to know

This article is based on change request (CR) 8268, which instructs the MACs to redact health insurance claim numbers (HICN) on all Medicare redetermination notices (MRN). Make sure that your billing staffs are aware of this change.

Background

Medicare contractors are required to issue a notice of Medicare redetermination after an appeal is requested in accordance with 42 CFR Section 405.956. One of the elements in the MRN is the beneficiary's HICN. To ensure that contractors protect personally identifiable information, the Centers for Medicare & Medicaid Services (CMS) is requesting that all contractors redact the HICNs in the MRNs. The HICNs will be redacted by replacing 5 or more values of the HICN with Xs or asterisks (*) with the last 4 or 5 digits of the HICN displayed. This applies to HICNs with both alpha and numeric digits.

Additional information

The official instruction, CR 8268, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1258OTN.pdf*.

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

MLN Matters® Number: MM8268
Related Change Request (CR) #: CR 8268
Related CR Release Date: July 25, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R12580TN
Implementation Date: January 6, 2014

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Claims returning to providers for reason code 31182

Provider types affected

This article provides information about claims returning to providers for reason codes 31182 for A/B rebilled inpatient claims.

First Coast has released held rebilled claims that received reason codes 31182 and 31796; however, there were some claims that returned with reason code 31182 and need to be resubmitted. The document control number (DCN) in the remarks field must be corrected to the format below and the claim can be PF9 for resubmittal once it's in a finalized location (T/B9997). The claim will continue to process through the fiscal intermediary standard system (FISS) and could possibly hit other reason codes.

- 31182 – reason code is assigned if A/B rebilling is present in the first iteration of the treatment authorization field and any of the following criteria is met
- Condition code W2 is not present
- DCN and date of the last adjudication is not present or not in the correct location and format
- Receipt date of the claim is prior to 03/13/2013
- We recommend that providers receiving this reason code follow the below billing instructions exactly as stated.
- Condition code W2
- First iteration of the treatment authorization field A/B Rebilling
- Remarks field ABRebill12345678901234-MMDDCCYY
- 12345678901234 = document control number from original 11x claim (numeric portion only)
- MMDDCCYY = receipt date of last claim adjudication (payment, denial, dismissal, etc)
- PF9 to resubmit the claim

We apologize for any inconvenience this may cause your facility. We are working diligently to resolve these billing issues as quickly as they become known.

Save time and money–resolve reason code N5052

Provider types affected

Remittance message: beneficiary identification incorrect - the beneficiary name and or other personal data in the common working file (CWF) transaction did not match the data stored on the beneficiary master record.

What does this really mean? The beneficiary information submitted on the claim does not match the information in the common working file (CWF).

Provider action required

This article is based on change request (CR) 8386 and instructs Medicare contractors to download and implement a new MPFSDB, effective October 1, 2013.

Confirm the beneficiary's eligibility via direct data entry (DDE), interactive voice response (IVR) system, SPOT (secure provider online tool), or 270/271 transactions report

If the information is correct, then re-file the claim.If the information is incorrect, then the beneficiary must contact the Social Security Administration (SSA) to update the records. Once the records are updated, re-file the claim to Medicare

There are also a few things you can do when a beneficiary comes to your facility

1. Always obtain a copy of their red, white, and blue Medicare card prior to providing services.
2. Make sure their name on the claim matches their name exactly as it appears on their Medicare red, white, and blue card. Do not use nicknames.
3. If the name on their card does not match their name submitted on the claim, make appropriate corrections and resubmit the claim.

Additional resources

Resolve reason code *C7010*

Resolve reason code *U5233*

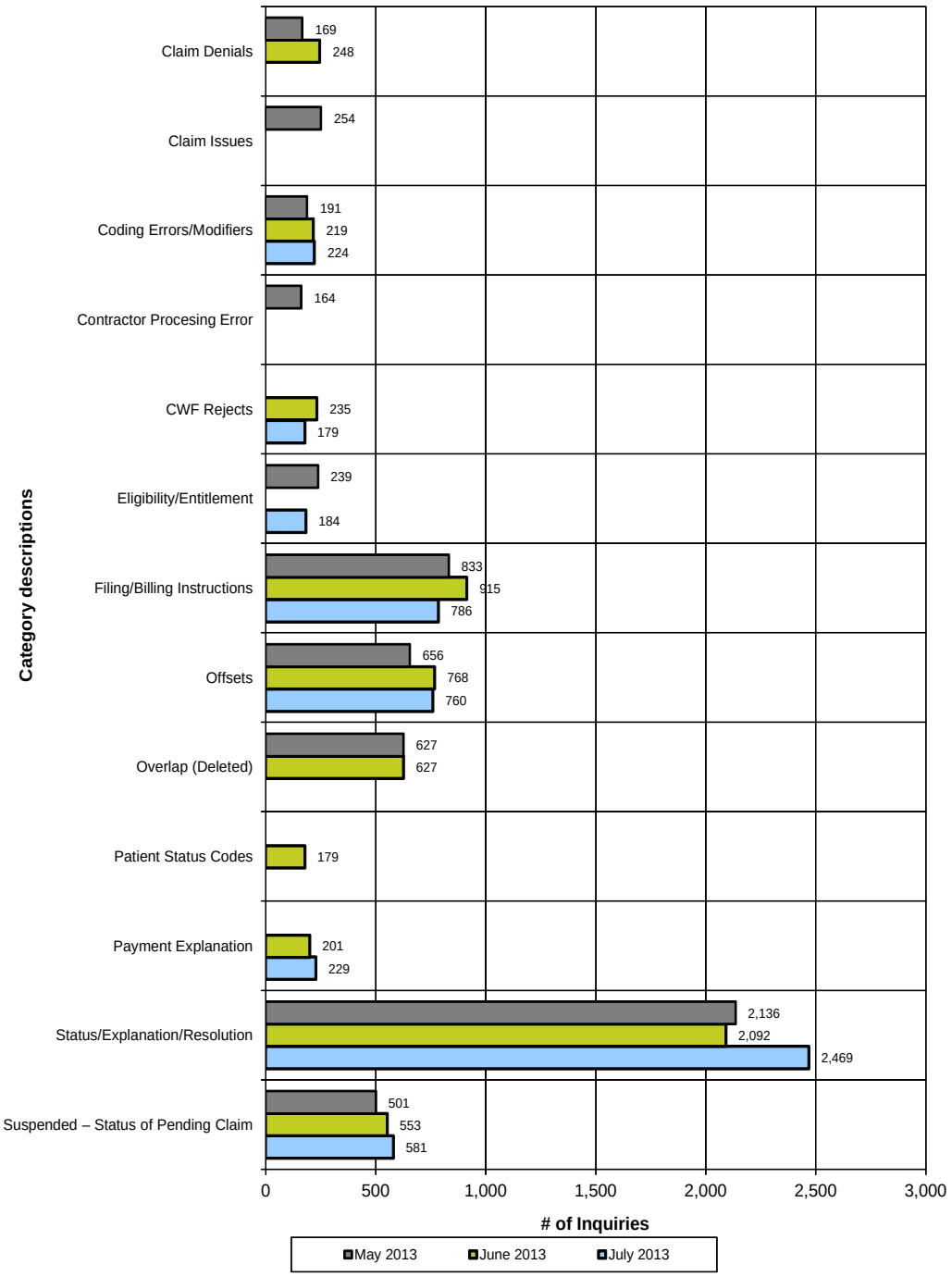
Source: *Direct Data Entry*, *Interactive Voice Response reference guide*, and *270/271 transactions*

