Medicare A CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

March 2014

In this issue

President Obama signs the Protecting Access to Medicare Act of 2014

On April 1, 2014, President Obama signed into law the "Protecting Access to Medicare Act of 2014." This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect April 1, 2014. This new law maintains the 0.5 percent update for such services that applied from January 1, 2014, through March 31, 2014 for the period April 1, 2014, through December 31, 2014. It also provides a zero percent update to the 2015 Medicare physician fee schedule (MPFS) through March 31, 2015.

The new law extends several expiring provisions of law. We have included Medicare billing and claims processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, and more information about other provisions will be forthcoming.

Section 101 – Physician payment update – As indicated above, the new law provides for a 0.5 percent update for claims with dates of service on or after January 1, 2014, through December 31, 2014. It also provides a zero percent update to the 2015 MPFS through March 31, 2015. CMS is currently revising the 2014 MPFS to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2014 conversion factor is $35.8228.

Section 102 – Extension of work GPCI floor - The existing 1.0 floor on the physician work geographic practice cost index is extended through March 31, 2015. As with the physician payment update, this extension will be reflected in the revised 2014 MPFS.

Section 103 – Extension of therapy cap exceptions process - The new law extends the exceptions process for outpatient therapy caps through March 31, 2015. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through March 31, 2015. In addition, the new law extends the application of the caps, exceptions process, and threshold to therapy services furnished in a hospital outpatient department (OPD). Additional information about the exception process for therapy services may be found in the *Medicare Claims Processing Manual, Pub.100-04, Chapter 5, Section 10.3.*

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received beginning on January 1, 2014. For physical therapy and speech language pathology services combined, the 2014 limit

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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.

Documenting therapy and rehabilitation services

The CERT A/B MAC Outreach & Education Task Force, a partnership of all A/B Medicare administrative contractors, created this guide to educate providers on common documentation errors for outpatient rehabilitation therapy services. These widespread errors contribute to Medicare's national payment error rate, as measured by the Comprehensive Error Rate Testing (CERT) program.

The leading cause of payment errors for therapy services is "insufficient" documentation in the medical records. Documentation is often missing the required elements as outlined in applicable local coverage determinations and the *Medicare Benefit Policy Manual* (BPM), Chapter 15, *Section 220* and *Section 230*. Providers in jurisdiction 9 (J9) can locate the applicable LCD for their locality and line of business on First Coast Service Options' *LCD Lookup tool*. The J9 LCD identification numbers are:

- Florida: Part A L28992, Part B L29289
- Puerto Rico and U.S. Virgin Islands: Part A L29024, Part B L29339

For example, a provider indicates in the plan of care: "We would like to see the patient three times per week to initiate exercises and modalities to decrease pain and increase range of motion, stretching, strengthening and function."

This plan is missing key elements to support the medical necessity of the service, such as measurable long term goals, the patient's diagnosis, the proposed type, duration and frequency of services required to achieve each goal, or anticipated plan of discharge.

Additional widespread issues that result in "insufficient" documentation errors include:

- Missing or illegible signature on the plan of care;
- Missing or illegible signature for physician's certification; and
- Missing legible signature and required treatment minutes in narrative or on flow sheet.

The CERT A/B MAC Outreach & Education Task Force recommends providers carefully review the following documentation requirements and tips for ensuring complete and accurate medical records.

Contents of plan of care

The plan of care shall contain, at minimum, the following information as required by regulation (*42CFR§424.24* and *410.61* and BPM, Chapter 15, Section 220.1.2(B)):

- Diagnoses
- Long term treatment goals – should be developed for the entire episode of care and not only for the services provided under a plan for one interval of care

- Type – may be physical therapy, occupational therapy, or speech language pathology, or when appropriate, the type may be a description of a specific treatment of intervention. When a physician or non-physician practitioner (NPP) establishes a plan, the plan must specify the type of therapy planned.
- Amount – refers to the number of times in a day the type of treatment will be provided. When amount is not specified, one treatment session a day is assumed.
- Duration – number of weeks or the number of treatment sessions for the plan of care
- Frequency of therapy services – refers to the number of times in a week the type of treatment is provided. When frequency is not specified, one treatment is assumed.

The plan of care shall be consistent with the related evaluation. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.

Signature and certification of the plan of care

The legible signature and professional identity (e.g., MD, OTR/L) of the individual, who established the plan, as well as the date it was established, must be recorded with the plan. A physician or NPP must certify (and date) the plan of care (*note: for CORF services, NPPs may not order or certify therapy services). Certification may be established in the patient's medical record through:

- Physician's or NPP's progress note
- Physician or NPP's order*
- Plan of care that is signed and dated by a physician/NPP*
- Documentation must indicate that the physician/

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NPP* is aware that the therapy service is or was in progress; and

- Agrees with the plan, when there is evidence the plan was sent to the physician/NPP, or is available in the patient's medical record for the physician/NPP to review.

Treatment note

The purpose of treatment notes is to create a record of all treatments and skilled interventions that are provided and to record the time of the services to justify the use of billing codes and units on the claim. Documentation is required for every treatment day and every therapy service. Documentation of each treatment note must include the following required elements:

- Date of treatment
- Identification of each specific intervention/modality provided and billed (both timed and untimed codes)
- Total timed code treatment minutes and total treatment time in minutes
- Signature and professional identification of the qualified professional who furnished the services; or, for incident to services, supervised the services, including a list of each person who contributed to the treatment

Functional reporting

Claims for therapy services that are required to contain the nonpayable G-codes and corresponding modifiers should include documentation of Functional Reporting in the medical record.

Specifically, documentation of the nonpayable G-codes and severity modifiers regarding functional limitations reported on claims must be included in the patient's medical record of therapy services for each required reporting interval as outlined in the BPM, Chapter 15, *Section 220.4*.

Documentation of functional reporting must be completed by the clinician furnishing the therapy services. Therapists must also document his/her clinical judgment in the assignment of the appropriate severity modifier.

Avoid CERT errors: Tips to improve therapy documentation

- Ensure the medical records submitted provide proof the service(s) was certified and rendered.
- Ensure the medical records provide justification supporting medical necessity and that skilled services were needed.
- Create a complete plan of care, making certain to include your legible signature, professional identification (e.g., PT, OTR/L) and date the plan was established.
- Document when the plan of care is modified, including how it has been modified and why the previous goals were not met or could not be met.
- Confirm the plan of care is certified (recertified when appropriate) with physician/NPP legible signature and date.
- Clearly document, in minutes, the total time spent on timed-code treatment only and the total treatment time (including timed and untimed codes) in the patient's record.

Additional resources

To find additional information regarding therapy and rehabilitation services, refer to the following resources on the CMS website:

- **CORFs**: Chapter 5 of the *Medicare Claims Processing Manual (Publication 100-04)* and *Chapter 12 of the Medicare Benefit Policy (Publication 100-02)*
- **Skilled therapy services** provided in *Skilled Nursing Facilities: Chapter 8 of the Medicare Benefit Policy Manual (Publication 100-02)*
- **Other guidance**: the *CMS Therapy Services Web page*

Disclaimer: The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare Fee-for-Service improper payment rate.

Denial of inpatient service claims related to a hospice terminal diagnosis

Provider types affected

Note: This article was rescinded February 20, 2014, as the related change request (CR) 8273 was rescinded.

It was previously published in the November 2013 edition of *Medicare A Connection*, Pages 33-34.

MLN Matters® Number: MM8273
Related Change Request (CR) #: CR 8273
Related CR Release Date: November 7, 2013
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Related CR Transmittal #: R1312OTN
Implementation Date: April 7, 2014

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General Coverage

Therapy services billed by the specialty 25 – Puerto Rico only

On July 24, 2012, First Coast activated a prepayment edit for therapy services rendered by specialty 25 (Physical Medicine and Rehabilitation) in Puerto Rico. This was due to medical review findings that revealed this specialty presents an 88 percent error rate. The purpose of the edit is to prevent the payment of non-covered, incorrectly coded, and inappropriately billed services. Also, with medical review assistance, customer service now advises providers in correcting the billing and documentation errors.

Data for October 1 through December 31, 2013, show an error rate of 81 percent. A significant amount of this error rate is due to either non-response to requests for documentation or to the submission of incomplete documentation. These same claims on many occasions are paid at the appeals level. Although, while an increase in claims being paid on appeal is noticeable, the error rate remains high.

Providers can be removed from the prepayment edit. Providers who decrease their error rate to less than 10 percent can be released from the prepayment edit. However, claims must be evaluated for payment at the prepayment level to lower the error rate.

Providers must:

- Submit documentation in a timely manner, and
- Submit all documentation necessary to properly evaluate the claims for payment.

Once you have received the request for documentation (ADR), submit a copy of the ADR letter with the medical records within 30 days.

First Coast recommends you visit our specialty page for rehabilitation services at *http://medicare.fcso.com/Landing/138325.asp*. This page offers resources that outlines documentation requirements and offers a *rehabilitation services documentation checklist* that will assist you in responding to documentation requests.

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on incurred expenses for a beneficiary is $1,920. There is a separate cap for occupational therapy services which is $1,920 for 2014. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

The new law also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2014 through March 31, 2015, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services, including OPD therapy services, for a year. There are two separate $3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services combined, and (2) occupational therapy services.

Section 104 – Extension of ambulance add-on payments - The new law extends the following two expiring ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas is extended through March 31, 2015 and (2) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus) is extended through March 31, 2015. The provision relating to air ambulance services that continued to treat as rural any area that was designated as rural December 31, 2006, for purposes of payment under the ambulance fee schedule, expired on June 30, 2013.

Section 105 – Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals - The new law extends, through March 31, 2015, a provision that allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges from the hospital. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital.

Section 106 – Extension of the Medicare-dependent hospital (MDH) program - The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program through March 31, 2015.

Aprepitant for chemotherapy induced emesis

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Part A Medicare administrative contractors (A/MACs) and/or durable medical equipment MACs (DME MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8418, which informs MACs that, effective for claims with dates of service on or after May 29, 2013 , the Centers for Medicare & Medicaid Services (CMS) extends coverage of the oral antiemetic three-drug regimen of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone to beneficiaries who are receiving certain anti-cancer chemotherapeutic agents. Make sure that your billing personnel are aware of these changes.

Background

Chemotherapy induced emesis is the occurrence of nausea and vomiting during or after anticancer treatment with chemotherapy agents.

The Social Security Act (the Act) permits oral drugs to be paid under Part B in very limited circumstances, one of which is antiemetic therapy administered immediately before and within 48 hours after anticancer chemotherapy as described in section 1861(s)(2) of the Act. These drugs must fully replace the non-self-administered drug that would otherwise be covered.

On April 4, 2005, CMS announced a national coverage determination (NCD) for the use of the oral three-drug regimen of aprepitant, a 5HT3 antagonist, and dexamethasone for patients who are receiving certain highly emetogenic chemotherapeutic agents.

On May 29, 2013, CMS announced an update to that NCD, to cover the use of the oral antiemetic three-drug combination of oral aprepitant (J8501), an oral 5HT3 antagonist (Q0166, Q0179, Q0180), and oral dexamethasone (J8540) for patients receiving highly and moderately emetogenic chemotherapy.

As a result, effective for services on or after May 29, 2013, the following anticancer chemotherapeutic agents have been added to the list of anticancer chemotherapeutic agents for which the use of the oral antiemetic 3-drug combination of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone is deemed reasonable and necessary:

- Alemtuzumab (J9010);
- Azacitidine (J9025);
- Bendamustine (J9033);
- Carboplatin (J9045);
- Clofarabine (J9027);
- Cytarabine (J9098, J9100, J9110);
- Daunorubicin (J9150, J9151);
- Idarubicin (J9211);
- Ifosfamide (J9208);
- Irinotecan (J9206); and
- Oxaliplatin (J9263).

Please note the entire list includes the 11 new codes listed above and the nine existing anticancer chemotherapeutic agents listed below:

- Carmustine (J9050);
- Cisplatin (J9060, J9062);
- Cyclophosphamide (J8530, J9070, J9080, J9090, J9091, J9092, J9093, J9094, J9095, J9096, J9097);
- Dacarbazine (J9130, J9140);
- Mechlorethamine (J9230);
- Streptozocin (J9320);
- Doxorubicin (J9000, J9001, J9002, Q2048, Q2049);
- Epirubicin (J9178); and
- Lomustine (S0178).

CMS also permits the MACs to determine coverage for other all-oral three-drug anti-emesis regimens of aprepitant or any other Food and Drug Administration (FDA) approved oral NK-1 antagonist in combination with an oral 5HT3 antagonist and oral dexamethasone with the chemotherapeutic agents listed, or any other anticancer chemotherapeutic agents that are FDA-approved and may in the future be defined as highly or moderately emetogenic.

CMS is defining highly emetogenic chemotherapy and moderately emetogenic chemotherapy as those anticancer agents so designated in at least two of three guidelines published by the National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO), and European Society of Medical Oncology (ESMO)/Multinational Association of Supportive Care in Cancer (MASCC). The inclusive examples are: NCCN plus ASCO, NCCN plus ESMO/MASCC, or ASCO plus ESMO/MASCC.

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Until a specific code is assigned to the new drug, any new FDA-approved oral anti-emesis drug (oral NK-1 antagonist or oral 5HT3 antagonist) as part of the three-drug regimen must be billed with the following not-otherwise-classified (NOC) code effective April 1, 2014, in the I/OCE update:

- Q0181 – Unspecified oral dosage form, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for a IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.

This NOC code must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy (ICD9/10 codes V58.11/Z51.11).

This coverage policy applies only to the oral forms of the three-drug regimen as a full replacement for their intravenous equivalents. All other indications or combinations for the use of oral aprepitant are non-covered under Medicare Part B, but may be considered under Medicare Part D.

For claims with dates of service on or after May 29, 2013, MACs will adjust claims processed before CR 8418 was implemented if you bring those claims to the attention of your MAC.

Effective for claims with dates of service on or after May 29, 2013, MACS will deny lines for oral aprepitant (J8501), or NOC code Q0181 if an encounter for antineoplastic chemotherapy identified by ICD 9/10 codes V58.11/Z51.11 is not present. The denied lines will reflect the following messages on the remittance advice:

- Claim adjustment reason code 96: non-covered charge(s)
- Remittance advice remarks code (RARC) M100: We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy; and
- RARC N386: This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have Web access, you may contact the contractor to request a copy of the NCD.

Additional information

The official instruction, CR 8418, was issued to your MAC via three transmittals. The first updates the *Medicare Benefit Policy Manual* and that is available *at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R180BP.pdf*.

The second updates the *Medicare Claims Processing Manual* and is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2883CP.pdf*, and the third updates the *Medicare National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R163NCD.pdf*.

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

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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.**

Medicare coverage of psychiatry and psychotherapy services

Note: This article was revised March 18, 2014. It was previously published in the February 2014 edition of *Medicare A Connection*, Page 13.

Provider types affected

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

Provider action needed

Stop – impact to you

The comprehensive error rate testing (CERT) program's reviews of claims for Part B psychiatry and psychotherapy services have identified many improper payments. This SE article provides an overview of billing for psychiatry and psychotherapy services with Healthcare Common Procedure Coding System (HCPCS)/*Current Procedural Terminology*® (*CPT*®) codes. Major changes to the American Medical Association's (AMA) *CPT*® took effect January 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 main error that CERT has identified with the revised psychiatry and psychotherapy codes is not clearly documenting the amount of time spent only on psychotherapy services. The correct evaluation and management (E&M) code selection must be based on the elements of the history and exam and medical decision making required by the complexity/intensity of the patient's condition. The psychotherapy code is chosen on the basis of the time spent providing psychotherapy.

When a beneficiary receives an evaluation and management service (E&M) service with a psychotherapeutic service on the same day, by the same provider, both services are payable if they are significant and separately identifiable and billed using the correct codes. New add-on codes (in the bulleted list below) designate psychotherapeutic services performed with E&M codes. An add-on code (often designated with a "+" in codebooks) describes a service performed with another primary service.

An add-on code is eligible for payment only if reported with an appropriate primary service performed on the same date of service. Time spent for the E&M service is separate from the time spent providing psychotherapy and time spent providing psychotherapy cannot be used to meet criteria for the E&M service.

Because time is indicated in the code descriptor for the psychotherapy *CPT*® codes, it is important for providers to clearly document in the patient's medical record the time spent providing the psychotherapy service rather than entering one time period including the E&M service.

For psychotherapy services provided with an E&M service:

- + *90833:* Psychotherapy, 30 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure)
- + *90836*: Psychotherapy, 45 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure)
- + *90838*: Psychotherapy, 60 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure)

For psychotherapy services provided without an E&M service, the correct code depends on the time spent with the beneficiary.