Top inquiries, rejects, and return to provider claims May 2013 through July 2013

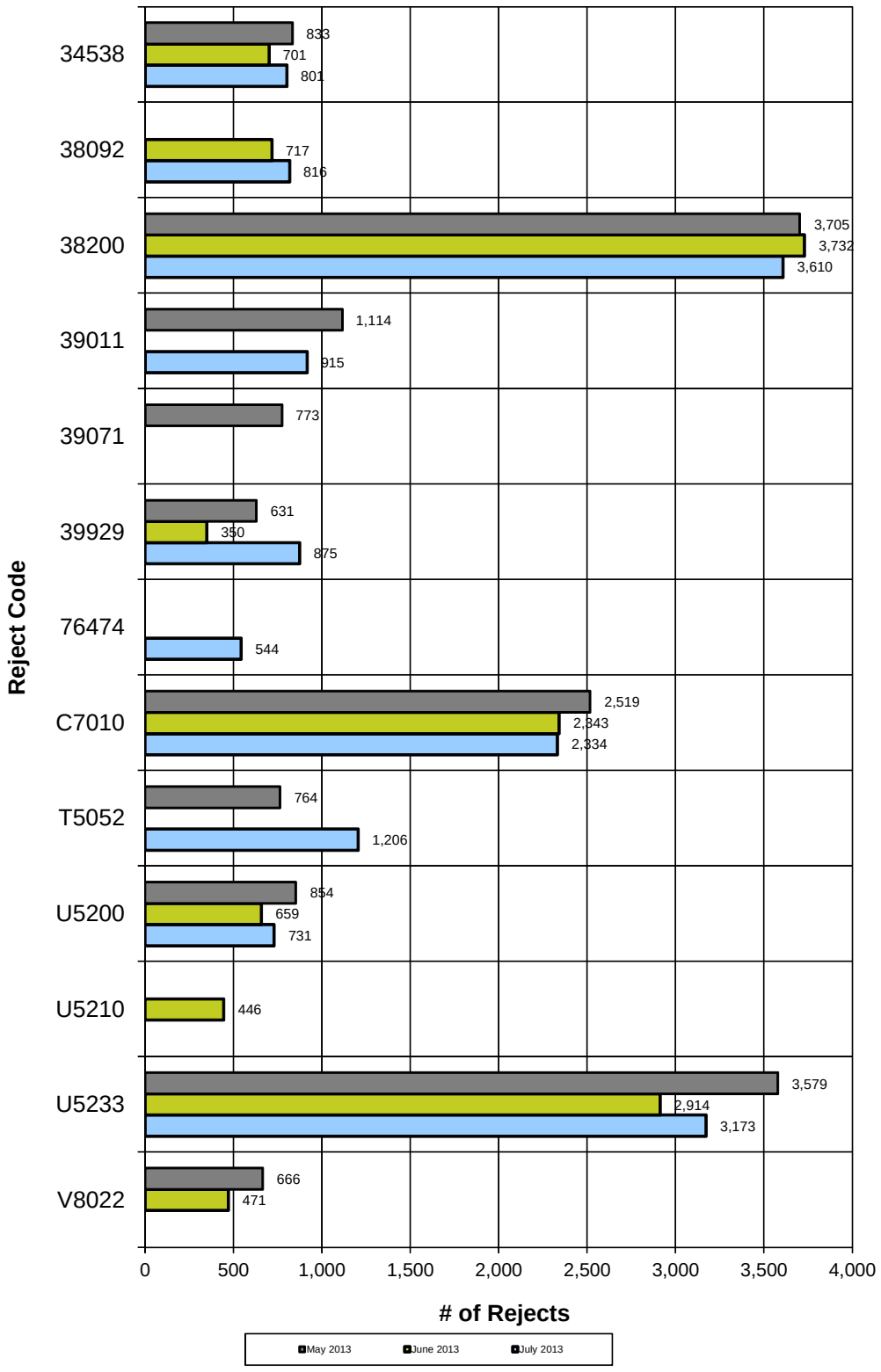
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during May 2013 through July 2013.