- 90832: Psychotherapy, 30 minutes with patient and/or family member
- 90834: Psychotherapy, 45 minutes with patient and/or family member
- 90837: Psychotherapy, 60 minutes with patient and/or family member

In general, providers should select the code that most closely matches the actual time spent performing psychotherapy. *CPT*® provides flexibility by identifying time ranges that may be associated with each of the three codes:

- *90832* (or + *90833*): 16 to 37 minutes,
- *90834* (or + *90836*): 38 to 52 minutes, or
- *90837* (or + *90838*): 53 minutes or longer

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Do not bill psychotherapy codes for sessions lasting less than 16 minutes.

Psychotherapy codes are no longer dependent on the service location (i.e., office, hospital, residential setting, or other location is not a factor). However, effective January 1, 2014, when E&M services are paid under Medicare's partial hospitalization program (PHP) and not in the physician office setting, the *CPT*® outpatient visit codes *99201-99215* have been replaced with one Level II HCPCS code G0463. Further information about this code can be found in the 2014 OPPS/ASC final rule that was published in the *Federal Register* on December 10, 2013.

Example: A geriatric psychiatrist (physician) billed for a level three E&M service (*99213*) and 45 minutes of psychotherapy (*90836*). The medical record contained one entry for the date of service and, at the top, a notation: "45 minutes". It did not indicate whether the 45 minutes was spent providing the psychotherapy services or both services. An overpayment for the psychotherapy service and a billing error occur when there is no separate entry for the amount of time spent performing psychotherapy services.

Additional information

You can find more information on how to avoid errors on claims for psychiatric and psychotherapy services by reviewing the following resources:

- Local coverage determinations, which are available at *http://www.cms.gov/medicare-coverage-database/*;
- *CPT*® 2014 available from the AMA; Refer to page xxiv (E/M and Psychotherapy Coding Algorithm) of the 2014 *CPT*® Professional Edition in choosing the appropriate psychotherapy codes.
- *Federal Register*, December 10, 2013, Table 42, 2013 Clinic and Emergency Department Visit HCPCS Codes and APC Assignments Compared to 2014 Clinic and Emergency Department Visit HCPCS Codes and APC Assignments. p. 75042 - 75043. This table is available in the file at *http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf*.
- *Federal Register*, November 15, 2012, Table 42. Crosswalk of Deleted and New PHP *CPT*® and HCPCS Billable Codes for 2013 p. 68416. This table is available within the document at *http://www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf*.
- Psychotherapy notes are discussed in *MLN Matters*® article MM3457, Revised February 4, 2013. This article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm3457.pdf*.
- Add-on HCPCS/*CPT*® codes without primary codes are discussed in *MLN Matters*® article SE1320, Revised August 16, 2013, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMatters/Articles/Downloads/SE1320.pdf*. If you have any questions, please contact your MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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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**

Local Coverage Determinations

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.

Revised LCDs

Pegfilgrastim (Neulasta®) – revision to the Part A LCD

LCD ID number: L28946 (Florida)
LCD ID number: L29967 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pegfilgrastim (Neulasta®) was most recently revised February 13, 2013.

Since that time, the LCD has been revised to add ICD-9-CM diagnosis code 209.30 (Malignant poorly differentiated neuroendocrine carcinoma, any site) under the *ICD-9 Codes that Support Medical Necessity* section of the LCD. 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 March 27, 2014**. First Coast Service Options, Inc. LCDs are available through the CMS Medicare coverage database at: *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

Note: To review active, future, and retired LCDs for jurisdiction 9, please *click here.*

Molecular pathology procedures for human leukocyte antigen (HLA) typing – revision to the LCD

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

The local coverage determination (LCD) molecular pathology procedures for human leukocyte antigen (HLA) typing was effective October 7, 2013.

Since that time, the LCD has been revised to add ICD-9-CM diagnosis codes 287.30 (Primary thrombocytopenia unspecified) and 287.49 (Other secondary thrombocytopenia) under the *ICD-9 Codes that Support Medical Necessity* section of the LCD. In addition, the *CMS National Coverage Policy* section of the LCD was revised.

Effective date

This LCD revision is effective for claims processed on or after March 20, 2014, for services rendered **on or after October 7, 2013**. First Coast Service Options, Inc. LCDs are available through the CMS Medicare coverage database at: *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

Note: To review active, future, and retired LCDs for jurisdiction 9, please *click here.*

Additional information

Changes affecting Medicare coverage of fluorodeoxyglucose (FDG) positron emission tomography (PET) scans

Effective for claims with dates of service June 11, 2013

- The Centers for Medicare & Medicaid Services (CMS) covers three FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy after completion of the initial anti-cancer therapy for the same cancer diagnosis.
- Each (different) cancer DX is allowed one initial treatment strategy PET scans (billed with PI modifier) and three subsequent treatment strategy PET scans (billed with PS modifier).
- Coverage with evidence development (CED) requirements have ended; therefore modifier Q0/Q1, condition code 30 (institutional claims), and diagnosis code V70.7 (institutional and practitioner claims), are no longer required.

To ensure proper processing of claims please coordinate with your billing entities to discontinue the use of modifiers Q0/Q1.

Effective for claims with dates of service July 7, 2014

- First Coast will deny subsequent treatment strategy claims for oncologic FDG PET scans when no initial treatment strategy claim is present in history when appropriate.
- Coverage of additional FDG PET scans used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be allowed when billed with the KX modifier.
- Use of the KX modifier indicates that requirements specified in in the medical policy have been met

To prevent unnecessary claim denials it is strongly suggested that claims contain both the PET scan *Current Procedural Terminology* (*CPT*®) code and the tracer HCPCS code A9552 on the same claim form.

Skin substitutes – clarification of coverage

Effective January 1, 2014, the Centers for Medicare & Medicaid Services (CMS) implemented an Outpatient Prospective Payment System (OPPS) change request (CR 8572) that requires hospitals to report all high cost skin substitute products in combination with one of the skin application procedures described by *Current Procedural Terminology*® (*CPT*®) codes *15271-15278* and to report all low cost skin substitute products in combination with one of the skin application procedures described by HCPCS codes C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by *CPT*® codes *15271-15278*.

Based on this change in payment methodology in OPPS, the varied application of these products in the hospital setting, and the additional controls in the hospital setting, the Medicare Administrative Contractor (MAC) J9 retired the Part A skin substitutes local coverage determination (LCD). Currently, the MAC J9 is silent on coverage for skin substitute services in the hospital setting, given there is no LCD or national coverage determination (NCD) in play.

If a claim is audited, any service/procedure utilizing these products in an episode of care would have to meet the Medicare reasonable and necessary (R&N) threshold of coverage as documented in the patient's medical record, assuming all other requirements of the Medicare program are met.

The Part B LCD remains in effect and has limited coverage to the following four products- Apligraft®, Dermagraft®, Integra Dermal Regeneration Template®, and Oasis® Wound Matrix and Oasis® Ultra Tri-Layer Matrix, with the R&N criteria as outlined in the indications and limitations section of the LCD.

To review the products that remain non covered, as medical necessity for these products has not been established, please refer to the Part B LCD-skin substitutes, L29279 (Florida) and L29393 (Puerto Rico/U.S. Virgin Islands).

Widespread probe results for DRGs 074, 092, 419, and 491

First Coast Service Options Inc. (First Coast) conducted four widespread probes on the below MS-DRGs in response to medical record review findings identified by the recovery auditor (RA) in Florida. The RA identified inpatient hospital stays that were not considered medically necessary. Widespread probes were completed to validate the RA findings. RA error rates as well as First Coast medical review findings and corrective action are noted below.

MS-DRG 074 Cranial & peripheral nerve disorders w/o MCC

- RA error rate was 89.87 percent.
- First Coast error rate was 7.77 percent. In 100 percent of the cases denied the review of the medical record did not indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient. The documentation did not support that the patient demonstrated signs and/or symptoms severe enough to warrant the need for inpatient care. Additionally, the services received were not of such intensity that they could be furnished safely and effectively only on an inpatient basis.
- No corrective action will be pursued by First Coast at this time.

MS-DRG 092 Other disorders of nervous system w/ CC

- RA error rate was 14.29 percent.
- First Coast error rate was 6.49 percent. In 100 percent of the cases denied the review of the medical record did not indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient. The documentation did not support that the patient demonstrated signs and/or symptoms severe enough to warrant the need for inpatient care. Additionally, the services received were not of such intensity that they could be furnished safely and effectively only on an inpatient basis.
- No corrective action will be pursued by First Coast at this time.

MS-DRG 419 Laparoscopic cholecystectomy w/o C.D.E. w/o CC/MCC

- RA error rate was 91.55 percent.
- First Coast error rate was 2.74 percent. In 100 percent of the cases denied the review of the medical record did not indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient. The documentation did not support that the patient demonstrated signs and/or symptoms severe enough to warrant the need for inpatient care. Additionally, the services received were not of such intensity that they could be furnished safely and effectively only on an inpatient basis.
- No corrective action will be pursued by First Coast at this time.

MS-DRG 491 Back & neck procedure except spinal fusion w/o CC/MCC

- RA error rate was 91.98 percent.
- First Coast error rate was 23 percent. In 100 percent of the cases denied the review of the medical record did not indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient. The documentation did not support that the patient demonstrated signs and/or symptoms severe enough to warrant the need for inpatient care. Additionally, the services received were not of such intensity that they could be furnished safely and effectively only on an inpatient basis.

Twenty-one providers were included in this widespread probe with an average sample size of 3-5 claims. Error rates for these providers ranged from 0 to 66 percent, with an overall error rate of 23 percent. First Coast will deliver provider specific education and feedback as needed addressing the reasons for denial.

Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*.

This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders.

Electronic Data Interchange

ICD-10 testing with providers through the CEM and CEDI

Note: This article was revised March 10, 2014, to reflect a revised change request (CR). The due date for the contractor report to the Centers for Medicare & Medicaid Services (CMS) was changed to March 12, 2014, under *Background*. This date was also added to the implementation date for this reporting requirement only. On February 27, 2014, the article was revised to provide additional information to providers, suppliers, and clearinghouses about how claims will be submitted for testing (under *What providers need to know*). The transmittal number, CR release date and link to the CR were also changed. This information was previously published in the November 2013 *Medicare A Connection*, Page 24.

Provider types affected

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

What providers need to know

This article is based on CR 8465, which announces plans for front-end ICD-10 testing between MACs and their trading partners.

For dates of service of October 1, 2014, (and after) providers are required to submit ICD-10 codes on their claims. MACs must provide the opportunity for providers and suppliers to submit test claims through the CEM or the CEDI on the designated testing days.

- **Test claims with ICD-10 codes must be submitted with current dates of service (i.e. October 1, 2013, through March 3, 2014), since testing does not support future dated claims.**
- **Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system.**
- **Testing will not confirm claim payment or produce remittance advice.**
- **MACs and CEDI will be staffed to handle increased call volume during this week.**

Make sure that your billing staff is aware of these upcoming ICD-10 testing periods.

Background

CMS is in the process of implementing ICD-10. All covered entities have to be fully compliant on October 1, 2014.

CR 8465 instructed all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the HIPAA 5010 implementation. The ICD-10 testing week was created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

This testing week gave trading partners access to the MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on each MAC, the CEDI website, and the CMS website. The testing week was March 3 through March 7, 2014.

Testing week information

- Your MAC announced and actively promoted the testing week via listserv messages and posted the testing week announcement on their website.
- Your MAC hosted a registration site for the testing week, or provide an email address for the trading partners to provide registration information. The registration site or email address information was available and publicized to trading partners at least four weeks prior to the testing week.
- During the testing week, EDI help desk support was available, at a minimum, from 9:00 a.m. to 4:00 p.m. local contractor time, with enough support to handle any increased call volume.
- Providers and suppliers participating during the testing week will receive electronic acknowledgement confirming that the submitted test claims were accepted or rejected.
- **On or before March 12, 2014, your contractor reported the following to CMS:**
  - Number of trading partners conducting testing during the testing week.
  - Percent of trading partners that conducted

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ICD-10 limited end-to-end testing with submitters

Note: This article was revised March 10, 2014, to add a link to a related *MLN Matters*® special edition (SE) article.

SE1409 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1409.pdf*) conveys the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for International Classification of Diseases, Tenth Revision (ICD-10) implementation. All other information is the same.

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare claims administration contractors (durable medical equipment Medicare administrative contractors (DME MACs), A/B Medicare administrative contractors (A/B MACs), and/or home health and hospices (HH & H MACs) for services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8602 which instructs providers and clearinghouses on how to volunteer to be chosen for (ICD-10) end-to-end testing with Medicare in July 2014. Potential testers had to complete the volunteer form by March 24, 2014.

Background

The ICD-10 must be implemented by October 1, 2014. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS.

CR 8602 will allow for a small subset of Medicare claims submitters to test with MACs and the common electronic data interchange (CEDI) contractor to demonstrate that CMS systems are ready for the ICD-10 implementation. This additional testing effort will further ensure a successful transition to ICD-10.

To facilitate this testing, CR 8602 requires MACs to do the following:

- Conduct a limited end-to-end testing with submitters in July 2014. Test claims will be submitted July 21-25, 2014.
- Each MAC (and CEDI with assistance from DME MACs) will select 32 submitters to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will select 16 submitters.) Testers will be selected randomly from a list of volunteers. At least five, but not more than ten of the testers will be a clearinghouse, and submitters should be a mix of provider types.
- By March 7, 2014, the MACs and CEDI posted a volunteer form to their website to collect volunteer information with which to select volunteers. The form will provide information to verify that volunteers are ready to test, meet the requirements to test, and collect needed data about the tester (how they submit claims, what type of claims will be tested, etc.). Volunteers had to submit the completed forms to the MACs and CEDI by March 24, 2014.
- By April 14, 2014, the MACs and CEDI (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:

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testing during the testing week (versus number of trading partners supported) by contract.

- Percent of test claims accepted versus rejected.
- Report of any significant issues found during testing.

Additional information

The official instruction, CR 8465, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1357OTN.pdf*.

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

MLN Matters® Number: MM8465 *Revised*
Related Change Request (CR) #: CR 8465
Related CR Release Date: March 7, 2014
Effective Date: December 3, 2013
Related CR Transmittal #: R1357OTN
Implementation Date: March 3, 2014; March 12, 2014, for contractor report to CMS

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- How to submit test claims (for example, what test indicators should be set)
- What dates of service may be used for testing
- How many claims may be submitted for testing (test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files)
- Request for national provider identifiers (NPIs) and health insurance claim numbers (HICNs) that will be used in testing (no more than five NPIs and 10 HICNs per submitter)
- Notice that if more than 50 claims are submitted, they may not be processed
- Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed, and
- Notice of potential protected health information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).

- MACs and CEDI (for the DME MACs) will collect information from the selected test volunteers to request the HICNs, NPIs, and provider transaction access numbers (PTANs) the testers will use during the testing. The forms for this information must be completed and returned to the MAC/CEDI by May 2, 2014. If these forms are not returned by May 2, the tester may lose the opportunity to test.
- CEDI will instruct suppliers to submit claims with ICD-10 codes with dates of service (DOS) October 1, 2014, through October 15, 2014. They may also submit claims with ICD-9 codes with DOS before October 1, 2014.
- MACs will instruct testers to submit test claims with ICD-10 codes with DOS on or after October 1, 2014. They may also submit test claims with ICD-9 codes with DOS before October 1, 2014.
- MACs and CEDI will be prepared to support increased call volume from testers during the testing window, and up to two weeks following the receipt of the electronic remittance advices (ERAs) from testing. MACs and CEDI will provide information to the testers on who to contact for testing questions. There may be separate contacts for front end questions and remittance questions.
- MACs will post an announcement about the testing to their websites.

Additional information

The official instruction, CR 8602, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1352OTN.pdf*.

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

MLN Matters® Number: MM8602
Related Change Request (CR) #: CR 8602
Related CR Release Date: February 21, 2014
Effective Date: July 7, 2014
Related CR Transmittal #: R1352OTN
Implementation Date: July 7, 2014

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Learn the secrets to billing Medicare correctly

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

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

April 2014 update to the healthcare provider taxonomy codes

Provider types affected

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

Provider action needed

Change request (CR) 8611, from which this article is taken, instructs Medicare contractors to obtain the most recent 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 for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used.

Both the current Accredited Standards Committee (ASC) X-12 837 institutional and professional technical report type 3 (TR3s) 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 the reporting of provider specialty information via a HPTC be on every claim, nor for every provider to be identified by specialty. The standard implementation guides 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."

Note: Medicare does not use HPTCs to adjudicate its claims and would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC set.

The transactions and code sets final rule, published August 17, 2000, establishes that the maintainer of the code set determines its effective date. See *http://aspe.hhs.gov/admnsimp/final/txfin00.htm*. This rule also mandates that covered entities must use the nonmedical data code set specified in the standard implementation guide that is valid at the time the transaction is initiated. For implementation purposes, Medicare generally uses the date the transaction is received for validating a particular nonmedical data code set required in a standard transaction.

The HTPC set is maintained by the NUCC for standardized classification of health care providers, and the NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at *http://www.wpc-edi.com/codes*.

CR 8611 implements the NUCC HPTC code set that is effective April 1, 2014, and instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

- New items are green
- Modified items are orange, and
- Inactive items are red.

Additional information

The official instruction, CR 8611 issued to your carriers, FIs, A/B MACs, RHHIs, HHHs, and DME MACs, regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2888CP.pdf*.

If you have any questions, please contact your carriers, FIs, A/B MACs, RHHIs, HHHs, or DME 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: MM8611
Related Change Request (CR) #: CR 8611
Related CR Release Date: February 28, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R2888CP
Implementation Date: July 7, 2014 (Contractors with the capability to do so will implement April 1, 2014)

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April 2014 integrated outpatient code editor specifications version 15.1

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for outpatient services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency (HHA) 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) 8658, which informs the MACs that the I/OCE was updated for April 1, 2014. Make sure your billing staffs are aware of these changes.

Background

CR8658 informs the MACs, including the home health & hospice (HH&H) MACs, that the I/OCE is being updated for April 1, 2014. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

The modifications of the I/OCE for the April 2014 release (V15.1) are summarized in the table below. Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications in the update may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective date' column.

Type	Effective date	Edits affected	Modification
Logic	1/1/2014	–	Change the Status Indicator (SI) from N to A for any laboratory code (code list) submitted on 12x bill type when the claim does not contain condition code W2 (Duplicate of Original Bill).
Content	4/1/2014	–	Make HCPCS/ APC/SI changes as specified by CMS (data change files).
Content	4/1/2014	20, 40	Implement version 20.1 of the National Correct Coding Initiative (NCCI) (as modified for applicable institutional providers).
Content	4/1/2014	8	Update procedure/sex conflict edit list. Note that change to remove code *81266* from the female only list is retroactive to 1/1/2012.
Content	1/1/2014	71, 77	Update procedure/ device & device/ procedure edit requirements.
Content	4/1/2014	87	Update the skin substitute product list (Appendix N) to move specific skin substitute product codes from List A (low-cost) to List B (high-cost).
Content	1/1/2014	41	Add new revenue codes 690 – 696, and 699 to the valid revenue code list.
Doc	1/1/2014	–	Added documentation for laboratory services submitted on 12x or 14x bill type to page 9, Appendix F(a) (associated with edit 27), and Appendix L.

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Medicare fee-for-service ICD-10 testing approach

Note: This article was revised March 10, 2014, to add a link to a related *MLN Matters*® article. MM8602 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8602.pdf*) instructs providers and clearinghouses on how to volunteer to be chosen for International Classification of Diseases, 10th Edition (ICD-10) end-to-end testing with Medicare in July 2014.

Potential testers must complete the volunteer form on the MAC website by March 24, 2014. This article was previously revised February 27, 2014, to add information about the second week of acknowledgement testing and to provide more details about end-to-end testing. This article was previously published in the *February 2014 edition* of *Medicare A Connection*, Pages 46-47. All other information is the same.

Provider types affected

This *MLN Matters*® article is intended for all physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider action needed

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA.

The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014. Be sure you are ready. This *MLN Matters*® special edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2014, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing to ensure that CMS as well as the Medicare fee-for-service (FFS) provider community is ready.

When "you" is used in this publication, we are referring to the FFS provider community. The four-pronged approach includes:

- CMS internal testing of its claim processing systems;
- Provider-initiated beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail in this article.

CMS internal testing of its claims processing systems

CMS has a very mature and rigorous testing program for its Medicare FFS claim processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for four weeks;
- Beta testing is performed by a separate integration contractor for eight weeks; and
- Acceptance testing is performed by each MAC for four weeks to ensure that local coverage requirements are met and the systems are functioning as expected.
- CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claim processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-initiated beta testing tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as national coverage determination (NCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*;
- The ICD-10 Medicare severity-diagnosis related groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the general equivalence mappings to convert ICD-9 codes to ICD-10, clinical modification codes, located at *http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html*. On this Web page, you can also find current versions of the ICD-10-CM MS-DRG grouper, Medicare code editor (available from National Technical Information Service), and MS-DRG definitions manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- A pilot version of the October 2013 integrated

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outpatient code editor (I/OCE) that utilizes ICD-10-CM located at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf*. The final version of I/OCE that utilizes ICD-10-CM is scheduled for release in August 2014.

Crosswalks for local coverage determinations (LCDs) will be available in April 2014.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2014, you should investigate the free billing software that CMS offers from their MACs. The software has been updated to support ICD-10 codes and requires an Internet connection.

This billing software only works for submitting fee-for-service claims to Medicare. Alternatively, many MACs offer provider internet portals, and some MACs offer a subset of these portals that you can register for to ensure that you have the flexibility to submit professional claims this way as a contingency.

Acknowledgement testing

CMS offered ICD-10 acknowledgement testing March 3-7, 2014. This testing allowed all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims were not adjudicated, the MACs returned an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected. For more information about acknowledgement testing, refer to the information on your MAC's website.

CMS plans to offer a second week of acknowledgement testing in early May 2014.

End-to-end testing

In late July 2014, CMS will offer end-to-end testing to a small sample group of providers.

End-to-end testing includes the submission of test claims to CMS with ICD-10 codes and the provider's receipt of a remittance advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available in March 2014. Over 500 volunteer submitters will be selected nationwide to participate in the end-to-end testing. The small sample group of participants will be selected to represent a broad cross-section of provider types, claims types, and submitter types. Additional details about the end-to-end testing process will be disseminated at a later date in a separate *MLN Matters*® article.

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

MLN Matters® Number: SE1409
Related Change Request (CR) #: n/a
Related CR Release Date: n/a
Effective Date: October 1, 2014
Related CR Transmittal #: n/a
Implementation Date: n/a

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IOC/E

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Additional information

The official instruction, CR 8658 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2900CP.pdf.*

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

MLN Matters® Number: MM8658
Related Change Request (CR) #: CR 8658
Related CR Release Date: March 7, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R2900CP
Implementation Date: April 7, 2014

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Special instructions for the ICD-10-CM coding on home health episodes

Note: This article was revised on March 4, 2014, to remove references to the general equivalence mappings. All other information is unchanged.

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, suppliers, and other covered entities who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in home health (HH) care settings.

Provider action needed

This *MLN Matters*® special edition (SE) 1410 alerts providers that on October 1, 2014, all Medicare claims submissions of diagnosis codes will change from the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) to the 10th Edition (ICD-10-CM). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make this transition requiring systems changes throughout the entire health care industry.

Background

In 2011, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7492, which provided information on reporting guidelines and claims submissions requirements for ICD-10-CM. Particularly, CR 7492 provided instructions regarding claims with service dates that span the ICD-10 effective date.

Recently, CMS issued an updated article (SE1408) at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf*, which provides special billing instructions for home health agencies (HHAs) to apply to HH claims where the episode begins in August or September 2014 and ends in October 2014.

MLN Matters® article SE1408 also provides details for coding other types of claims for services that span the ICD-10 implementation date of October 1, 2014. This article provides further details regarding HH claims for episodes that span the October 1 date.

Key points of this article

Three factors affect how ICD-10-CM must be used on these episodes for services that span the October 1 date:

1. The claim "From" date (episode start date);

2. The outcome and assessment information set (OASIS) assessment completion date (OASIS item M0090 date); and

3. The claim "Through" date.

Episodes starting before October 1, 2014, with OASIS completion dates before October 1, 2014

In the case of initial HH episodes, the OASIS assessment must be completed within five days of the start of care. The assessment completion date (M0090 date) determines whether the HH grouper software that determines the payment group for the episode will apply ICD-9-CM or ICD-10-CM codes to the episode.

In the case where the episode start of care date is before October 1, 2014, and the M0090 date is also before October 1, 2014, ICD-9-CM codes will be used on the OASIS and to determine the payment group code (the Health Insurance Prospective Payment System (HIPPS) code).

For HH claims (type of bill 032x), ICD-10-CM reporting is required based on the claim "Through" date. On requests for anticipated payment (RAPs), Medicare billing instructions require that the "From" and "Through" dates are the same. So if the episode begins in September 2014, the "From" and "Through" dates on the RAP would report the same date in September. These RAPs would report ICD-9-CM diagnosis codes using codes matching the OASIS assessment.

If the HH episode spans into October 2014, the corresponding final claim for the episode will be required to report ICD-10-CM codes. HH claims cannot be split into periods before and after October 1, 2014, so these claims will have claim "Through" dates of October 1, 2014, or later. The HIPPS code on the final claim must match the HIPPS code that was reported on the RAP. The HIPPS code on the RAP was based on the ICD-9-CM codes matching the OASIS assessment.

CR 7492 stated that CMS will:

> "Allow HHAs to use the payment group code derived from ICD-9-CM codes on claims which span 10/1, but require those claims to be submitted using ICD-10-CM codes."

This means that HHAs do not have to re-group the episode based the ICD-10-CM codes. But this could result in some inconsistency between the HIPPS code and the ICD-10-CM codes on the claim. CMS will alert medical reviewers at our MACs to ensure that the ICD-10-CM codes on these claims are not used in making determinations. CMS will also alert researchers using CMS data files of this inconsistency. The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes that were used on the RAP and which are stored in the OASIS system.

These same procedures will apply to resumption of care assessments (M0100 = 03) and to recertification (M0100 = 04) and follow-up (M0100 = 05) assessments when the episode start date and the M0090 date on those assessments are both before October 1, 2014 but the episode ends in October 2014 (see table on the following page).

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CODING

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Episodes starting before October 1, 2014, with OASIS completion dates in October 2014

There may be cases where the episode start of care date is before October 1, 2014, and, due to the five day completion window, the M0090 date is in October 2014.

For example, an initial episode with a start of care date of September 28, 2014, could have an M0090 date of October 2, 2014. In these cases, ICD-10-CM codes will be used on the OASIS and to determine the HIPPS code.

The RAP for this example would have "From" and "Through" dates of September 28, 2014. As a result, these RAPs would need to report ICD-9-CM diagnosis codes even though ICD-10-CM codes were used on the OASIS assessment.

Since RAPs are not subject to medical review and are replaced in Medicare claims history by the final claim, there is no need to account for adverse impacts in these situations.

The ICD-9-CM codes are required in order for the RAP to be processed. The corresponding final claim for the episode will report ICD-10-CM codes matching the OASIS assessment.

Recertification episodes beginning in the first days of October 2014

In the case of recertification episodes, the M0090 date can be up to 5 days earlier than the episode start date. So, a recertification episode starting on October 2, 2014, could have an M0090 date of September 28, 2014. ICD-9-CM codes are used on the OASIS assessment and will be used to determine the HIPPS code.

But in this case, both the RAP and claim will require ICD-10-CM codes since the "Through" date on both will be after October 1, 2014.

The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes which are stored in the OASIS system. In these cases also, CMS will alert medical reviewers at our MACs and researchers using CMS data files to prevent adverse impacts.Table 1 at the end of this article summarizes these scenarios:

Additional information

To find additional information about ICD-10, visit *http://www.cms.gov/Medicare/Coding/ICD10/index.html*. The ICD-10-related implementation date is now October 1, 2014, as announced in final rule CMS-0040-F issued on August 24, 2012. This final rule is available at *http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html*.

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

MLN Matters® Number: SE1410 Revised
Related Change Request (CR) #: n/a
Related CR Release Date: n/a
Effective Date: n/a
Related CR Transmittal #: n/a
Implementation Date: na/

Table 1 - Home health episode scenarios spanning October 1, 2014

Type of OASIS assessment	RAP "from/ through" dates	OASIS M0090 date/OASIS version	Claim "through" date	Diagnosis coding used on OASIS	Diagnosis coding used on RAP	Diagnosis coding used on claim
Start of Care/ Resumption of Care	9/28/2014	9/30/2014 OASIS-C	11/26/2014	ICD-9-CM	ICD-9-CM	ICD-10-CM
Recertification	9/28/2014	9/25/2014 OASIS-C	11/26/2014	ICD-9-CM	ICD-9-CM	ICD-10-CM
Start of care/ Resumption of care	9/28/2014	10/2/2014 OASIS-C1	11/26/2014	ICD-10-CM	ICD-9-CM	ICD-10-CM
Recertification	10/2/2014	9/28/2014 OASIS-C	11/30/2014	ICD-9-CM	ICD-10-CM	ICD-10-CM

Provider resources for ICD-10 coding and training opportunities

Training for ICD-10 coding is not being provided by Medicare administrative contractors (MACs) or legacy contractors in jurisdictions that are not yet administered by a MAC. Training will instead be provided by several external sources.

The resources below are external to the First Coast and Centers for Medicare & Medicaid Services (CMS) websites but are being offered for your convenience.

First Coast and CMS are not responsible for the content or maintenance of these external sites.

- *AAPC Web resources*: Find ICD-10 news and information from the American Academy of Professional Coders (AAPC).
- *AHA Web resources*: Here you will find ICD-10 information from the American Hospital Association.
- *AHIMA Web resources*: The American Health Information Management Association (AHIMA) website shares information and training sessions for ICD-10.
- *HIMSS Web resources*: The Health Information and Management Systems Society (HIMSS) website offers ICD-10 information and guidance.
- *CDC Web resources*: The Centers for Disease Control and Prevention website offers ICD-10 information.

In addition, *view a list of helpful links to educational resources* designed to assist providers during and after the ICD-10 implementation process.

Updated intern and resident database files available for teaching hospitals

The Centers for Medicare & Medicaid Services' (CMS) Office of Financial Management posted two intern and resident information system (IRIS) programs with updated files on the CMS website, February 28, 2014.

The uploaded files include medical school codes, residency type codes, and operating instructions for using the IRIS system.

Teaching hospitals and others in the provider community use these programs to collect and report information on resident training in hospital and non-hospital settings. The primary purpose of IRIS is to ensure that Medicare counts interns and residents as only one full-time equivalent employee in the calculation of payments for the costs of direct graduate medical education and indirect medical education.

IRIS program files and instructions are available for download.

Your feedback matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs.

Discover the results of your feedback on our Website highlights page at *http://medicare.fcso.com/Feedback/160958.asp*.