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 May-July 2013

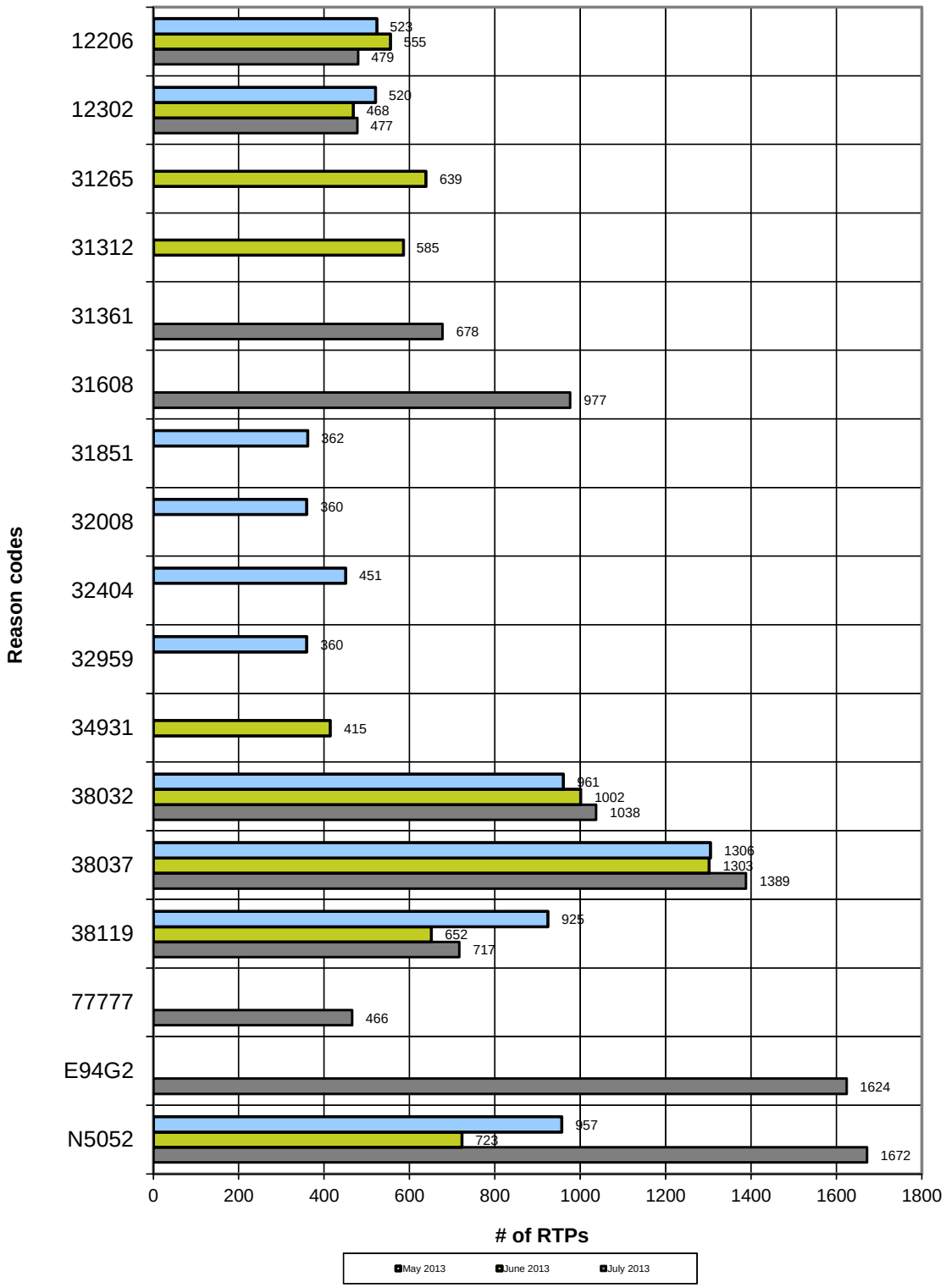


Part A top rejects for May 2013 through July 2013



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

Top RTPs for May- July 2013



July 2013 update to DMEPOS fee schedule

Note: This article was revised on August 1, 2013, to add additional language to address questions raised about the implementation of the non-mail order fee schedule changes required by the American Taxpayer Relief Act. This article was previously published in the June 2013 edition of *Medicare A Connection*, Pages 51-52.

Provider types affected

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

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

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable and to apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

Key points of CR 8325

- CR 8325 updates fees for Healthcare Common Procedure Coding System (HCPCS) codes E2378, L5859, and L7902. These HCPCS codes were added to the HCPCS file effective January 1, 2013. Previously these items were paid on a local fee schedule. If claims for these codes with dates of service on or after January 1, 2013 have already been processed, they will be adjusted to reflect the new fees if you bring the claims to your contractor's attention.
- As part of this update fee schedule amounts are also established for HCPCS code K0009 (Other Manual Wheelchair/Base). Payment on a fee schedule basis is mandated for all DME by section 1834(a) of the Social Security Act (the Act), other than items that meet the definition of customized DME at 42 CFR section 414.224 of the regulations. Effective July 1, 2013, payment for claims for manual wheelchairs, that receive a HCPCS code verification of K0009 by the pricing data analysis and coding (PDAC) contractor, will be made on a capped rental basis with the fee schedule amounts established in accordance with Section 1834 (a) (8) of the Act using data for all manual wheelchair codes effective in 1986.

Diabetic Testing Supplies

Effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the American Taxpayer Relief Act (ATRA), the fee schedule amounts for non-mail order diabetic supplies are adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established in implementing the national mail order competitive bidding program under Section 1847 of the Act. The national competitive bidding program for mail order diabetic supplies takes effect July 1, 2013. This provision of the ATRA achieves competitive non-mail order prices for the same diabetic testing supplies furnished through the national mail order program without requiring local pharmacies to compete and be awarded contracts while still providing Medicare beneficiaries a choice in where they obtain supplies.

Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as described by the HCPCS codes below:

- A4233 replacement battery, alkaline (other than j cell), for use with medically necessary home blood glucose monitor owned by patient, each.
- A4234 replacement battery, alkaline, j cell, for use with medically necessary home blood glucose monitor owned by patient, each.
- A4235 replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each.
- A4236 replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each.
- A4253 blood glucose test or reagent strips for home glucose monitor, per 50 strips.
- A4256 normal, low and high calibration solution / chips.

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DMEPOS *(continued)*

- A4258 spring-powered device for lancet, each.
- A4259 lancets, per box of 100.

Effective for dates of service on or after July 1, 2013, the non-mail order fee schedule amounts for the diabetic testing supplies listed above will be adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established under the national mail order competition for diabetic testing supplies.

The annual covered item update will not be applied to the new national fee schedule amounts for non-mail order diabetic testing supplies. Rather, the non-mail order fee schedule amounts on the fee schedule file will be updated each time the single payment amounts are updated, which can happen no less often than every three years as contracts are recompeted. The rules related to assignment of claims for non-mail order diabetic testing supplies are not affected by this new law. Since claim assignment is not mandatory for diabetic testing supplies furnished on a non-mail order basis, beneficiaries should ask the pharmacy or supplier storefront for the supplier's charge and whether they will accept assignment of the claim before purchase.

The definitions of mail order item and non-mail order item set forth in 42 CFR 414.402 are:

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

Effective July 1, 2013, only national mail order contract suppliers will be paid by Medicare for diabetic testing supplies other than those that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront. The single payment amount public use file for the national mail order competitive bidding program is available at *http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts*.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order diabetic testing supplies, the mail order fee schedule amounts (KL modifier) for these codes will remain on the DMEPOS fee schedule file as reference data. The mail order diabetic testing supply fee schedule amounts will be maintained and updated annually by the covered item update for use in establishing bid limits for future competitive bidding competitions.

Additional information

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

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

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

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Enrollment denials when overpayment exists

Note: This article has been rescinded due to the related change request (CR) being rescinded. The CR and article will be replaced at a later date. It was previously published in the June 2013 edition of *Medicare A Connection*, P. 46

Additional information

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

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

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

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Medicare manuals on debt collection and extended repayment updated

Provider types affected

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

Provider action needed

Change request (CR) 8347 is a policy change that streamlines the extended repayment schedules (ERS) process by updating the policy language and standard practices. See the *Key points* section of this article for specifics.

Background

Overpayments are Medicare payments to a provider that are in excess of amounts due and payable under the statute and regulations. When an overpayment is determined, a demand letter is sent requesting repayment. A provider is expected to repay any overpayment promptly. If repaying an overpayment within 30 days would constitute a "hardship" for the provider, the provider may request an ERS at any time the overpayment is outstanding. Medicare contractors and/or Centers for Medicare & Medicaid Services (CMS) staff will review the request to determine if extending a repayment schedule is justified.

Key points

The following points are based on the revised manual, *Medicare Financial Management*, Chapter 4 – Debt Collection.

- Medicare contractors are charged with establishing an ERS formerly called an extended repayment plan (ERP). Contractors must process ERS requests within 30 days of receipt and make certain providers complete all instructions. Contractors are required to post information and instructions on their websites and supply paper copies if requested.
- Your Medicare contractor will approve/disapprove an ERS request from 6 months up to 36 months and the CMS for an ERS up to 60 months—again within 30 days of receipt.
- Your Medicare contractor will not refund monies recouped during the review process. The recouped amounts will be applied to the overpayment.
- Contractors will notify a provider of approval or no approval within 5 days of decision.
- Contractors will recoup ERS payments from a provider's future Medicare payment, unless the contractor determines there is a valid reason to send in a check.

- Chapter 4, Section 100.6.4 details the ERS process that occurs if a request is received by the recovery audit contractor (RAC) from a provider. The point of contact information for the ERS at the RAC location will be provided in a separate instruction.

Additional information

The official instruction, CR 8347 regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R224FM.pdf*.

You may review CR 7688 for an explanation of the policy that implements a standard "immediate recoupment" process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date at: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7688.pdf*.

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

MLN Matters® Number: MM8347
Related Change Request (CR) #: CR 8347
Related CR Release Date: August 2, 2013
Effective Date: September 3, 2013
Related CR Transmittal #: R224FM
Implementation Date: September 3, 2013

October 2013 Medicare physician fee schedule database update

Provider types affected

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

What you need to know

This article is based on change request (CR) 8386 and instructs Medicare contractors to download and implement a new MPFSDB, effective October 1, 2013.

Background

Section 1848(c)(4) of the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the U.S. Secretary of Health and Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians' services.

CR 8386, from which this article is taken, announces that the MPFSDB has been updated effective October 1, 2013; and new payment files were issued to your contractor(s) based upon the 2013 Medicare physician fee schedule (MPFS) final rule (published in the *Federal Register* on November 16, 2012); as modified by the American Taxpayer Relief Act of 2012 (applicable January 1, 2013, see *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*), and the October 1, 2013 updated payment files.

Key changes for the October are as follows:

- Medicare contractors add HCPCS code G9187 (BPCI home visit) to their systems with an effective date of October 1, 2013; and
- The effective date of HCPCS code G0460 (Autologous Platelet-Rich Plasma (PRP) for Chronic Non-Healing Wounds) is adjusted to be August 2, 2012.

For more information and access to the 2013 final rule, see the physician fee schedule webpage available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*.

The Centers for Medicare & Medicaid Services (CMS) will notify your contractors when the new files are available for retrieval, and CR 8386 instructs them to provide you 30 days' notice before implementing the changes. Further, while they do not have to search their files to either retract payment for claims already paid, or to retroactively pay claims; they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 8386 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2754CP.pdf*.

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

MLN Matters® Number: MM8386
Related Change Request (CR) #: CR 8386
Related CR Release Date: August 2, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2754CP
Implementation Date: October 7, 2013

SSI/Medicare beneficiary data for fiscal year 2011 for IPPS facilities

Provider types affected

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

What you need to know

This article is based on change request (CR) 8406 which provides updated data for determining the disproportionate share adjustment for inpatient prospective payment system (IPPS) hospitals, the low income patient adjustment for inpatient rehabilitation facilities (IRFs) and the payment adjustment for short-stay outlier cases for long term care hospitals (LTCHs).

The Supplemental Security Income (SSI)/Medicare beneficiary data for hospitals are available electronically and contain the name of the hospital, Centers for Medicare & Medicaid Services (CMS) certification number, SSI days, total Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients.

Background

Change request (CR) 8406 provides updated data for determining the disproportionate share adjustment

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IPPS *(continued)*

for Inpatient Prospective Payment System (IPPS) hospitals, the low income patient adjustment for Inpatient Rehabilitation Facilities (IRFs) and the short-stay outlier payments for long term care hospitals (LTCHs).

The Supplemental Security Income (SSI)/Medicare beneficiary data for hospitals are available electronically and contains the following information:

1. The name of the hospital,
2. Centers for Medicare & Medicaid Services (CMS) certification number,
3. SSI days,
4. Total Medicare days, and
5. The ratio of Medicare Part A patient days attributable to SSI recipients.

These files are located at the following CMS website addresses:

- Inpatient prospective payment system (IPPS): *http://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/AcuteInpatientPPS/dsh.html*
- Inpatient rehabilitation facility (IRF): *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html*
- Long term care hospital (LTCH): *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html*

These data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during fiscal year (FY) 2011 (cost reporting periods beginning on or after October 1, 2010 and before October 1, 2011).

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Section 9105) provides that for discharges occurring on or after May 1, 1986, an additional payment must be made to IPPS hospitals serving a disproportionate share of low income patients.

The additional payment is determined by multiplying the federal portion of the diagnosis-related group (DRG) payment by the disproportionate share hospital (DSH) adjustment factor. (See 42 CFR 412.106 at *http://www.ecfr.gov/cgi-bin/textidx?c=ecfr&SID=0b55788517668e098f07fb8f1695dd4b&rgn=div8&view=text&node=42:2.0.1.2.12.7.49.11&idno=42*)

Under IRF PPS, IRFs receive an additional payment amount to account for the cost of furnishing care to low income patients.

The additional payment is determined by multiplying the federal prospective payment by the LIP adjustment factor. (See 42 CFR 412.624(e)(2) at *http://www.ecfr.gov/cgibin/textidx?c=ecfr&SID=0b55788517668e098f07fb8f1695dd4b&rgn=div8&view=text&node=42:2.0.1.2.12.16.57.13&idno=42*)

Under the LTCH PPS, the payment adjustment for short-stay outlier (SSO) cases at 42 CFR 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (i.e., the "IPPS comparable amount.").

This calculation includes the DSH adjustment where applicable, using the best available SSI data at the time of claim payment (See 42 CFR 412.529(d)(4) at *http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=0b55788517668e098f07fb8f1695dd4b&rgn=div8&view=text&node=42:2.0.1.2.12.15.57.14&idno=42*).