You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

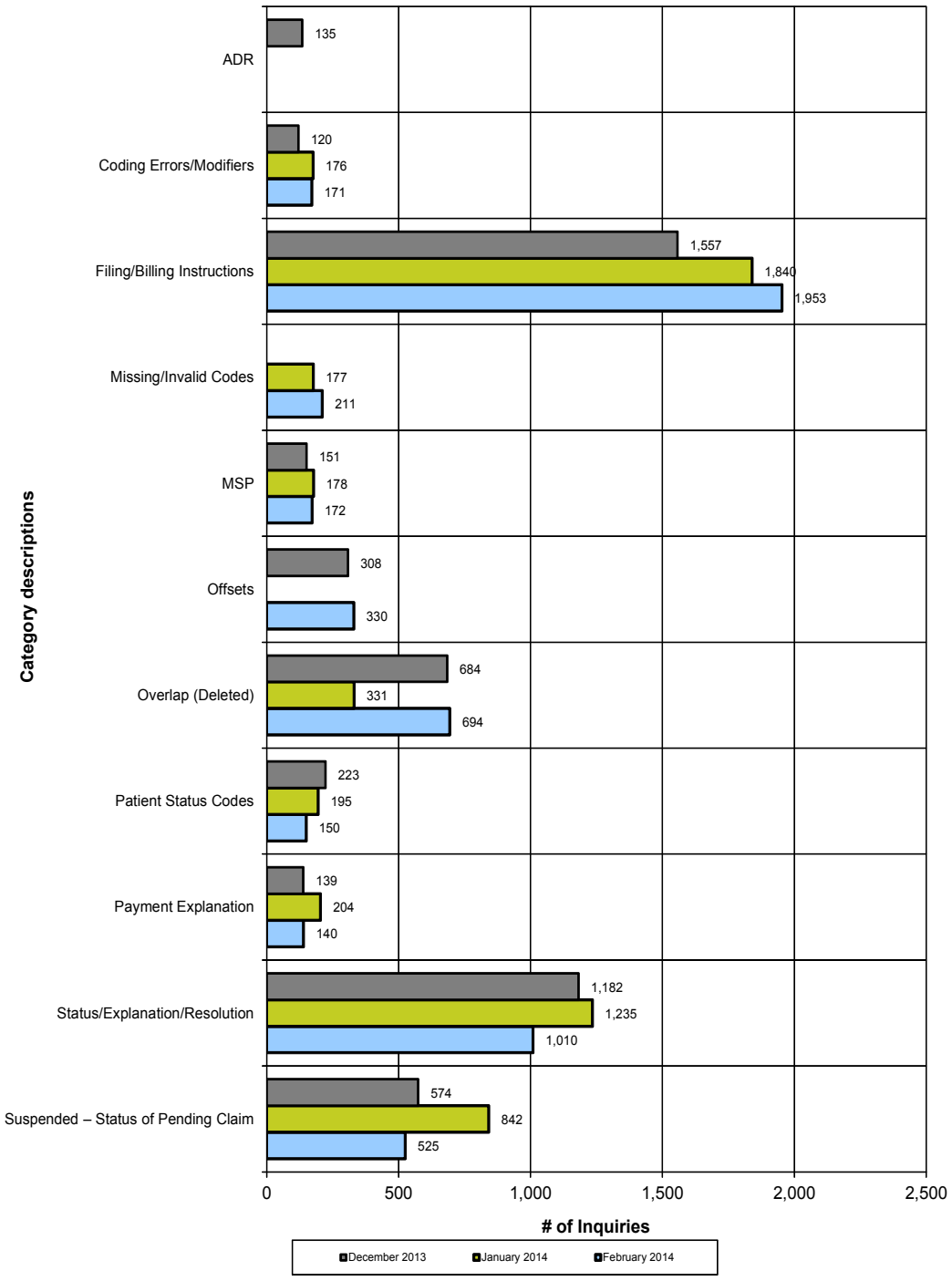
Claims and Inquiry Summary Data

Top inquiries, rejects, and return to provider claims

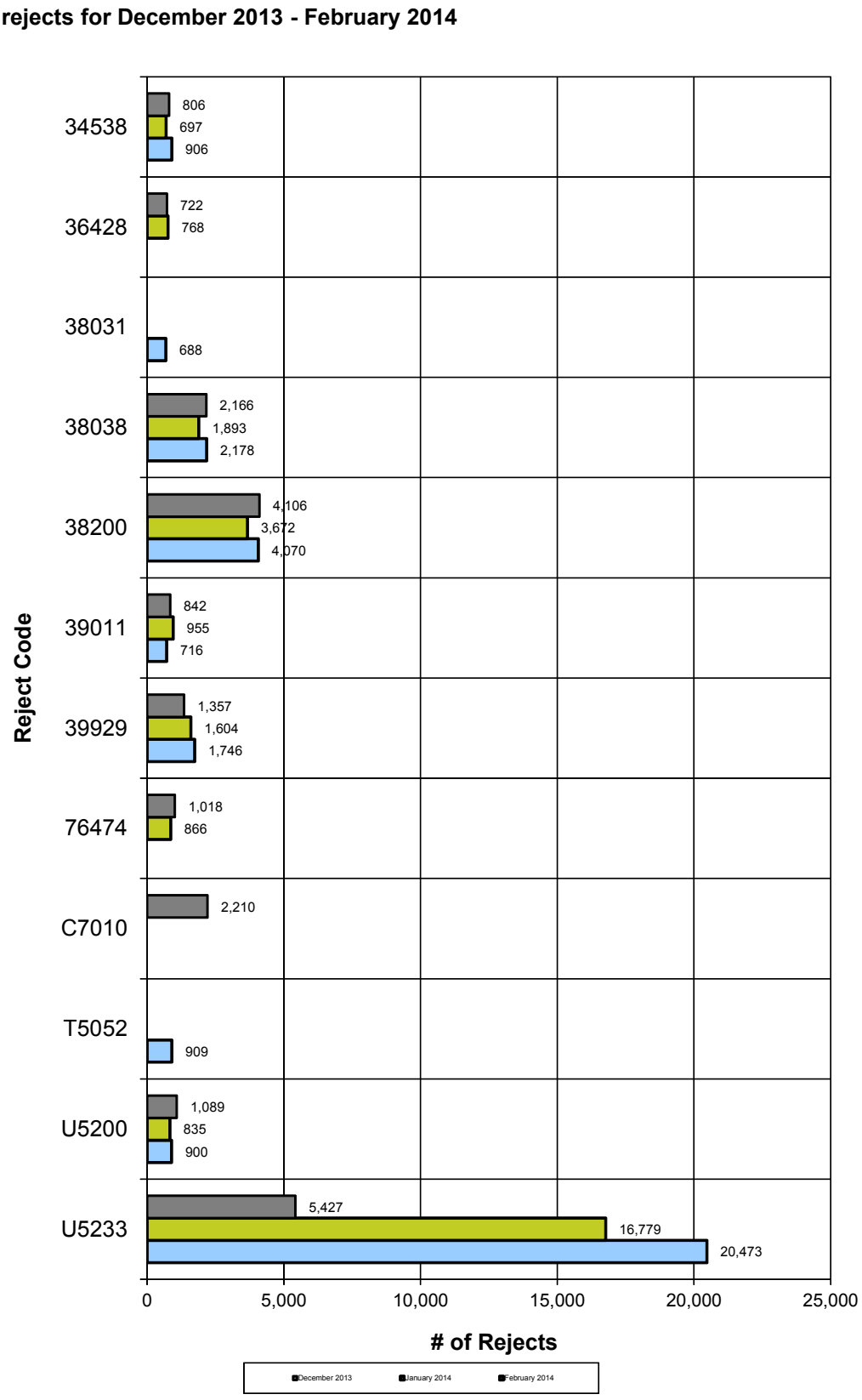
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during December 2013 through February 2014.

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 December 2013 - February 2014

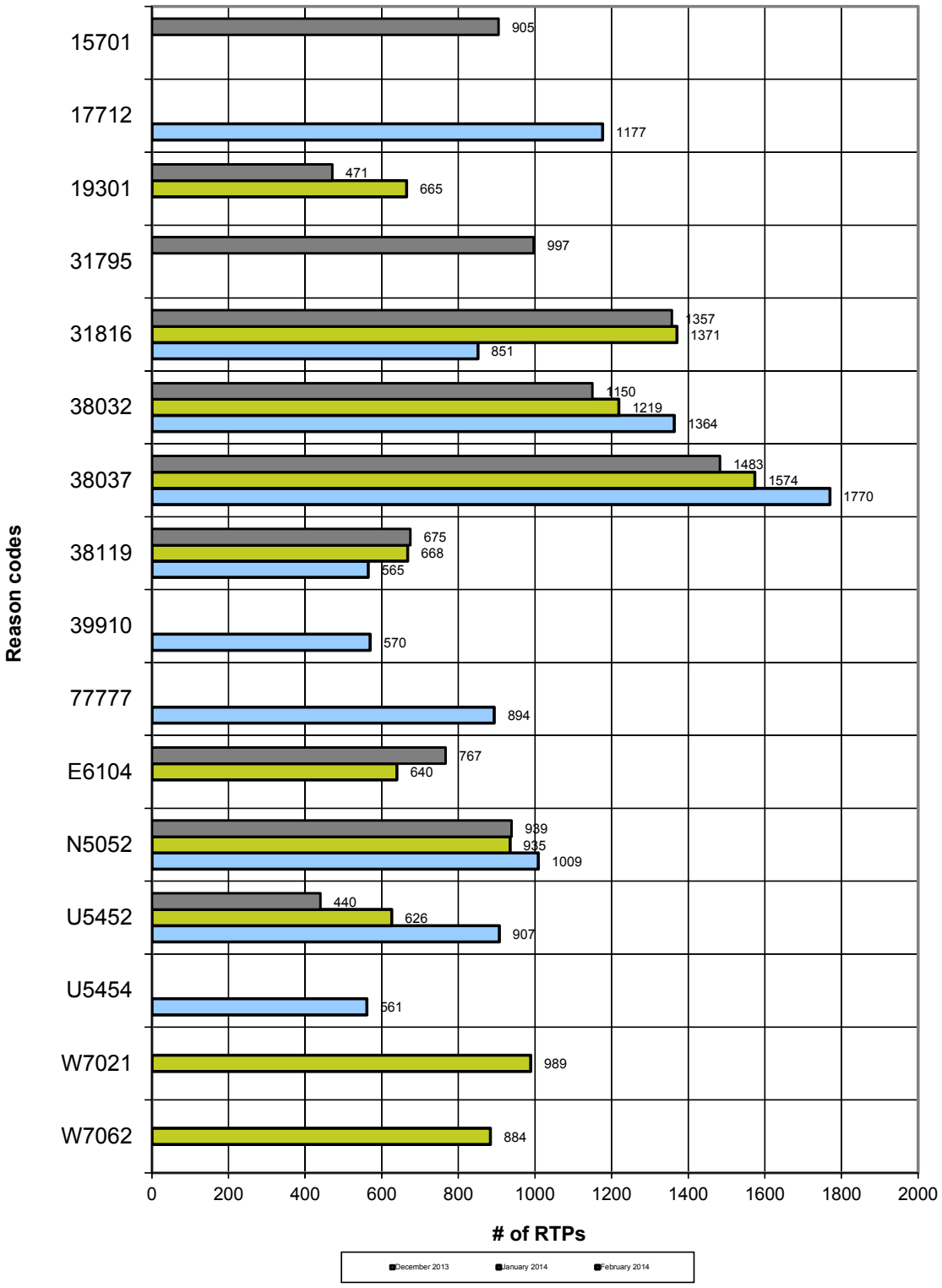


Part A top rejects for December 2013 through February 2014



Part A top return to providers (RTPs) for December 2013 through February 2014

Top RTPs for December 2013 - February 2014



Reimbursement

Implementation of HIPAA standards for health care EFTs

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs) and home health and hospice (HH&H) MACs, for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8619, which informs Medicare contractors that Section 1104 of the Affordable Care Act mandates the adoption of a standard for the health care electronic funds transfers (EFT) HIPAA transaction and operating rules for the health care EFT and remittance advice transaction.

The main intent of these standards and operating rules is to assure health plans transmit a trace number that allows providers to re-associate the EFT health care payment with its associate electronic remittance advice. Make sure that your billing staffs are aware of these changes.

Note that CR 8619 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) network with electronic health care payments.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider's financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the company entry description and the TRN segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR 8619.

We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of related CR 8629 (see the related article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8629.pdf* can be accommodated by your accounting processes and systems.

Background

The regulation adopting the health care EFT standards is available at *https://www.federalregister.gov/articles/2012/01/10/2012-132/administrative-simplification-adoption-of-standards-for-health-care-electronic-funds-transfers-efts* on the Internet.

The regulation adopting the EFT & ERA operating rules can be found at *https://www.federalregister.gov/articles/2012/08/10/2012-19557/administrative-simplification-adoption-of-operating-rules-for-health-care-electronic-funds-transfers#h-4*

A new National Automated Clearinghouse Association (NACHA) standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of electronic funds transfers (EFT) used to pay healthcare claims.

This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC x12 835 TRN data segment in the addenda record. The healthcare EFT standard requires the following:

- Company entry description of "HCCLAIMPMT" to identify the payment as healthcare;
- Company name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a record type code of "7" and an addenda type code equal to "05"; and
- Payment related information in the addenda record must contain the ASC x12 835 TRN (Re-association trace number) data segment that is included on the electronic remittance advice.

Healthcare providers will use the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments.

The TRN data segment must contain the following data elements, separated by an asterisk "*".

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EFT

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Example: TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

* data element separator

Element	Element name	Mandatory or optional	Data content
TRN	Re-association trace number	M	ASC X12 835 segment identifier. This is always "TRN".
TRN01	Trace type code	M	Trace type code is always a "1".
TRN02	Re-association Information	M	This data element must contain the EFT trace number.
TRN03	Origination company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's tax identification number (TIN).
TRN04	Reference identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.
Segment terminator	Segment terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\".

Additional information

The official instruction, CR 8619 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1351OTN.pdf.*

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

MLN Matters® Number: MM8619
Related Change Request (CR) #: CR 8619
Related CR Release Date: February 21, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R1351OTN
Implementation Date: July 7, 2014

Implementation of operating rules for electronic funds transfers

Provider types affected

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

What you need to know

This article is based on change request (CR) 8629 which informs MACs that they must comply with NACHA operating rules that are applicable to initiators of health care payments. CR 8629 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) network with electronic health care payments. The overarching goal of the requirements of CR 8629 are to assure that providers receiving health care payments via EFT will receive a "trace number" that facilitates automatic re-association of the EFT health care payment with its associated remittance advice.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider's financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the company entry description and the TRN segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR 8629. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of CR 8629 can be accommodated by your accounting processes and systems.

Background

In support of Health Insurance Portability & Accountability Act of 1996 (HIPAA) Operating Rules for health care EFT and remittance advice transactions adopted by HHS, NACHA – The Electronic Payments Association has adopted its own operating rules that apply to ACH transactions that are health care payments from health plans to providers. NACHA manages the development, administration and governance of the ACH Network used by all types of financial networks and represents more than 10,000 financial institutions.

A new NACHA standard for electronic healthcare claim payments went into effect on September 20,

2013, impacting all originators and receivers of EFT used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the healthcare EFT standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The healthcare EFT standard requires the following:

- Company Entry Description of "HCCLAIMPMT" to identify the payment as healthcare;
- Company Name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a record type code of "7" and an addenda type code equal to "05"; and
- Payment related information in the addenda record must contain the ASC x12 835 TRN (Re-association trace number) data segment that is included on the electronic remittance advice.
- Healthcare providers will utilize the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. See "Healthcare EFT Standard Format" in the Medicare IOM for more information.

Example:

TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

* data element separator

See **RULES**, Next Page

RULES

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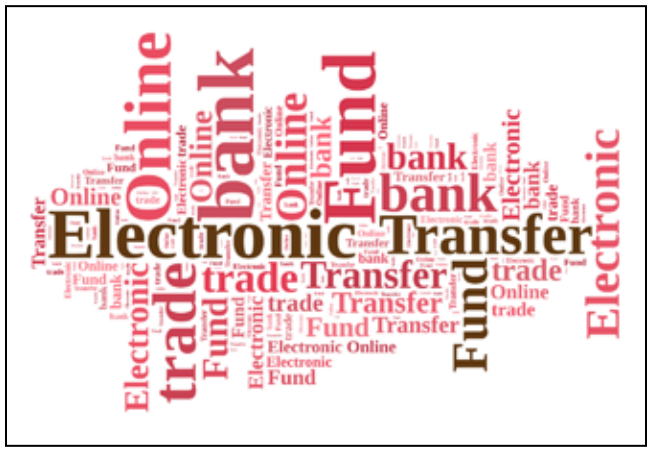
The following table explains this example:

Element	Element name	Mandatory or optional	Data content
TRN	Re-association trace number	M	ASC X12 835 segment identifier. This is always "TRN".
TRN01	Trace type code	M	Trace Type Code is always a "1".
TRN02	Re-association information	M	This data element must contain the EFT trace number.
TRN03	Origination company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's Tax Identification Number (TIN).
TRN04	Reference identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.



Element	Element name	Mandatory or optional	Data content
Segment Terminator	Segment terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\".

Additional information

For information on the NACHA operating rules that apply to health care payments, particularly with regard to requirements for originators, see *https://healthcare.nacha.org/healthcarerules*.

The official instruction, CR 8629 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1349OTN.pdf.*

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

MLN Matters® Number: MM8629
Related Change Request (CR) #: CR 8629
Related CR Release Date: February 21, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R1349OTN
Implementation Date: July 7, 2014

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2014 Medicare travel allowances for collecting lab specimens

Provider types affected

This *MLN Matters*® article for clinical diagnostic laboratories submitting claims to Medicare administration contractors (A/B Medicare administrative contractors (MACs)) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 8641 which informs MACS and providers about changes to the clinical laboratory fee schedule (CLFS) related to travel allowances and specimen collection fees.

Caution – What you need to know

CR 8641 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat rate basis using HCPCS code P9604 for 2014.

Go – What you need to do

Make sure your billing staffs are aware of these changes.

Background

HCPCS travel codes allow for payment on either a per mileage basis (HCPCS code P9603) or a flat rate per trip basis (HCPCS code P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. MAC discretion allows the MAC to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs have established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory, or when the flat rate is set by the MAC.

Per mile travel allowance (P9603)

- The per mile travel allowance is to be:
- Used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and
- Prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The Internal Revenue Service determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile. The allowance per mile was computed using the federal mileage rate of **$0.56 per mile plus an additional $0.45 per mile** to cover the technician's time and travel costs.

Note: MACs have the option of establishing a higher per mile rate in excess of the minimum total of $1.01 per mile ($0.56 per mile plus $0.45 per mile) if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the CLFS, as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

Per flat-rate trip basis travel allowance (P9604)

The per flat-rate trip basis travel allowance is **$10.10**.