Additional information

You can review the CMS Medicare disproportionate share hospital (DSH) webpage at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*.

The official instruction, CR 8406 issued to your Medicare contractor regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1274OTN.pdf*.

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

MLN Matters® Number: MM8406
Related Change Request (CR) #: CR 8406
Related CR Release Date: August 2, 2013
Effective Date: September 3, 2013
Related CR Transmittal #: R12740TN
Implementation Date: September 3, 2013

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Annual clotting factor furnishing fee update 2014

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers billing Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services related to the administration of clotting factors to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8423 and announces that for 2014, the clotting factor furnishing fee of $0.192 per unit is included in the published payment limit for clotting factors. For dates of service of January 1, 2014, through December 31, 2014, the clotting factor furnishing fee of $0.192 per unit is added to the payment when no payment limit for the clotting factor is included in the average sales price (ASP) or not otherwise classified (NOC) drug pricing files. Please be sure your billing staffs are aware of this fee update.

Background

Section 1842(o)(5)(C) of the Social Security Act (added by the Medicare Modernization Act Section 303(e)(1)) requires, beginning January 1, 2005, that a clotting factor furnishing fee be paid separately if you furnish clotting factor; unless the costs associated with furnishing the clotting factor are paid through another payment system. The Centers for Medicare & Medicaid Services includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes.

When the national payment limit for a clotting factor is not included on the ASP Medicare Part B drug pricing file, or the NOC pricing file; your carrier, FI, RHHI, or A/B MAC must make payment for the clotting factor as well as make payment for the furnishing fee.

The clotting factor furnishing fees applicable for dates of service in each calendar year are listed in the table:

Clotting Factor Furnishing Fee	
2005	$0.140 per unit
2006	$0.146 per unit
2007	$0.152 per unit
2008	$0.158 per unit
2009	$0.164 per unit
2010	$0.170 per unit
2011	$0.176 per unit
2012	$0.181 per unit
2013	$0.188 per unit
2014	$0.192 per unit

Additional information

The official instruction, CR 8423, issued to your Medicare contractor regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2760CP.pdf*.

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

MLN Matters® Number: MM8423
Related Change Request (CR) #: CR 8423
Related CR Release Date: August 9, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2760CP
Implementation Date: January 6, 2014

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Affordable Care Act model 4 bundled payments for care improvement

Provider types affected

This *MLN Matters*® article is intended for hospitals, physicians, and non-physician providers participating in the Model 4 Bundled Payments for Care Improvement (BPCI) initiative and 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 provides an overview of Medicare's implementation of the Model 4 Bundled Payments for Care Improvement (BPCI) initiative. General program information is provided along with separate sections containing information of special interest to hospitals and physicians and non-physician providers. It addresses issues related to readmissions, claims crossover, remittance advice, and claims submission, among others. This pilot program is being conducted under the Centers for Medicare & Medicaid Services (CMS) Innovation Center's model testing authority. The program is slated to be implemented in October 2013.

Background

The Affordable Care Act provides a number of new tools and resources to help improve health care and

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Bundle *(continued)*

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

CMS is working in partnership with providers to develop models of bundling payments through the BPCI initiative. On August 23, 2011, CMS invited providers to apply to help test and develop four different models for bundling payments. Model 4, one of these four models, is discussed in this article.

In model 4, the episode of care is defined as the acute care hospital stay and includes inpatient hospital services, Part B services furnished during the hospitalization, and hospital and Part B services for related readmissions.

Information in this article is based on the change requests (CR) implemented for BPCI Model 4, including CRs 7887, 8070, and 8196.

General BPCI Model 4 Information - Beneficiary Eligibility

In order to be eligible for model 4, the beneficiary must meet the following requirements:

- Beneficiary is eligible for Part A and enrolled in Part B;
- At the time of admission, beneficiary either (a) has at least 1 day of utilization left and that day is also a day of entitlement or (b) has at least one lifetime reserve day remaining;
- Beneficiary does not have end-stage renal disease;
- Beneficiary is not enrolled in any managed care plans;
- Beneficiary must not be covered under the United Mine Workers; and
- Medicare must be the primary payer.
- If the beneficiary does not meet all of these requirements, the following codes will be assigned to rejected or cancelled NOAs:
- Claims adjustment reason code (CARC) B5: Coverage/program guidelines were not met or were exceeded.
- Remittance advice remarks code (RARC) N564: This patient did not meet the inclusion criteria for the demonstration project or pilot program.

Model 4 bundled payment provision

Hospitals that participate in the BPCI Model 4 initiative will receive a prospectively established bundled payment for agreed upon Medicare severity diagnosis related groups (MS-DRGs).

- This will not apply to claims that are paid on a transfer per-diem basis.
- This payment will include both the DRG payment for the hospital and a fixed amount for the Part B services anticipated to be rendered during the admission. Separate payment for providers' professional services rendered during the inpatient hospital stay will not be made.
- Participating Model 4 hospitals receiving a model 4 payment will be responsible for paying providers who would otherwise be paid separately for professional services under the physician fee schedule (PFS).
- Claims from physicians will be processed as no-pay claims if they occur between the inpatient hospital admission and discharge date in order to prevent duplicate payment of physicians under the bundled payment.

Co-payments, co-insurance, and deductibles

The regular Part A deductible, including the Part A blood deductible, and daily coinsurance amounts (when applicable) will continue to be applied to the claim.

The fixed Part B portion of the negotiated bundled payment will first be applied to the Part B deductible, if applicable.

A fixed Part B copayment will be applied to the claim. This will be the responsibility of the beneficiary and will be calculated as an approximation of what the Part B coinsurance would have been in the absence of Model 4.

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Bundle *(continued)*

Both the copayment and the deductible to be paid by the beneficiary for the Part B services will appear on the MSN along with the Part A deductible and any applicable coinsurance.

Appeals

Payments made under Model 4 have no rights of appeal, except in the case of calculation errors.

- RARC N83: No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

Information for hospitals - notification of admission (NOA)

Hospitals participating in this initiative should submit a notice of admission (NOA) when a beneficiary expected to be included in the model is admitted. Timely filing of the NOA allows subsequent Part B claims submitted before the hospital claim to be properly processed as "no-pay" claims, which indicates that payment for these claims are to be included in hospital payments under Model 4. By extension, these Part B claims will then be included timely on weekly Part B reports provided to the hospital to be used in calculating payments for Part B providers.

Hospitals will be paid a $500 payment upon submission of the NOA and will receive the balance of the prospectively established bundled payment when the hospital claim is processed.

- RARC N568: Initial payment based on the notice of admission (NOA) under the BPCI model IV initiative.
- If the patient ultimately does not qualify for a model 4 prospective payment based on the MS-DRG ultimately assigned to their inpatient stay, or if the NOA is cancelled, the $500 NOA payment will be recouped.
- Medicare systems will initiate a "look back" into the claims history records upon receipt of a canceled NOA to identify Model 4 BPCI claims- i.e., Part B physician or other professional claims - which were processed as "no pay" as a result of the NOA being opened. If such claims were processed, the Medicare contractor will adjust the claims automatically and remit payment for services rendered based on regular Medicare fee-for-service claims processing rules.
- Hospitals must submit the final claim within 60 days of the beneficiary's hospital admission or submit an interim claim during that time period to demonstrate that the beneficiary is still an inpatient. Otherwise, the beneficiary will be considered not subject to episode payment and the $500 will be recouped.

- The following codes will be assigned when a Model 4 claim matches an NOA for admission date and beneficiary, but not provider.
- CARC 208: National provider identifier – not matched
- RARC N562: The provider number of your incoming claim does not match the processed NOA for this bundled payment

The following codes shall be assigned when an NOA is cancelled because a matching claim is not received within 60 days. A match consists of beneficiary, admit date, and provider.

- CARC 226: Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete
- RARC N560: This pilot program requires an interim or final claim within 60 days of the notice of admission. A claim was not received.

Readmissions

Model 4 hospitals will not be paid for readmissions that occur to the same hospital (i.e., another admission with a date of admission within 30 days of discharge of the model 4 stay) under this model unless the MS-DRG assigned to that readmission is expressly excluded as unrelated to the MS-DRG assigned to the original admission.

- Unrelated readmissions have been defined by CMS, and a list of DRGs defining unrelated hospital. This list can also be found on the Bundled Payments collaboration site, accessible to Model 4 Awardees.
- Related readmissions to a hospital other than the original treating hospital, as well as payments for physicians' services during related readmissions to hospitals other than the original treating hospital, will be reconciled

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Bundle *(continued)*

retrospectively by a BPCI payment reconciliation contractor and payment will be recouped, as applicable, by the Model 4 awardee.

- If claims for a Model 4 anchor admission and a readmission are submitted out of order, the readmission claim will be canceled and must be resubmitted to receive payment. The following codes will be used in this situation:
- CARC 249: This claim has been identified as a readmission.
- RARC N561: The bundled payment for the episode of care includes payment for related readmissions. You may resubmit your claim to receive a corrected payment.

Payment rate updates and adjustors

Payment rates may be updated as often as quarterly to allow for ongoing updates to Medicare payment rates, including regular recurring changes made to the physicians fee schedule (PFS) and inpatient prospective payment system (IPPS). indirect medical education (IME) and disproportionate share hospital (DSH) payments, as well as outlier payments and hospital capital payments to Model 4 hospitals will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model.

This is true for both anchor admissions and related readmissions to the Model 4 hospital. In the case of readmissions, these payments will be denoted by the following:

- CARC 249: This claim has been identified as a readmission.
- RARC N524: Based on policy this payment constitutes payment in full.

Other applicable payment adjustors will also be calculated based on the base DRG that would otherwise have applied to the case, as opposed to the prospectively established amount paid through this initiative, which will be higher as it includes payment for Part B services in addition to the base DRG payment.

Information for physicians and non-physician providers – claims submission and processing

Physicians and non-physician practitioners shall submit claims for dates of service during an episode of care included in Model 4 BPCI as usual.

Physicians and non-physician practitioners shall be required to accept assignment for all claims covered under the Model 4 BPCI payment.

For those Part B services rendered during a Model 4 admission or a related readmission to that Model 4 hospital, Medicare will process claims as no-pay. In

processing no-pay professional claims, Medicare will assign the following:

- CARC 234: This procedure is not paid separately.
- RARC N67: Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or, if you furnished these services in another location on the date of admission or discharge from a demonstration hospital. If services furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.

Physicians submitting claims should take care not to include on the same claim services that are both within the dates (admission and discharge) of a Model 4 BPCI episode and outside the dates of the episode.

If such claims with both Model 4 and non-Model 4 services are received, Medicare contractors will reject the claims and advise the physician to separate the services and rebill. The following remittance messages will be used in this situation:

- CARC 239: Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
- RARC N61: Rebill services on separate claims.

Incentive payments

Bonus or incentive payments calculated by CMS, such as HPSA bonus payments, will not be affected by physician or non-physician practitioner participation in the bundled payments initiative.

Participation declination

Physicians have the right to decline participation in this program. Declination will be indicated by including a HCPCS modifier on each claim. Further details will be provided at a future date.

(continued on next page)

Bundle *(continued)*

Readmissions

Part B services provided during a related readmission to the original treating hospital will not be paid separately. If Part B claims were processed prior to receipt of the hospital's readmission claim, Medicare will take steps to recover payments to the physician.

- CARC A1: Claim/service denied; and
- RARC N68: Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment to the facility. You must contact the facility for payment. Prior payment made to you by the patient or another insurer for this claim must be returned within 30 days.

Claims crossover

In association with this initiative, CMS will make changes to allow for the reporting of two new claim adjustment reason codes (CARCs) within the 2320 claim adjustment segment (CAS), so that supplemental payers can more easily determine these amounts when adjudicating Medicare Health Insurance Portability and Accountability Act (HIPAA) 837 institutional coordination of benefits (COB)/ crossover claims.

- CARC 247 will be defined as "Part B deductible on a Part A claim."
- CARC 248 will be defined as "Part B coinsurance on a Part A claim."
- An adjusted RARC M137 will be defined as "Part B coinsurance under a demonstration project or pilot program.

This initiative will also result in the reporting of a new value code within the 2300 health care information codes (HI) value information (qualifier BE) portion of outbound HIPAA 837 institutional COB/crossover claims.

Additional information

The official instruction, CR 8070, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1251OTN.pdf*.

In addition, CR 8196 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1189OTN.pdf* and CR 7887 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1240OTN.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*.

MLN Matters® Number: MM8070
Related Change Request (CR) #: CR 8070
Related CR Release Date: June 27, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R12510TN
Implementation Date: July 1, 2013

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

Correct billing of aprepitant (J8501)

First Coast Service Options Inc. (First Coast) has identified potential claim payment errors for Healthcare Common Procedure Coding System (HCPCS) code J8501 Aprepitant (Emend®), oral, 5 mg when submitted by outpatient departments of the hospital. Potential payment errors may exist when HCPCS Code J8501 is reimbursed without an oral 5-HT3 antagonist and Dexamethasone.