CR 8641 includes as an attachment the revised Chapter 16, Section 60.2 (Travel Allowance) of the *Medicare Claims Processing Manual* to include the travel allowance payment rates for 2014.

Additional information

The official instruction, CR 8641 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2907CP.pdf.*

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

MLN Matters® Number: MM8641
Related Change Request (CR) #: CR 8641
Related CR Release Date: March 14, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R2907CP
Implementation Date: June 16, 2014

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April 2014 durable medical equipment, prosthetics, orthotics, and supplies fee schedule update

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8645 that alerts providers and suppliers that CMS issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing personnel are aware of these changes.

Background

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

Key points of CR 8645

Splints, casts, and certain intraocular lenses (IOLs)

The following are the HCPCS codes for splints, casts, and certain IOLs added to the DMEPOS fee schedule file:

A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010,

Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021,

Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032,

Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041, Q4042, Q4043,

Q4044, Q4045, Q4046, Q4047, Q4048, Q4049, V2630, V2631, V2632.

As written in the *MLN Matters*® article MM8523 (Change to the Reasonable Charge Update for 2014 for Splints, Casts, and Certain Intraocular Lenses) at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8523.pdf*, for dates of service on or after April 1, 2014, payment for splints, casts and IOLs inserted in a physician's office will be made using national fee schedule amounts.

For splints and casts, codes A4565 and Q4001-Q4049

are used when supplies are indicated for cast and splint purposes and:

- Payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast. Per the regulations at *42 CFR Section* 414.106, national fee schedule amounts for 2014 for these items were developed using 2013 reasonable charges updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June 2013, which is 1.8 percent; and
- For each year subsequent to 2014, the fee schedule amounts will be updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment as described in Section 1886(b)(3)(B)(xi)(II) of the Social Security Act.
- For intraocular lenses (codes V2630, V2631 and V2632), payment under the DMEPOS fee schedule is only made for lenses implanted in a physician's office:
- For payment of IOLs inserted in a physician's office furnished from April 1, 2014, through December 31, 2014, regulations at *42 CFR Section* 414.108 require national fee schedules be established based on the 2012 national average allowed charges updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 24-month period ending with June 2013, which is 3.5 percent;
- For each year subsequent to 2014, the fee schedule amounts will be updated by the percentage increase in the consumer price index for all urban consumers (United States city

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average) for the 12-month period ending with June of the preceding year, adjusted by the productivity adjustment as described in Section 1886(b)(3)(B)(xi)(II) of the Act; and

- For IOL codes V2630 and V2631, national fee schedules amounts have been established using the fee schedule amounts for comparable code V2632 since there is insufficient allowed charge data for use in calculating the fee schedule amounts.

Subject to coinsurance and deductible rules, Medicare payment for these items is to be equal to the lower of the actual charge for the item or the amount determined under the applicable fee schedule payment methodology.

Payment category reclassification of certain DME

Effective for dates of service on or after April 1, 2014, certain HCPCS codes for DME are reclassified from the payment category for inexpensive or other routinely purchased DME to the payment category for capped rental items, to align with the regulatory definition of routinely purchased equipment found at *42 CFR Section* 414.220(a)(2).

These changes were determined through rulemaking (CMS-1526-F) and as written in the *MLN Matters*® article MM8566 titled Rescind/Replace Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category, available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network/MLN/MLNMattersArticles/Downloads/MM8566.pdf*.

As part of the April 2014 update to the DMEPOS fee schedule, the methodology used to calculate fee schedule amounts for capped rental items has been used to establish new fee schedule amounts for the following HCPCS codes:

A4639, A7025, E0117, E0144, E0198, E0300, E0620, E0656, E0657, E0740, E0762, E0764, E0849, E0855, E0856, E0984, E0986, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1010, E1014, E1029, E1030, E1161, E1232, E1233, E1234, E1235, E1236, E1237, E1238, E1700, E2227, E2310, E2311, E2312, E2313, E2321, E2322, E2325, E2326, E2327, E2328, E2329, E2330, E2351, E2373, E2374, E2376, E2377, E2378, E2500, E2502, E2504, E2506, E2508, E2510, K0607, K0730.

Consistent with the capped rental payment methodology, only rental amounts (RR) will appear on the fee schedule file for the above codes, effective April 1, 2014, and:

- The HCPCS codes transitioning to the capped rental payment category with corresponding KC, KF or KE modifiers will continue to have rental amounts associated with these modifiers on the fee schedule file;
- The capped rental fee schedule amount is calculated based on ten percent of the base year purchase price increased by the covered item update;
- This is the fee schedule amount for rental months one through three. Beginning with the fourth month, the fee schedule amount is equal to 75 percent of the fee schedule amount paid in each of the first three rental months; and
- All of the payment rules for capped rental items, including guidelines regarding continuous use and transfer of title to the beneficiary following 13 months of continuous use, apply to these codes, effective for claims with dates of service on or after April 1, 2014.

Also effective April 1, 2014, MACs will process and pay claims for capped rental wheelchair accessories on a lump sum purchase basis when used with complex rehabilitative power wheelchairs (wheelchair base codes K0835 – K0864). In this case, the supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished.

The purchase fee schedule amount for capped rental accessories furnished in this manner is equal to the rental fee (for months one through three) multiplied by ten. If the beneficiary declines the purchase option, the supplier must furnish the accessory on a rental basis and payment will be made in accordance with the capped rental payment rules.

Specific coding and pricing issues

As part of this update, effective April 1, 2014, HCPCS code L8680 is not included on the 2014 DMEPOS fee schedule file and the coverage indicator is revised to "I" to show it is not payable by Medicare. Note that:

- For neurostimulator devices, HCPCS code L8680 is no longer separately billable for Medicare because payment for electrodes has been incorporated in *CPT*® code *63650 Percutaneous implantation of neurostimulator electrode array, epidural*.
- CMS established non-facility practice expense inputs for *CPT*® code *63650* in the Medicare physician fee schedule final rule (published November 27, 2013). As a result, practitioners should not report electrode(s) using code L8680 in conjunction with a lead implantation procedure furnished in any setting for Medicare.
- Also, this change for code L8680 will be available on the HCPCS Quarterly Update website at *http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html*.

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April 2014 Medicare physician fee schedule database update

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8664 which amends the payment files that were issued to Medicare contractors based upon the 2014 Medicare physician fee schedule database (MPFS), final rule. Make sure that your billing staffs are aware of these changes.

Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

In order to reflect appropriate payment policy based on current law and the 2014 MPFS final rule, the MPFSDB has been updated using the conversion factor from the 2014 final rule due to the expiration of the 0.5 percent update established in the Pathway for SGR Reform Act of 2013. Therefore, CR 8664 reflects payments with the conversion factor of $27.2006 and without the 1.0 GPCI work floors, effective April 1, 2014, to December 31, 2014.

Note: Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

CR 8664 summary of changes

The summary of changes for the April 2014 update consists of the following:

1. Short description corrections for HCPCS codes G0416-G0419

HCPCS code	Old short description	Revised 2014 short description
G0416	Sat biopsy prostate 1-20 spc	Biopsy prostate 1-20 spc
G0417	Sat biopsy prostate 21-40	Biopsy prostate 21-40
G0418	Sat biopsy prostate 41-60	Biopsy prostate 41-60
G0419	Sat biopsy prostate: >60	Biopsy prostate: >60

2. Adjust the facility and non-facility PE RVUs for HCPCS code 77293-global and 77293-TC via CMS update files.

HCPCS	Mod	Status	Description	Non-facility PE RVUs	Facility PE RVUs	Global	
77293		A	Respirator motion mgmt simul	9.96	NA	ZZZ	Jan 1 to March 31, 2014
77293	TC	A	Respirator motion mgmt simul	9.16	NA	ZZZ	Jan 1 to March 31, 2014
77293		A	Respirator motion mgmt simul	10.72	NA	ZZZ	Correction April 1, 2014
77293	TC	A	Respirator motion mgmt simul	9.92	NA	ZZZ	Correction April 1, 2014

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3. **HCPCS code G9361 will be added to your Medicare contractor's systems as indicated in the chart below.**

Field	Indicator
Procedure status	M
Short descriptor	Doc comm risk calc
Effective date	01/01/2014
Work RVU	0
Full non-facility PE RVU	0
Full non-facility NA indicator	(blank)
Full facility PE RVU	0
Full facility NA indicator	(blank)
Malpractice RVU	0
Multiple procedure indicator	9
Bilateral surgery indicator	9
Assistant surgery indicator	9
Co-surgery indicator	9
Team surgery indicator	9
PC/TC	9
Site of service	9
Global surgery	XXX
Pre	0.00
Intra	0.00
Post	0.00
Physician supervision diagnostic indicator	09
Diagnostic family imaging indicator	99
Non-facility PE used for OPPS payment amount	0.00
Facility PE used for OPPS payment amount	0.00
MP used for OPPS payment amount	0.00
Type of service	9
Long descriptor	Medical indication for induction [Documentation of reason(s) for elective delivery or early induction (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-premature, prolonged maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, malposition and mal-presentation of fetus, late pregnancy, prior uterine surgery, or participation in clinical trial)]

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4. Correct the physician supervision of diagnostic procedures indicator (Phys diag supv) for the TC's of the following codes, effective January 1, 2014.

HCPCS code	Description	Phys diag supv indicator	Effective date
70450-TC	CT head/brain w/o dye - Phys diag supv correction (TC)	01	01/01/2014
70460-TC	CT head/brain w/dye - Phys diag supv correction (TC)	02	01/01/2014
70551-TC	MRI brain stem w/o dye - Phys diag supv correction (TC)	01	01/01/2014
70552-TC	MRI brain stem w/dye - Phys diag supv correction (TC)	02	01/01/2014
70553-TC	MRI brain stem w/o & w/dye - Phys diag supv Correction (TC)	02	01/01/2014
72141-TC	MRI neck spine w/o dye - Phys diag supv correction (TC)	01	01/01/2014
72142-TC	MRI neck spine w/dye - Phys diag supv correction (TC)	02	01/01/2014
72146-TC	MRI chest spine w/o dye - Phys diag supv correction (TC)	01	01/01/2014
72147-TC	MRI chest spine w/dye - Phys diag supv correction (TC)	02	01/01/2014
72148-TC	MRI lumbar spine w/o dye - Phys diag supv correction (TC)	01	01/01/2014
72149-TC	MRI lumbar spine w/dye - Phys diag supv correction (TC)	02	01/01/2014
72156-TC	MRI neck spine w/o & w/dye - Phys diag supv correction (TC)	02	01/01/2014
72157-TC	MRI chest spine w/o & w/dye - Phys diag supv correction (TC)	02	01/01/2014
72158-TC	MRI lumbar spine w/o & w/dye - Phys diag supv correction (TC)	02	01/01/2014
72191-TC	CT angiograph pelv w/o&w/dye - Phys diag supv correction (TC)	02	01/01/2014
74174-TC	CT angio abd&pelv w/o&w/dye - Phys diag supv correction (TC)	02	01/01/2014
74175-TC	CT angio abdom w/o & w/dye - Phys diag supv correction (TC)	02	01/01/2014
93880-TC	Extracranial bilat study - Phys diag supv correction (TC)	01	01/01/2014
93882-TC	Extracranial uni/ltd study - Phys diag supv correction (TC)	01	01/01/2014
77001-TC	Fluoroguide for vein device - Phys diag supv correction (TC)	03	01/01/2014

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HCPCS code	Description	Phys diag supv indicator	Effective date
77002-TC	Needle localization by Xray - Phys diag supv correction (TC)	03	01/01/2014
77003-TC	Fluoroguide for spine inject - Phys diag supv correction (TC)	03	01/01/2014

Additional information

The official instruction, CR 8664 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2912CP.pdf*.

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

MLN Matters® Number: MM8664
Related Change Request (CR) #: CR 8664
Related CR Release Date: March 14, 2014
Effective Date: January 1, 2014, and April 1, 2014
Related CR Transmittal #: R2912CP
Implementation Date: April 7, 2014

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Additional information

The official instruction, CR 8645 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2902CP.pdf.*

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

MLN Matters® Number: MM8645
Related Change Request (CR) #: CR 8645
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Effective Date: April 1, 2014
Related CR Transmittal #: R2902CP
Implementation Date: April 7, 2014

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2014 annual update for DMEPOS fee schedule

Note: This article was revised March 6 to provide updates regarding healthcare common procedure coding system (HCPCS) code changes that were effective January 1, 2014. The changes are listed in bold under the HCPCS code section. This information was previously published in the December 2013 *Medicare A Connection*, Pages 48-51.

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8531 to advise providers of the 2014 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Make sure your staffs are aware of these updates.

Background and key points of CR 8531

The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834 (a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN) and splints, casts, and certain intraocular lenses.

Fee schedule files

The DMEPOS fee schedule file will also be available for providers and suppliers, as well as state Medicaid agencies, managed care organizations, and other interested parties at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/*.

HCPCS codes added/deleted

The following new codes are effective January 1, 2014;

- A7047 in the inexpensive/routinely purchased (IN) payment category
- E0766 in the frequently serviced (FS) payment category; and E1352

The following new codes are in the prosthetics and orthotics (PO) payment category: L5969, L8679, L0455, L0457, L0467, L0469, L0641-L0643, L0648-L0651, L1812, L1833, L1848, L3678, L3809, L3916, L3918, L3924, L3930, L4361, L4387, and L4397.

The following code is deleted from the HCPCS effective January 1, 2014, and therefore, is removed from the DMEPOS fee schedule files: L0430

The following codes are deleted from the DMEPOS fee schedule files as of January 1, 2014: A4611, A4612, A4613, E0457, E0459, L8685, L8686, L8687, and L8688.

For gap-filling purposes, the 2013 deflation factors by payment category are listed in the following table:

Factor	Category
0.469	Oxygen
0.472	Capped rental
0.473	Prosthetics and orthotics
0.600	Surgical dressings
0.653	Parental and enteral nutrition

Specific coding and pricing issues

As part of this update, fee schedules for the following codes will be added to the DMEPOS fee schedule file effective January 1, 2014:

- A4387 Ostomy pouch, closed, with barrier attached, with built-in convexity, (I piece), each; and
- L3031 Foot, insert/plate, removable, addition to lower extremity orthotic, high strength, lightweight material, all hybrid lamination/prepreg composite, each

CMS is adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of

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this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes, A5512 or A5513.

To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of 2004. For 2014, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during 2012. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2014.

Off-the-shelf orthotics

Section 1847(a)(2)(C) of the Act mandates implementation of competitive bidding programs throughout the United States for awarding contracts for furnishing off-the-shelf (OTS) orthotics which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

Regulations at 42 CFR 414.402 define the term "minimal self-adjustment" to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthontist, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc, or by the Board for orthotist/prosthetist certification or an individual who has specialized training.

As shown in the following table, 22 new codes are added to the HCPCS for OTS orthotics. In addition, as part of the review to determine which HCPCS codes for prefabricated orthotics describe OTS orthotics, it was determined that HCPCS codes for prefabricated orthotics describe items that are furnished OTS and items that require expertise in customizing the orthotic to fit the individual patient.

Therefore, it was necessary to explode these codes into two sets of codes. One set is the existing codes revised, effective January 1, 2014, to only describe devices customized to fit a specific patient by an individual with expertise and a second set of new codes describing the OTS items.

Also, as shown in the table that follows for 2014, the fee schedule amounts for existing codes will

be applied to the corresponding new codes added for the items furnished OTS. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the *Medicare Claims Processing Manual*, Chapter 23, Section 60.3.1, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

Prefabricated orthotic codes split into two codes – effective January 1, 2014

Fee from existing code	Crosswalk to new off-the-shelf and revised custom fitted orthotic codes
L0454	L0455 and L0454
L0456	L0457 and L0456
L0466	L0467 and L0466
L0468	L0469 and L0468
L0626	L0641 and L0626
L0627	L0642 and L0627
L0630	L0643 and L0630
L0631	L0648 and L0631
L0633	L0649 and L0633
L0637	L0650 and L0637
L0639	L0651 and L0639
L1810	L1812 and L1810
L1832	L1833 and L1832
L1847	L1848 and L1847
L3807	L3809 and L3807
L3915	L3916 and L3915
L3917	L3918 and L3917

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Fee from existing code	Crosswalk to new off-the-shelf and revised custom fitted orthotic codes
L3923	L3924 and L3923
L3929	L3930 and L3929
L4360	L4361 and L4360
L4386	L4387 and L4386
L4396	L4397 and L4396

Further information on the development of new OTS orthotic codes can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html*.