Per the *National Coverage Determination (NCD) for Aprepitant for Chemotherapy-Induced Emesis (110.18)*: Effective for services performed on or after April 4, 2005, the Centers for Medicare & Medicaid Services (CMS) makes the following determinations regarding the use of Aprepitant in the treatment of reducing chemotherapy-induced emesis:

The evidence is adequate to conclude that the use of the oral anti-emetic 3-drug combination of Aprepitant (Emend®), a 5-HT3 antagonist, and dexamethasone is reasonable and necessary for a specified patient population. The defined patient population for which the use of the oral anti-emetic three drug combination of Aprepitant (Emend®), a 5- HT3 antagonist, and dexamethasone is reasonable and necessary as only to those patients who receives one or more of the following anti-cancer chemotherapeutic agents:

- Carmustine (J9050)
- Cisplatin (J9060)
- Cyclophosphamide (J9070)
- Dacarbazine (J9130)
- Mechlorethamine (J9230)
- Streptozocin (J9320)
- Doxorubicin (J9000 J9002)
- Epirubicin (J9178)

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Oral anti-emetic drugs should be prescribed only on a per chemotherapy treatment basis. Reimbursement will be provided for the three drug combination oral anti-emetic drugs when used as a full therapeutic replacement for intravenous dosage when the drugs are administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent.

The first dose is to be administered before, at, or immediately after the time of the anti-cancer chemotherapy administration. The second day, on which only Aprepitant is given, is defined as "within 24 hours," and the third day, on which only Aprepitant is given, is defined as "within 48 hours" of the chemotherapy administration.

These drugs may be supplied by the physician in the office, by an inpatient or outpatient provider (e.g., hospital, critical access hospital, or skilled nursing facility) or through a supplier, such as a pharmacy.

The physician must indicate on the prescription that the beneficiary is receiving the oral anti-emetic drugs as full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen.

Where the drug is provided by a facility, the beneficiary's medical record maintained by the facility must be documented to reflect that the beneficiary is receiving the oral anti-emetic drug as part of a cancer chemotherapeutic regimen.

See the Centers for Medicare & Medicaid Services, *Internet Only Manual (IOM), "Medicare Claims Processing Manual," Publication 100-04, Chapter 17, Section 80.2*.

Billing requirements for J8501

You must bill your claims for Aprepitant, on Form CMS-1450 (UB-92), or the electronic equivalent, with the appropriate cancer diagnosis and HCPCS code of J8501 (Aprepitant, oral, 5 mg) or appropriate *Current Procedural Technology*® (*CPT*®) code.

Those providers submitting claims to Medicare fiscal intermediaries (FIs) shall bill Aprepitant (J8501) with revenue code 0636 (drugs requiring detailed coding). An audit will be implemented effective August 8, 2013, to include the requirements documented in the NCD for claims to support the medical reasonableness and necessity for Aprepitant (HCPCS code J8501); and, claims will suspend for medical review when Aprepitant (J8501) is billed without a 5HT3 antagonist (HCPCS codes Q0162, Q0163, Q0164, Q0165, Q0166, Q0167, Q0168, Q0169, Q0170, Q0171, Q0172, Q0173, Q0174, Q0175, Q0176, Q0177, Q0178, Q0180, or Q0181); and dexamethasone (HCPCS code J8540) on the same claim. In a case where the patient already has the oral agents at home the provider must include a supporting statement to that fact.

2014 inpatient payment rule and payment/policy changes for SNFs

Rule improves value and quality focus in hospital payments

On August 2, the Centers for Medicare & Medicaid Services (CMS) issued a final rule updating fiscal year (FY) 2014 Medicare payment policies and rates for inpatient stays at general acute care and long-term care hospitals (LTCHs). The rule improves value and quality in hospital care and provides clarification about when a patient should be admitted to the hospital and responds to recent concerns about extended Medicare beneficiary stays in the hospital outpatient department.

The final FY 2014 hospital inpatient prospective payment system (IPPS) rule increases overall hospital payments (capital and operating) by $1.2 billion. The rule also moves forward with health care delivery system reforms made possible by the Affordable Care Act. These include a new program aimed at improving safety in hospitals and refining the hospital readmissions reduction program.

FY 2014 payment update

The final rule would increase IPPS operating rates by 0.7 percent after accounting for inflation and other adjustments required by the law. This increase reflects a temporary reduction of 0.8 percent to implement the American Taxpayer Relief Act's requirement to recoup overpayments from prior years as a result of a new patient classification system that better recognizes patient severity of illness.

CMS is also making an additional 0.2 percent reduction to offset projected spending increases associated with changes to admission and medical review criteria for inpatient services. CMS projects that LTCH PPS payments would increase by 1.3 percent, or approximately $72 million, in FY 2014.

Key FY 2014 payment and quality changes

New hospital-acquired condition (HAC) reduction program

As part of a new HAC reduction program created by the Affordable Care Act, beginning in FY 2015 hospitals that are in the lowest quartile for medical errors or serious infections that patients contract while in the hospital will be paid 99 percent of what they otherwise would have been paid under the IPPS. This rule finalizes the criteria to rank hospitals with a high rate of hospital-acquired conditions.

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Inpatient *(continued)*

Readmissions reduction program

In October 2012, Medicare began encouraging to hospitals with excess 30-day readmissions to lower 30-day readmission rates for heart attack, heart failure, and pneumonia patients by reducing a portion of the hospital's payments by up to one percent, depending on their performance on key readmissions measures.

As required by law, the FY 2014 IPPS rule increases the maximum reduction of payments to up to two percent. It adds hip and knee surgery and chronic obstructive pulmonary disease to the list of conditions used to determine the reduction, effective in FY 2015. CMS has increased the number and types of planned readmissions that no longer count against a hospital's readmission rate.

Admission and medical review criteria for inpatient services

The final rule provides greater clarity regarding when inpatient hospital admissions are generally appropriate for Medicare Part A payment. The new rules are intended to address concerns about Medicare beneficiaries having long stays in the hospital as outpatients and improve program integrity.

Under the rule, if a physician expects a beneficiary's surgical procedure, diagnostic test or other treatment to require a stay in the hospital lasting at least two midnights, and admits the beneficiary to the hospital based on that expectation, it is presumed to be appropriate that the hospital receive Medicare Part A payment.

The final rule emphasizes the need for a formal order of inpatient admission to begin inpatient status, but permits the physician to consider all time a patient has already spent in the hospital as an outpatient receiving observation services, or in the emergency department, operating room, or other treatment area in guiding their two-midnight expectation.

The rule also finalizes the provision in a March 2013 proposed rule that set the timeframe in which to bill Medicare Part B for hospital inpatient services inappropriately billed under Part A at one year from the date of service. This portion of the rule makes clear that its terms apply to admissions with dates of service on or after October 1, 2013.