Neurostimulator devices

HCPCS codes, L8685, L8686, L8687, and L8688 are not included on the 2014 DMEPOS fee schedule file. They were removed from the file to reflect the change in the coverage indicators for these codes to invalid for Medicare ("I") effective January 1, 2014. However, code L8679 (Implantable neurostimulator, pulse generator, any type) is added to the HCPCS and DMEPOS fee schedule file, effective January 1, 2014, for billing Medicare claims previously submitted under L8685, L8686, L8687 and L8688.

The fee schedule amounts for code L8679 are based on the established Medicare fee schedule amounts for all types of pulse generators under the previous HCPCS code E0756 (Implantable neurostimulator pulse generator), which was discontinued December 31, 2005.

The payment amount is based on the explosion of code E0756 into four codes for different types of neurostimulator pulse generator systems, which were not materially utilized in the Medicare program. As such, payment for code L8679 will revert back to the fee schedule amounts previously established for code E0756.

Diabetic testing supplies

The fee schedule amounts for non-mail order diabetic testing supplies, without KL modifier, for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they are equal to the single payment amounts for mail order diabetic testing supplies (DTS) established in implementing the national mail order competitive bidding program (CBP) under Section 1847 of the Act. The non-mail order payment 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 CBP contracts are recompeted. The national CBP for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016. The program instructions reviewing these changes are transmittal 2709, CR 8325, dated May 17, 2013, and transmittal 2661, CR 8204, dated February 22, 2013. Additional information related to these CRs is available in the following *MLN Matters*® articles:

- **MM8325** *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf*
- **MM8204** *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf*

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs.

The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for multi-factor productivity (MFP), which results in update of 1.0 percent for 2014. 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*.

2014 fee schedule update factor

For 2014, the update factor of 1.0 percent is applied to the applicable 2013 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2014 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June 2013, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP).

The MFP adjustment is 0.8 percent and the CPI-U percentage increase is 1.8 percent. Thus, the 1.8 percentage increase in the CPI-U is reduced by the 0.8 percentage increase in the MFP resulting in a net increase of 1.0 percent for the update factor.

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2014 update to the labor payment rates

The 2014 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.8 percent effective for claims with dates of service from January 1, 2014, through December 31, 2014, and those rates are as follows:

State	K0739	L4205	L7520
AK	$27.40	$31.22	$36.73
AL	$14.55	$21.68	$29.43
AR	$14.55	$21.68	$29.43
AZ	$17.99	$21.66	$36.21
CA	$22.32	$35.59	$41.48
CO	$14.55	$21.68	$29.43
CT	$24.30	$22.16	$29.43
DC	$14.55	$21.66	$29.43
DE	$26.79	$21.66	$29.43
FL	$14.55	$21.68	$29.43
GA	$14.55	$21.68	$29.43
HI	$17.99	$31.22	$36.73
IA	$14.55	$21.66	$35.23
ID	$14.55	$21.66	$29.43
IL	$14.55	$21.66	$29.43
IN	$14.55	$21.66	$29.43
KS	$14.55	$21.66	$36.73
KY	$14.55	$27.76	$37.64
LA	$14.55	$21.68	$29.43
MA	$24.30	$21.66	$29.43
MD	$14.55	$21.66	$29.43
ME	$24.30	$21.66	$29.43
MI	$14.55	$21.66	$29.43
MN	$14.55	$21.66	$29.43
MO	$14.55	$21.66	$29.43
MS	$14.55	$21.68	$29.43
MT	$14.55	$21.66	$36.73
NC	$14.55	$21.68	$29.43
ND	$18.13	$31.16	$36.73
NE	$14.55	$21.66	$41.04
NH	$15.62	$21.66	$29.43
NJ	$19.63	$21.66	$29.43
NM	$14.55	$21.68	$29.43
NV	$23.18	$21.66	$40.12
NY	$26.79	$21.68	$29.43
OH	$14.55	$21.66	$29.43
OK	$14.55	$21.68	$29.43
OR	$14.55	$21.66	$42.32
PA	$15.62	$22.30	$29.43
PR	$14.55	$21.68	$29.43
RI	$17.34	$22.32	$29.43
SC	$14.55	$21.68	$29.43
SD	$16.26	$21.66	$39.35
TN	$14.55	$21.68	$29.43
TX	$14.55	$21.68	$29.43
UT	$14.59	$21.66	$45.83
VA	$14.55	$21.66	$29.43
VI	$14.55	$21.68	$29.43
VT	$15.62	$21.66	$29.43
WA	$23.18	$31.77	$37.74
WI	$14.55	$21.66	$29.43
WV	$14.55	$21.66	$29.43
WY	$20.28	$28.89	$41.04

2014 national monthly payment amounts for stationary oxygen equipment

CR 8531 implements the 2014 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2014.

As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE). The updated 2014 monthly payment amount of $178.24 includes the 1 percent update factor for the 2014 DMEPOS fee schedule.

Please note that when updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems.

Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2014 maintenance and servicing payment amount for certain oxygen equipment

CR 8531 also updates the 2014 payment amount for maintenance and servicing for certain oxygen equipment. You can read more about payment for

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claims for maintenance and servicing for oxygen equipment in the following *MLN Matters*® articles:

- **MM6792** *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf*
- **MM6990** *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf*

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act.

Thus, the 2013 maintenance and servicing fee is adjusted by the 1 percent MFP-adjusted covered item update factor to yield a 2014 maintenance and servicing fee of $68.73 for oxygen concentrators and transfilling equipment.

Additional information

The official instruction, CR 8531, issued to your

MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2836CP.pdf*.

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

MLN Matters® Number: MM8531 Revised
Related Change Request (CR) #: CR 8531
Related CR Release Date: December 13, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2836CP
Implementation January 6, 2014

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Clarification of discharge status codes and hospital transfer policies

This article was rescinded March 6, 2014, in order to be revised. It will be posted again when the revisions are completed.

MLN Matters® Number: SE1411
Related Change Request (CR) #: n/a
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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.

April 2014 hospital outpatient prospective payment system update

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Part A Medicare administrative contractors (A MACs) and home health and hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8653 which describes changes to and billing instructions for various payment policies implemented in the April 2014 OPPS update. The April 2014 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 8653. Be sure your billing staff are aware of these changes.

Background

CR 8653 describes changes to and billing instructions for various payment policies implemented in the April 2014 OPPS update. The April 2014 I/OCE and OPPS Pricer will reflect the HCPCS, APC, HCPCS modifier, status indicators (sis), and revenue code additions, changes, and deletions identified CR 8653.

The April 2014 revisions to I/OCE data files, instructions, and specifications are provided in the April 2014 I/OCE CR 8658. Upon release of CR 8658, a related *MLN Matters*® article can be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMatters/Articles/Downloads/MM8658.pdf* on the Centers for Medicare & Medicaid Services (CMS) website. The key changes in the April 2014 update to the hospital OPPS are summarized in the following sections.

Changes to device edits for April 2014

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

No cost/ full credit and partial credit devices

Effective January 1, 2014, CMS will no longer recognize the modifier FB (Item provided without cost to provider, supplier, or practitioner, or credit received for replaced device) or the modifier FC (Partial credit received for replaced device), which are used to identify a device that is furnished without cost or with a full or partial credit.

Also effective January 1, 2014, for claims with APCs that require implantable devices and have significant device offsets (greater than 40 percent), the amount of the device credit will be specified in the amount portion for value code "FD" (Credit received from the manufacturer for a replaced medical device) and will be deducted from the APC payment from the applicable procedure. The OPPS payment deduction for the applicable APCs referenced above will be limited to the total amount of the device offset when the FD value code appears on a claim.

The offset amounts for the above referenced APCs, along with the offsets for other APCs, are available under the "Annual Policy Files" link on the left column at *http://www.cms.gov/HospitalOutpatientPPS/*.

CMS is updating the *Medicare Claims Processing Manual* (Chapter 4, Sections 61.3.1 through 61.3.4) and adding Sections 61.3.5 through 61.3.6 to Chapter 4 of that manual to reflect these changes to the reporting guidelines for no cost/full credit and partial credit devices, and these revised and added sections are included as an attachment to CR 8653. Those added sections are included in the following sections.

61.3.5 - Reporting and charging requirements when a device is furnished without cost to the hospital or when the hospital receives a full or partial credit for the replacement device beginning January 1, 2014

Effective January 1, 2014, when a hospital furnishes a new replacement device received without cost or with a

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credit of 50 percent or more of the cost of a new replacement from a manufacturer, due to warranty, recall, or field action, the hospital must report the amount of the device credit in the amount portion for value code "FD" (Credit received from the manufacturer for a replaced medical device). Also effective January 1, 2014, hospitals must report one of the following condition codes when the value code "FD" is present on the claim:

- **49 Product replacement within product lifecycle** – Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
- **50 Product replacement for known recall of a product** – Manufacturer or FDA has identified the product for recall and therefore replacement.

61.3.6 - Medicare payment adjustment beginning January 1, 2014

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-14, Implementation: 01-05-09)

Effective January 1, 2014, Medicare payment is reduced by the amount of the device credit for specified procedure codes reported with value code "FD." The payment deduction is limited to the full device offset when the value code "FD" appears on a claim. Payment is only reduced for procedure codes that map to the APCs on the list of APCs subject to the adjustment that are reported with value code "FD" and that are present on claims with specified device HCPCS codes.

The OPPS Pricer deducts the lesser of the device credit or the full unadjusted device offset amount from the Medicare payment for a procedure code in an APC subject to the adjustment when billed with value code "FD" on the claim. This deduction is made from the Medicare payment after the multiple procedure discounting and terminated procedure discounting factors are applied, units of service are accounted for, and after the APC payment has been wage adjusted.

When two or more procedures assigned to APCs subject to the adjustment are reported with value code "FD," the OPPS Pricer will apportion the device credit to the applicable line on the claim for each procedure assigned to an APC subject to the adjustment.

When value code "FD" is reported on a claim where multiple APCs would be subject to the adjustment, the OPPS Pricer apportions the device credit to each of those lines. The percentage of the device credit apportioned to each applicable line is based on the percentage that the unadjusted payment of each applicable line represents, relative to the total unadjusted payment for all applicable lines.

Note: The tables of APCs and devices to which the offset reductions apply, and the full and partial offset amounts, are available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*.

New services

New services listed in Table 1 below, are assigned for payment under the OPPS, effective April 1, 2014.

Table 1 – New services payable under OPPS effective April 1, 2014

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9739	4/01/2014	T	0162	Cystoscopy prostatic imp 1-3	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	$2,007.32	$401.47
C9740	4/01/2014	T	1564	Cysto impl 4 or more	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	$4,750.00	$950.00

Extended assessment and management (EAM) composite APC (8009)

Effective January 1, 2014, CMS will provide payment for all qualifying extended assessment and management encounters through newly created composite APC 8009 (Extended Assessment and Management (EAM) Composite). Any clinic visit, Level 4 or Level 5 Type A Emergency Department (ED) visit, or Level 5 Type B

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ED visit furnished by a hospital in conjunction with observation services of eight or more hours will qualify for payment through APC 8009.

Effective January 1, 2014, CMS will no longer provide payment for extended assessment and management encounters through APCs 8002 (Level I Extended Assessment and Management Composite) and 8003 (Level I Extended Assessment and Management Composite). CMS is updating the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 4, Sections 10.2.1 and 290.5) to reflect these changes to the EAM composite APC reporting guidelines. These updated sections are included as an attachment to CR 8653.

Billing for drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) effective April 1, 2014

In the 2014 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. You can review the 2014 OPPS/ASC final rule at *http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf*. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the April 2014 release of the OPPS Pricer.

The updated payment rates, effective April 1, 2014 will be included in the April 2014 update of the OPPS Addendum A and Addendum B, which will be posted at *http://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

b. Drugs and biologicals with OPPS pass-through status effective April 1, 2014

Two drugs and biologicals have been granted OPPS pass-through status effective April 1, 2014. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and biologicals with OPPS pass-through status effective April 1, 2014

HCPCS code	Long descriptor	Short descriptor	APC	Status indicator
C9021*	Injection, obinutuzumab, 10 mg	Injection, obinutuzumab	1476	G
Q4121	Theraskin, per square centimeter	Theraskin	1479	G

Note: The HCPCS code identified with an "*" indicates that this is a new code effective April 1, 2014.

c. Revised status indicator for HCPCS codes A9545, J1446, J7178, and Q0181

Effective April 1, 2014, the status indicator for HCPCS code A9545 (Iodine I-131 tositumomab, therapeutic, per treatment dose) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective January 1, 2014, the status indicator for HCPCS code J1446 (Injection, TBO-Filgrastim, 5 micrograms) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (Paid under OPPS; separate APC payment).

Effective January 1, 2014, the status indicator for HCPCS code J7178 (Injection, human fibrinogen concentrate, 1 mg) will change from SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.) to SI=K (Paid under OPPS; separate APC payment).

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Effective January 1, 2014, the status indicator for HCPCS code Q0181 (Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.).

These codes are listed in Table 3 below, along with the effective date for the revised status indicator.

Table 3 – Drugs and biologicals with revised status indicators

HCPCS code	Long descriptor	APC	Status indicator	Effective date
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose		E	4/1/2014
J1446	Injection, TBO-Filgrastim, 5 micrograms	1477	K	1/1/2014
J7178	Injection, human fibrinogen concentrate, 1 mg	1478	K	1/1/2014
Q0181	Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as		N	1/1/2014

d. Updated payment rate for Q4127 effective April 1, 2013, through June 30, 2013

The payment rate for Q4127 was incorrect in the April 2013 OPPS Pricer. The corrected payment rate is listed in Table 4 below, and it has been installed in the April 2014 OPPS Pricer, effective for services furnished on April 1, 2013, through June 30, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 4 – Updated payment rates for certain HCPCS codes effective April 1, 2013 through June 30, 2013

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
Q4127	G	1449	Talymed	$13.78	$2.76

e. Updated payment rate for Q4127 effective July 1, 2013, through September 30, 2013

The payment rate for Q4127 was incorrect in the July 2013 OPPS Pricer. The corrected payment rate is listed in Table 5 below, and it has been installed in the April 2014 OPPS Pricer, effective for services furnished on July 1, 2013, through September 30, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 5 – Updated payment rates for certain HCPCS codes effective July 1, 2013, through September 30, 2013

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
Q4127	G	1449	Talymed	$13.78	$2.76

f. Updated payment rates for certain HCPCS codes effective October 1, 2013 through December 1, 2013

The payment rates for three HCPCS codes were incorrect in the October 2013 OPPS Pricer. The corrected payment rates are listed in Table 6 below, and they have been installed in the April 2014 OPPS Pricer, effective for

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services furnished on October 1, 2013, through December 31, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 6 – Updated payment rates for certain HCPCS codes effective October 1, 2013, through December 31, 2013

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
A9600	K	0701	Sr89 strontium	$1,196.47	$239.29
J2323	K	9126	Natalizumab injection	$12.99	$2.60
Q4127	G	1449	Talymed	$13.78	$2.76

g. Reassignment of skin substitute products that are new for 2014 from the low cost group to the high cost group

In the 2014 OPPS/ASC final rule, CMS finalized a policy to package payment for skin substitute products into the associated skin substitute application procedure. You can review the 2014 OPPS/ASC final rule at *http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf* on the Internet. For packaging purposes, CMS created two groups of application procedures: application procedures that use high cost skin substitute products (billed using *Current Procedural Terminology*® (*CPT*®) codes *15271-15278*) and application procedures that use low cost skin substitute products (billed using HCPCS codes C5271-C5278).

Assignment of skin substitute products to the high cost or low cost groups depended upon a comparison of the July 2013 payment rate for the skin substitute product to $32, which is the weighted average payment per unit for all skin substitute products using the skin substitute utilization from the 2012 claims data and the July 2013 payment rate for each product.

Skin substitute products with a July 2013 payment rate that was above $32 per square centimeter are paid through the high cost group and those with a July 2013 payment rate that was at or below $32 per square centimeter are paid through the low cost group for 2014. As a reminder, for 2015, CMS will follow the usual policy with regard to the specific quarterly ASP data sets used for proposed and final rule-making in that CMS will use April 2014 ASP data to establish the proposed rule low/high cost threshold, and CMS will use July 2014 ASP data to establish the final low/high cost threshold for 2015.

CMS also finalized a policy that for any new skin substitute products approved for payment during 2014, CMS will use the $32 per square centimeter threshold to determine mapping to the high or low cost skin substitute group. Any new skin substitute products without pricing information were assigned to the low cost category until pricing information becomes available.

There were nine new skin substitute products that were effective January 1, 2014, and that were assigned to the low cost payment group because pricing information was not available for these products at the time of the January 2014 update. There is now pricing information available for three of these nine products. Table 7 below, shows the three new products and their low/high cost status based on the comparison of the price per square centimeter for each product to the $32 square centimeter threshold for 2014.

Table 7– Updated payment rates for certain HCPCS codes effective April 1, 2014

HCPCS code	Long descriptor	Status indicator	Low/high cost status
Q4143	Repriza, per square centimeter	N	Low
Q4147	Architect extracellular matrix, per square centimeter	N	High
Q4148	Neox 1k, per square centimeter	N	High

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h. Billing guidance for the topical application of Mitomycin during or following ophthalmic surgery

Hospital outpatient departments should only bill HCPCS code J7315 (Mitomycin, ophthalmic, 0.2 mg) or HCPCS code J3490 (unclassified drugs) for the topical application of mitomycin during or following ophthalmic surgery. J7315 may be reported only if the hospital uses mitomycin with the trade name Mitosol®. Any other topical mitomycin should be reported with J3490. Hospital outpatient departments are not permitted to bill HCPCS code J9280 (Injection, mitomycin, 5 mg) for the topical application of mitomycin.

New HCPCS code effective April 1, 2014

One new HCPCS code has been created for reporting services, supplies, and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration. This code is listed in Table 8 below, and it is effective for services furnished on or after April 1, 2014.

Table 8 – New HCPCS codes effective April 1, 2014

HCPCS code	Long descriptor	Short descriptor	Status indicator effective 4/1/14
Q2052	Services, supplies and accessories used in the home under the Medicare intravenous immune globulin (ivig) demonstration	Ivig demo, services/supplies	N

Changes to OPPS pricer logic

Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), a device offset cap will be applied to the applicable procedure line based on the credit amount listed in the “FD” (Credit received from the manufacturer for a replaced medical device) value code. The credit amount in value code “FD,” which reduces the post wage-adjusted APC line payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs, along with the offsets for other APCs, is available under the “Annual Policy Files” link on the left column *at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*.

Coverage determinations

The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program.

MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

Additional information

The official instruction, CR 8653 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2903CP.pdf.*

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

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2014 hospital outpatient clinical lab test payment and billing update

Provider types affected

This *MLN Matters*® special edition article is intended for outpatient prospective payment system (OPPS) providers submitting claims to Medicare A/B Medicare administrative contractors (MACs) for outpatient clinical diagnostic laboratory services to Medicare beneficiaries.

What you need to know

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

Background

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

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

(1) Non-patient (referred) specimen;

(2) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or

(3) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.

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

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

To alleviate this concern, for 2014, a new modifier will be used on the 013x TOB (instead of the 014X TOB) when non-referred lab tests are eligible for separate payment under the CLFS for exceptions (2) and (3) listed in the column on the left. The 014x will only be used for non-patient (meaning referred) laboratory specimens (exception 1 above) and will not include this new modifier.

The new modifier will be effective for claims received on or after July 1, 2014, and retroactive for dates of service on or after January 1, 2014. Please note that CMS views this new modifier as an immediate solution to hospitals' concern for 2014 and that we may evaluate better means to bill for laboratory services next year.

Additionally to alleviate concerns on what hospitals can do in the interim period until the new modifier is implemented on July 1, 2014, CMS, at the request of the NUBC, will continue to allow providers to utilize the 014x TOB during this interim period when a hospital seeks separate payment under any of the three exceptions listed above, as per the 2014 OPPS final rule. This will allow time for providers to make necessary system adjustments without having to hold claims until the July implementation.

It will continue to be the hospital's responsibility to determine when laboratory tests qualify to receive separate payment. Starting with claims received July 1, 2014, and after, when a hospital appends the new modifier to a laboratory service, the provider is attesting that exception (2) or (3) listed above is met.

The requirement for all OPPS services to be submitted on a single 13x claim (other than recurring services) continues to apply. In addition, laboratory tests for molecular pathology tests described by *Current Procedural Terminology* (*CPT*®) codes in the ranges of *81200* through *81383*, *81400* through *81408*, and *81479* are not packaged in the OPPS and do not require the new modifier.

Note: Under the 2014 OPPS final rule, it is optional for OPPS hospitals to seek separate payment under the CLFS for a given outpatient lab test. To minimize administrative burden, OPPS hospitals are not required to distinguish related and unrelated outpatient lab tests, and may bill "unrelated" outpatient labs on

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the 013x TOB prior to July 1, 2014, or on the 013x TOB without the new modifier on or after July 1, 2014, to receive packaged payment under the OPPS. Hospitals are not required to reprocess any previously submitted claims.

The table below summarizes the billing discussed above.

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

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

Sole community hospitals (SCHs)

SCHs are paid under the OPPS. Therefore, the new OPPS packaging policies apply to SCHs as to other OPPS hospitals for laboratory and other services furnished on or after January 1, 2014.

However, SCHs with qualified laboratories continue to be eligible for the 62 percent CLFS payment amount described in the *Medicare Claims Processing Manual* (Publication. 100-04 Chapter 16, Section 40.3) when they furnish outpatient lab tests that are separately payable under exceptions (2) or (3) listed above. The 014x TOB does not provide differential CLFS payment rates for SCHs with qualified laboratories and other OPPS hospitals.

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

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

Billing scenarios for the new modifier (on or after July 1, 2014):

1) A patient goes to hospital and the hospital only collects the specimen and furnishes only laboratory services on that date of service. No other services are rendered on this date of service. It is generally appropriate to append the new modifier to the laboratory services (see example 2).

2) A beneficiary has a pre-surgery exam in a provider-based clinic for an outpatient cataract surgery that is scheduled in two weeks with the ophthalmologist. On the same day, while at the hospital the beneficiary goes to the hospital lab to have blood drawn for long-term psychiatric medication monitoring, by order of a community psychiatrist. In this situation, the hospital can use the new modifier to bill Medicare for separate payment under the CLFS of the lab test to monitor the patient's psychiatric medication level. However, any lab tests run by the hospital lab that day upon the order of the ophthalmologist or another physician in the ophthalmologist's group practice in preparation for the cataract surgery cannot be billed for separate payment.

3) The beneficiary in example 2 goes to the hospital lab to have blood drawn for long-term psychiatric medication monitoring, by order of a community

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psychiatrist, and has no other hospital services that day. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS of the lab test to monitor the patient's psychiatric medication level.

4) The beneficiary in example 2 has the pre-surgery exam in the ophthalmologist's free-standing physician office. The ophthalmologist refers the beneficiary to the hospital lab located across the street for diagnostic lab tests in preparation for the upcoming outpatient surgery. The beneficiary has to immediately return to work and chooses to have the lab work done at the hospital 2 days later. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS.

5) The beneficiary in example 3 goes to the hospital lab the same day to have the pre-surgical labs drawn. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS.

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

Additional information

The read the related article, CR 8572 go to *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8572.pdf*

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

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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.

Inpatient prospective payment system (IPPS) hospital extensions per the pathway for SGR Reform Act of 2013

Provider types affected

This *MLN Matters*® article is intended for hospitals that submit claims to Medicare claims administration contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8627 which provides information and implementation instructions for Sections 1105 and 1106 of the Pathway for SGR (Medicare sustainable growth rate) Reform Act of 2013. Make sure your billing staffs are aware of these changes.

Background

On December 26, 2013, the President signed into law the Pathway for "SGR (Medicare sustainable growth rate) Reform Act of 2013," and the new law includes the extension of certain provisions of the Affordable Care Act. Specifically, the following Medicare fee-for-service (FFS) policies have been extended through March 31, 2014:

- Section 1105 - Extension of Medicare inpatient hospital payment adjustment for low-volume hospitals
- The Affordable Care Act provided for temporary changes to the low-volume hospital adjustment for fiscal years (FY) 2011 and 2012. To qualify, the hospital must have less than 1,600 Medicare discharges, and be 15 miles or greater from the nearest like hospital.
- The temporary changes to the low-volume hospital adjustment were extended for FY 2013 by the American Taxpayer Relief Act (ATRA). This provision extends those temporary changes to the payment adjustment through March 31, 2014, retroactive to October 1, 2013.
- Section 1106 - Extension of the Medicare-dependent hospital (MDH) program

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until March 31, 2014, and it is retroactive to October 1, 2013.

Low-volume hospitals – criteria and payment adjustments for FY 2014

The Affordable Care Act (Sections 3125 and 10314)

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amended the low-volume hospital adjustment in the Social Security Act (Section 1886(d)(12); see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*) by revising, for FYs 2011 and 2012, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment.

These amendments were extended for FY 2013 by Section 605 of the ATRA. Prior to the recently enacted Pathway for SGR Reform Act of 2013, beginning with FY 2014, the low-volume hospital qualifying criteria and payment adjustment had returned to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act and the ATRA.

The Pathway for SGR Reform Act of 2013 (Section 1105) extends, for FY 2014 discharges occurring before April 1, 2014, the temporary changes in the low-volume hospital payment policy provided for by the Affordable Care Act, as amended by the ATRA. The Centers for Medicare & Medicaid Services (CMS) implemented the changes to the low-volume payment adjustment provided by the Affordable Care Act and the ATRA in:

- The regulations at 42 CFR 412.101 in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50238 through 50275; see *http://www.gpo.gov/fdsys/pkg/FR-2010-08-16/html/2010-19092.htm*), and
- The FY 2014 IPPS/LTCH PPS final rule (78 FR 50611 through 50613; see *http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm*).

You can review 42 CFR 412.101 at *http://www.ecfr.gov/cgi-bin/text-idx?SID=c2e502868ec2817574e80c0791868945&node=42:2.0.1.2.12.7.50.6&rgn=div8*.

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2014 discharges occurring before April 1, 2014, provided for by the Pathway for SGR Reform Act of 2013 (Section 1105), in accordance with the existing regulations at 42 CFR 412.101(b)(2)(ii) and consistent with the CMS implementation of the low-volume hospital payment adjustment in FYs 2011 through 2013, CMS published an interim final rule with comment (IFC) in the *Federal Register* (CMS-1599-IFC2) updating the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) for FY 2014 discharges that occur before April 1, 2014. CMS-1599-IFC2 is available at *http://www.ofr.gov/OFRUpload/OFRData/2014-05922_PI.pdf* on the Internet.

In that IFC, CMS established for FY 2014 discharges occurring before April 1, 2014, the low-volume payment adjustment will be determined using FY 2012 Medicare discharge data from the March 2013 update of the MedPAR files. In Table 14 of the Addendum of

the IFC, CMS provides a list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files.

This list of IPPS hospitals with fewer than 1,600 Medicare discharges is not a listing of the hospitals that qualify for the low-volume adjustment for FY 2014 discharges occurring before April 1, 2014, since it does not reflect whether or not the hospital meets the mileage criterion (that is, to qualify for the low-volume adjustment, the hospital must also be located more than 15 road miles from any other IPPS hospital).

In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2014 discharges occurring before April 1, 2014, a hospital must meet both the discharge and mileage criteria

In order to receive a low-volume hospital payment adjustment for FY 2014 discharges occurring before April 1, 2014, consistent with the previously established procedure, CMS is continuing to require a hospital to notify and provide documentation to its MAC that it meets the mileage criterion.

Specifically, a hospital must make its request for low-volume hospital status in writing to its MAC and provide documentation that it meets the mileage criterion, so that the applicable low-volume percentage increase is applied to payments for its discharges occurring on or after October 1, 2013 (that is, the beginning of FY 2014).

The MAC must be in receipt of the hospital's written request by March 31, 2014, in order for the effective date of the hospital's low status to be October 1, 2013. A hospital that qualified for the low-volume payment adjustment in FY 2013 may continue to receive a low-volume payment adjustment for FY 2014 discharges occurring before April 1, 2014, without reapplying, if it continues to meet the Medicare discharge criterion, based on the FY 2012 MedPAR data (shown in Table 14 of the IFC and the distance criterion. The hospital must verify in writing to its MAC that it continues to be more than 15 miles from any other "subsection (d)"

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hospital no later than March 31, 2014.

For requests for low-volume hospital status for FY 2014 discharges occurring before April 1, 2014, received after March 31, 2014, if the hospital meets the criteria to qualify as a low-volume hospital, the MAC will establish a low-volume hospital status effective date that would be applicable prospectively within 30 days of the date of the MAC's low-volume status determination, consistent with historical CMS policy.

However, given the timing of this partial year extension of the temporary changes to the low-volume hospital payment adjustment, which expires March 31, 2014, any applicable low-volume payment adjustment will not be applied in determining payments to the hospital' s FY 2014 discharges occurring before April 1, 2014, since CMS policy does not provide for retroactive effective dates.

However, in case of a future subsequent extension, the MAC should process those requests and send a letter to the hospital indicating that although the provider meets the low-volume hospital criteria for FY 2014 set forth at 412.101(b)(2)(ii), those provisions are expired under current law. In the event the temporary changes to the low-volume hospital payment adjustment are subsequently extended, then the MAC can establish the effective date as 30 days from the date of the letter.

MACs will verify that the hospital meets the discharge criteria by using the Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files as shown in Table 14 of the IFC (CMS-1599-IFC2) and available on the Acute Inpatient PPS Web page at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp*. (click on the link on the left side of the screen titled, "FY 2014 IPPS Final Rule Home Page").

CMS notes that in order to facilitate administrative implementation, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume payment adjustment for FY 2014 discharges occurring before April 1, 2014, is the data from the March 2013 update of the FY 2012 MedPAR file.

In order to implement this policy for FY 2014, the Pricer will include a table containing the provider number and discharge count determined from the March 2013 update of the FY 2012 MedPAR file.

The discharge count includes any billed Medicare Advantage claims in the MedPAR file but excludes any claims serviced in non-IPPS units. The table in Pricer includes IPPS providers with fewer than 1,600 Medicare discharges but does not consider whether the IPPS hospital meets the mileage criterion (that is, located more than 15 road miles from the nearest IPPS hospital).

The applicable low-volume payment adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, disproportionate share hospital (DSH), uncompensated care, IME and outliers. For sole-community hospitals (SCHs) and Medicare dependent hospitals (MDHs), the applicable low-volume percentage increase is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Reinstatement of Medicare dependent hospital (MDH) status

Under the Affordable Care Act (Section 3124), the MDH program authorized by the Social Security Act (Section 1886(d)(5)(G); see the end of FY 2012. These provisions were extended for FY 2013 by Section 606 of the ATRA.

Prior to the recently enacted Pathway for SGR Reform Act of 2013, the MDH program was set to expire at the end of FY 2013. As part of the Pathway for SGR Reform Act of 2013, Congress provided for a temporary reinstatement of the MDH program which had expired as of October 1, 2013.

The Pathway for SGR Reform Act of 2013 (Section 1106) extends the MDH program through March 31, 2014. CMS implemented the extension of the MDH program provided by the Affordable Care Act and the ATRA in the regulations at 42 CFR 412.108 in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50287) and the FY 2014 IPPS/LTCH PPS final rule (78 FR 50647 through 50649), respectively.

Consistent with the CMS implementation of the MDH program extension in FY 2013, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective October 1, 2013, with no need to reapply for MDH classification. There are two exceptions:

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a. MDHs that classified as SCHs on or after October 1, 2013

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by August 31, 2013, to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification received SCH status as of October 1, 2013.

Additionally, some hospitals that had MDH status as of the September 30, 2013, expiration of the MDH program may have missed the August 31, 2013 application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than October 1, 2013.

b. MDHs that requested a cancellation of their rural classification under 42 CFR 412.103(b)

In order to meet the criteria to become an MDH, a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at 42 CFR 412.103 (see *http://www.ecfr.gov/cgi-bin/text-idx?SID=c2e502868ec2817574e80c0791868945&node=42:2.0.1.2.12.7.50.8&rgn=div8*). With the expiration of the MDH program, some of these providers may have requested a cancellation of their rural classification.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to October 1, 2013.

All other former MDHs will be automatically reinstated as MDHs effective October 1, 2013. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). Specifically, the regulations at 42 CFR 412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (42 CFR §412.108(b)(2)).
2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (42 CFR §412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital (42 CFR §412.108(b)(4)).

CMS notes, given the timing of this partial year extension of the MDH program, the current regulations governing the cancellation of SCH status 412.92(b)(4), the request for rural reclassification under 412.103, and the effective date of MDH classification at 412.108(b) may not allow for sufficient time for hospitals that have reclassified as SCHs or canceled their rural status in anticipation of the expiration of the MDH program to cancel their SCH status or request rural reclassification and then reapply and be approved for MDH status. These regulations may not allow for sufficient time for a hospital seeking to classify as an MDH to be approved prior to the March 31, 2014 expiration of the MDH program.