Medicare disproportionate share hospitals (DSH)

The Affordable Care Act directs CMS to revise the methodology used to recalculate the additional amount Medicare pays hospitals that serve a disproportionate share of low-income patients. Under the new rules, part of those payments will be distributed to hospitals based on an estimate of how much uncompensated care they provide relative to other hospitals. The final rule determines the total amount of money available as uncompensated care payments based on a federal fiscal year determination of the uninsured.

Other changes

The August rule also finalizes a number of payment policies as proposed, among them rebasing the hospital market basket and the method to recover documentation and coding. The final rule also will allow the LTCH 25-percent patient threshold payment adjustment policy moratorium to expire.

The rule's changes to Medicare quality incentive programs will reduce providers' reporting burden in both the electronic health record (EHR) incentive program and the hospital inpatient quality reporting (IQR) program. It finalizes new measures for the hospital inpatient quality reporting program, the hospital value-based purchasing program, and quality reporting programs for LTCHs, PPS-exempt cancer hospitals, and inpatient psychiatric facilities.

For more information on these and other payment and quality of care provisions in the FY 2014 IPPS/LTCH rule:

Final IPPS/LTCH PPS rule

Payment and quality fact sheet

This rule is scheduled to be published in the Federal Register on August 19, 2013.

FY 2014 payment and policy changes for Medicare skilled nursing facilities

On July 31, 2013, CMS issued a final rule (CMS-1446-F) outlining FY 2014 Medicare payment rates for skilled nursing facilities (SNFs). The major provisions of the final rule are summarized below.

Changes to payment rates under the SNF PPS for FY 2014

Based on the changes contained within this final rule, CMS estimates that aggregate payments to SNFs will increase by $470 million, or 1.3 percent, for FY 2014 relative to payments in FY 2013. This estimated increase is attributable to the 2.3 percent market basket increase, reduced by the 0.5 percentage

(continued on next page)

Inpatient *(continued)*

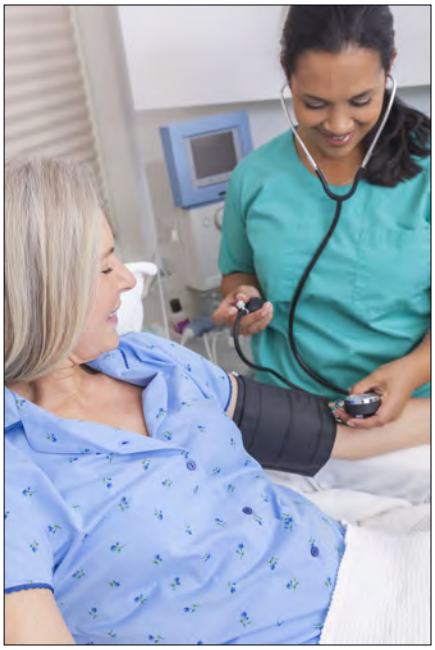
point forecast error correction (explained below) and further reduced by the 0.5 percentage point multifactor productivity adjustment required by law.

The FY 2014 SNF PPS payment rates and policies will be effective on October 1, 2013.

Revise and rebase the market basket

The Medicare statute requires CMS to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services.

CMS has developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses.



The SNF market basket index is a factor used to update the SNF PPS payments on an annual basis. CMS is rebasing and revising the SNF market basket for FY 2014 and subsequent years to reflect more recent data. The current SNF market basket reflects data from FY 2004 and CMS is updating the SNF market basket using data from FY 2010.

In addition, CMS will make changes to the components of the SNF market basket index by adding five new cost categories and dividing the existing nonmedical professional fees cost category into two separate categories, labor-related and non-labor-related nonmedical professional fees (for a total of 29 cost categories), and revising several price proxies, including the price proxy for the wages and salaries and employee benefit cost component.

Reporting of distinct therapy days

To ensure accuracy in case-mix assignment and payment, CMS is adding an item to the minimum data set (MDS) to record the number of distinct calendar days of therapy provided by all the rehabilitation disciplines to a beneficiary over the seven-day look-back period.

CMS is clarifying that the qualifying condition for the medium rehab (RM) category requires five distinct calendar days of therapy. Similarly, CMS is clarifying that the qualifying condition for the low rehab (RL) category requires three distinct calendar days.

Currently, the number of days for each therapy discipline reported on the MDS is summed without regard to the number of separate and unique days per week during which the patient receives therapy services across all rehabilitation disciplines. This results in some residents qualifying inappropriately for an RM or RL resource utilization group (RUG). The addition to the MDS ensures SNFs are paid accurately for the therapy services they provide to their residents.

Forecast error correction

A forecast error correction is applied when the difference between the actual and projected market basket percentage change for a given year (the most recent available FY for which there is final data) exceeds the 0.5 percentage point threshold.

While CMS normally reports the forecast error to one significant digit, such reporting makes it difficult to determine if the threshold has been exceeded in those instances where the difference between the projected and actual market basket percentage change rounds to 0.5 percentage point.

Therefore, only in those instances where the difference between the projected and actual market basket percentage change rounds to 0.5 percentage point at one significant digit, CMS will report the difference to the second significant digit to determine if the threshold has been exceeded. The most recent available FY for which there is final data is FY 2012.

For FY 2012, the projected market basket percentage change exceeded the actual market basket percentage change by 0.51 percentage point. As the projected market basket percentage change exceeded the actual market basket percentage change by an amount greater than the 0.5 percentage point threshold, the FY 2014 market basket update will include a downward adjustment of 0.5 percentage point.

A link to the final rule, which will be published in the *Federal Register* on August 6, 2013, is available at *https://www.federalregister.gov/public-inspection*.

For further information, please visit the *SNF PPS Web page*.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: *PERL 201308-02*

Educational Events

Provider outreach and educational events – September/October 2013

Medicare Part A: changes and regulations

When: Tuesday, September 17
Time: 11:30 a.m.-1:00 p.m. ET – Delivery language: English
Type of Event: Webcast

"Ask the contractor" teleconference on Medicare signature requirements

When: Tuesday, September 24
Time: Noon -1:00 p.m. ET – Delivery language: English
Type of Event: Webcast

"Ask the contractor" Provider enrollment process

When: Tuesday, October 1
Time: 11:30 a.m. -1:00 p.m. 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: July 25, 2013, – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-25-Enews.pdf*
- CMS MLN Connects™ Provider eNews: August 1, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-01-enews.pdf*
- CMS MLN Connects™ Provider eNews: August 8, 2013– *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-08-Enews.pdf*
- CMS MLN Connects™ Provider eNews: August 15, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-15-Enews.pdf*

Source: CMS PERL 201307-06, 201307-07, 201308-03, 201308-06

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