Cancellation of MDH status

As required by the regulations at 42 CFR 412.108(b)(5), MACs must "evaluate on an ongoing basis" whether or not a hospital continues to qualify for MDH status. Therefore, as required by the regulations at 42 CFR 412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at 42 CFR 412.108(a) and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the MAC provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2013, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

Attachment 1 of CR 8627 outlines the various possible actions to be followed for each former MDH and the corresponding examples for each scenario. CR 8627 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1347OTN.pdf*.

Notification to provider

Each MAC will notify each affected provider with information specific to that provider regarding how it is affected by the MDH program extension by notifying the provider of its status under the extension of the MDH program. The status of each former MDH will either be:

- MDH status reinstated effective October 1, 2013; or
- MDH status not reinstated; additional action required by the provider in order to be classified as an MDH.
- The provider must request a cancellation of SCH status or submit a request for rural classification under 42 CFR 412.103 (see *http://www.ecfr.gov/cgi-bin/text-idx?SID=c2e502868ec2817574e80c0791868945&node=42:2.0.1.2.12.7.50.8&rgn=div8*).

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Clarification of patient discharge status codes and transfer policies

Note: This article was revised March 6, 2014, to remove the reference to SE1411. SE1411 is being revised and will be reposted at a later date. It was previously published in the February 2008 edition of Medicare A Connection, Pages 32-37. All other information is the same.

Provider types affected

Providers billing Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs).

Provider action needed

Stop – impact to you

This special edition article is based on information from the Centers for Medicare & Medicaid Services (CMS) regulations and transmittals and the *National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2008* (Version 2.00 July 2007) Section Form Locator 17 (Patient Discharge Status) Effective Date: March 1, 2007 copyrighted by the American Hospital Association (AHA); NUBC UB-04 version 2.00 Clarifications and Errata (as of 8/22/07). It provides clarifications and instructions on determining the correct patient discharge status code to use when completing your claims.

Important: The NUBC is responsible for the maintenance and dissemination of guidance for the UB-04 code set. The CMS has provided a subset of information below for Medicare-participating providers. For greater detail, providers should visit *http://www.nubc.org/* in order to purchase a UB-04 manual.

Caution – What you need to know

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter or at the end time of a billing cycle. It belongs in Form Locator 17 on a UB-04 claim form or its electronic equivalent in the HIPAA compliant 837 format.

Go – What you need to do

See the *Background* section of this article for more details regarding instructions and clarifications for patient discharge status coding.

Background

This special edition article is being provided to help you determine the right discharge status code to use with your claims. Assigning the correct patient discharge status code is just as important as any

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- The provider will then have to reapply for MDH status in accordance with the regulations under 42 CFR 412.108(b).
- MDH status reinstated and then subsequently cancelled due to the provider not continuing to meet the criteria for MDH classification under the requirements at 42 CFR §412.108(b)(5).

Additional information

The official instruction, CR 8627 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1347OTN.pdf.*

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

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other coding used when filing a claim and the same processes should be applied for patient discharge status codes as with any other coding.

Choosing the patient discharge status code correctly avoids claim errors and helps you receive payment for your claim sooner.

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter (this could be a visit or an actual inpatient stay) or at the time end of a billing cycle (the 'through' date of a claim). CMS requires patient discharge status codes for:

- Hospital inpatient claims (type of bills (TOBs) 11x and 12x);
- Skilled nursing claims (TOBs 18x, 21x, 22x and 23x);
- Outpatient hospital services (TOBs 13x, 14x, 71x, 73x, 74x, 75x, 76x and 85x); and
- All hospice and home health claims (TOBs 32x, 33x, 34x, 81x and 82x).

It is important to select the correct patient discharge status code, and in cases in which two or more patient discharge status codes apply, you should code the highest level of care known. Omitting a code or submitting a claim with an incorrect code is a claim billing error and could result in your claim being rejected or your claim being cancelled and payment being taken back. Applying the correct code will help assure that you receive prompt and correct payment.

Identifying the appropriate patient discharge status code can sometimes be confusing, so be sure to read the frequently asked questions (FAQ) section at the end of this article for further guidance.

Patient discharge status codes and their appropriate use

The following describes patient discharge status codes and provides details regarding their appropriate use:

01- Discharge to home or self care (routine discharge)

This code includes discharge to home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

02 - Discharged/transferred to a short-term general hospital for inpatient care

This patient discharge status code should be used when the patient is discharged or transferred to a

short-term acute care hospital. Discharges or transfers to long-term care hospitals should be coded with patient discharge status Code 63.

03 - Discharged/transferred to a skilled nursing facility (snf) with medicare certification in anticipation of skilled care.

This code indicates that the patient is discharged/transferred to a Medicare certified nursing facility in anticipation of skilled care. For hospitals with an approved swing bed arrangement, use code 61- swing bed.

This code should be used regardless of whether or not the patient has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay will be covered by Medicare. For reporting other discharges/transfers to nursing facilities see codes 04 and 64.

Code 03 should not be used if:

- The patient is admitted to a non-Medicare certified area.

04 - Discharged/transferred to an intermediate care facility (ICF)

Patient discharge status code 04 is typically defined at the state level for specifically designated intermediate care facilities. It is also used:

To designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification, or

For discharges/transfers to state designated assisted living facilities.

05 - Discharged/transferred to another type of health care institution not defined elsewhere in this code list

Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of health care institutions.

New definition for patient discharge status code

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05- Effective, per NUBC, on April 1, 2008

05 - Discharged/transferred to a designated cancer center or children's hospital

Usage note: Transfers to non-designated cancer hospitals should use code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at *http://cancercenters.cancer.gov/cancer_centers/cancer-centers-names.html*.

06 - Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care

This code should be reported when a patient is:

- Discharged/transferred to home with a written plan of care for home care services (tailored to the patient's medical needs) -- whether home attendant, nursing aides, certified attendants, etc.
- Discharged/transferred to a foster care facility with home care; and
- Discharged to home under a home health agency with DME.
- This code should not be used for home health services provided by a:
- DME supplier or
- Home IV provider for home IV services.

07 - Left against medical advice or discontinued care

The important thing to remember about this patient discharge status code is that it is to be used when a patient leaves against medical advice or the care is discontinued. According to the NUBC, discontinued services may include:

Patients who leave before triage, or are triaged and leave without being seen by a physician; or

Patients who move without notice, and the home health agency is unable to complete the plan of care.

08 - Reserved for national assignment

This patient discharge status code is reserved for national assignment.

09 - Admitted as an inpatient to this hospital

This code is for use only on Medicare outpatient claims, and it applies only to those Medicare outpatient services that begin greater than three days prior to an admission.

10-19 - Reserved for national assignment

These patient discharge status codes are reserved for national assignment.

20 - Expired

This code is used only when the patient dies.

21-29 - Reserved for national assignment

These patient discharge status codes are reserved for national assignment.

30 - Still patient or expected to return for outpatient services

This code is used when the patient is still within the same facility and is typically used when billing for leave of absence days or interim bills. It can be used for both inpatient or outpatient claims,

It is used for inpatient claims when billing for leave of absence days or interim billing (i.e., the length of stay is longer than 60 days).

On outpatient claims, the primary method to identify that the patient is still receiving care is the bill type frequency code (e.g., Frequency Code 3: Interim - Continuing Claim).

31-39 - Reserved for national assignment

These patient discharge status codes are reserved for national assignment.

Hospice patient discharge status codes - hospice claims only (TOBs: 81x & 82x)

The following patient discharge status codes should only be used when submitting hospice claims:

- 40 - Expired at home; This code is for use only on Medicare and TRICARE claims for hospice care.
- 41 - Expired in a medical facility, such as a hospital, skilled nursing facility (SNF), intermediate care facility (ICF), or free-standing hospice; and
- 42 - Expired - place unknown; This code is for use only on Medicare and TRICARE claims for hospice care

43 - Discharged/transferred to a federal hospital

This code applies to discharges and transfers to a government operated health care facility including:

- Department of Defense hospitals;
- Veteran's Administration hospitals; or
- Veteran's Administration nursing facilities.

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This patient discharge status code should be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.

The NUBC has also clarified that this code should also be used when a patient is transferred to an inpatient psychiatric unit of a Veterans Administration (VA) hospital.

44-49 Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

50 and 51 - Discharged/transferred to a hospice

These two patient discharge status codes are used to identify when a patient is discharged or transferred to hospice care.

The level of care that will be provided by the hospice upon discharge is essential to determining the proper code to use. NUBC clarified the following hospice levels of care:

- Routine or continuous home care. Patient discharge status code "50: Hospice home" should be used if the patient went to his/her own home or an alternative setting that is the patient's "home," such as a nursing facility, and will receive in-home hospice services.
- General inpatient care. Patient discharge status code "51 Hospice medical facility" should be used if the patient went to an inpatient facility that is qualified and the patient is to receive the general inpatient hospice level of care.
- Inpatient respite. Patient discharge status code "51 Hospice medical facility" should be used if the patient went to a facility that is qualified and the patient is receiving hospice inpatient respite level of care. Unless a patient has already been admitted to/accepted by a hospice, level of care cannot be determined.

  Therefore, it is recommended that, if a patient is going home or to an institutional setting with a hospice "referral only," (without having already been accepted for hospice care by a hospice organization) the patient discharge status code should simply reflect the site to which the patient was discharged, not hospice **(i.e. 01: home or self care, or 04**: an intermediate care nursing facility, assuming it is not a Medicare SNF admission).

Additional guidance on use of patient discharge status code 50 or 51:

- Patient discharge status code 50 should be used if the patient went to his/her own home or an alternative setting that is the patient's "home,"

such as a nursing facility, and will receive in-home hospice services.

- Patient discharge status code 51 should be used when a patient is:
- Discharged from acute hospital care but remains at the same hospital under hospice care,
- Transferred from an inpatient acute care hospital to a Medicare-certified SNF under the following conditions:
  - The patient has elected the hospice benefit and will be receiving hospice care under arrangement with a hospice organization; the patient is receiving residential care only.
  - The patient does not qualify for skilled level of care outside the hospice benefit for conditions unrelated to the terminal illness.
  - Admitted from home (a private residence) to an acute setting. Upon discharge, the patient is transferred as a new nursing home placement to a designated hospice unit/bed.

52-60 - Reserved for national assignment

These patient discharge status codes are reserved for national assignment.

61 - Discharged/transferred to a hospital-based Medicare approved swing bed

This code is used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.

When a patient is discharged from an acute hospital to a critical access hospital (CAH) swing bed, use patient discharge status code 61. Swing beds are not part of the post acute care transfer policy

62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital

Inpatient rehabilitation facilities (or designated units) are those facilities that meet a specific requirement

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that 75 percent of their patients require intensive rehabilitative services for the treatment of certain medical conditions. This code should be used when a patient is transferred to a facility or designated unit that meets this qualification.

63 - Discharged/transferred to long term care hospitals

This code is for hospitals that meet the Medicare criteria for LTCH certification as follows: Long term care hospitals are facilities that provide acute inpatient care with an average length of stay of 25 days or greater. This code should be used when transferring a patient to a long term care hospital. If you are not sure whether a facility is a long term care hospital or a short term care hospital, you should contact the facility to verify their facility type before assigning a patient discharge status code.

64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

Nursing facilities may elect to certify only a portion of their beds under Medicare, and some nursing facilities choose to certify all of their beds under Medicare. Still others elect not to certify any of their beds under Medicare. When a patient is transferred to a nursing facility that has no Medicare certified beds, this code should be used. If any beds at the facility are Medicare certified, then the provider should use either patient discharge status code 03 or 04, depending on:

- The level of care the patient is receiving; and
- Whether the bed is Medicare certified or not.

65 - Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

This code should be used when a patient is transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.

Note: This code should not be used when a patient is transferred to an inpatient psychiatric unit of a federal hospital (e.g. Veterans Administration Hospitals). In this case, see patient discharge status code 43.

66 - Discharged/transferred to a critical access hospital (CAH)

Patient discharge status code 66 is used to identify a transfer to a critical access hospital (CAH) for inpatient care. Providers will need to establish a process for identifying whether a hospital is paid under the prospective payment system (PPS) or whether the facility is designated as a CAH.

Note: Discharges or transfers to a critical access hospital (CAH) swing bed should still be coded with patient discharge status code 61.

67-69 - Reserved for national assignment

These patient discharge status codes are reserved for national assignment.

New patient discharge status code 70 – Per NUBC, effective April 1, 2008:

70 – Discharged/transferred to another type of health care institution not defined elsewhere in this code list

New patient discharge status code 70 was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for discharges/to dates on or after April 1, 2008. (See code 05)

71-99 - Reserved for national assignment

These patient discharge status codes are reserved for national assignment.

Patient discharge status codes affected by the hospital transfer policies for inpatient PPS and IRF PPS

The IPPS acute to acute transfer policy applies to transfers coded with patient discharge status code 02 and applies to all DRGs and when the length of stay is less than the average length of stay for the DRG.

Under Medicare's post-acute care transfer policy (42 CFR 412.4), a discharge of a hospital inpatient is considered to be a post-acute care transfer when the patient's discharge is assigned to one of the qualifying diagnosis-related groups (DRGs), and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (IPPS) (includes: inpatient rehabilitation facilities, long-term care hospitals, psychiatric hospitals, cancer hospitals and children's hospitals);
- To a skilled nursing facility (not swing beds); and
- To home under a written plan of care for the

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provision of home health services from a home health agency and those services begin within three days after the date of discharge.

Note: A list of the FY 2008 DRGs is available in Table 5 of the IPPS final rule for 2008. That table is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download-Items/CMS1247844.html*.

Based on the above, the IPPS post-acute care transfer policy applies to claims coded with patient discharge status codes 03, 05, 06, 62, 63, and 65.

Inpatient rehabilitation facilities (IRFs) *42 CFR 412.624(f)* The following patient discharge status codes are applicable under the IRF transfer policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

NUBC frequently asked questions and answers

Q: A patient is discharged from our facility (disposition code 01) and is to go to a doctor's appointment the same day. The patient is then admitted to another hospital after seeing the doctor. What disposition code is appropriate, 01 or 02?

A: Based on the information the hospital had at discharge, the patient was discharged to home (01). If your facility was unaware of the planned admission at the second facility, it is likely that you will have to modify/adjust your previously submitted claim to indicate a disposition code 02, which reflects where the patient was later admitted on the same date.

Q: If a facility discharges a patient to a personal care home, which is similar to assisted living facilities, are they most appropriately coded as 01 or 04?

A: If the personal care home is the person's place of residence, even temporarily, use code 01, discharged to home or self-care.

Q: What discharge status code should be used when a patient is sent to another acute care facility for an outpatient procedure later in the day? This occurs when we do not have the equipment to perform the procedure and the intention is that the patient will not be returning to our facility after the procedure.

A: Since this is a discharge to outpatient treatment, and it is expected that the patient will go home afterward, use discharge status 01, discharged to home or self care.

Q: We have a home health agency with DME. Often we find the orders reads "home with walker". We do not see a physician order for home health care nor has there been an assessment documented by the receiving home health nurse. The nursing discharges instructions check "home". Is the Patient discharge status code still 06?

A: No. "home with walker" does not imply a discharge to home under care of organized home health service organization in anticipation of covered skilled care. Accordingly, code 01, discharged to home or self care (routine discharge) would be appropriate.

Q: What is the difference between residential care and assisted living care?

A: In terms of patient discharge status codes, there is no difference. Discharges to residential care and private (non-state designated/supported) assisted living facilities are coded alike (01).

Q: An established nursing home patient (i.e. the nursing home is their permanent residence) is transferred to an acute setting. Upon discharge, they are sent back to the same nursing home with a hospice referral only. What patient discharge status code would be appropriate?

A: If the patient has not made a hospice election, and has a referral only, use code 01, discharged to home.

Q: A patient was discharged to home with home health services. Two days later the patient was readmitted to our hospital. We were notified by the discharge planner of the patient's readmission and the fact that home health services were not started for the patient and the discharge status code needed to be changed to 01. By the time of the discharge planner's notification, we had already submitted the patient's bill with the discharge status code of 06. In this instance what should the correct discharge status code be on this patient?

A: To ensure accurate reimbursement and reporting, send a replacement claim with the correct discharge status code (01).

Q: What status code should be used for a patient transferred to a SNF rehabilitation unit? This unit is within the SNF. Is this considered a transfer to a SNF or to a rehabilitation facility?

A: A rehabilitation unit that is part of a skilled nursing facility is paid under the SNF prospective payment system. Moving a patient from one unit to another

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does not constitute a transfer for billing purposes and should not result in separate claims. If a patient is discharged from an acute inpatient hospital to a Medicare-certified SNF in anticipation of skilled care, use 03. Status code 03 is also used if the patient moves from an acute inpatient hospital to a rehab unit in a SNF.

Q: What is the appropriate patient discharge status code for a patient transferred from an acute care hospital to a nursing facility for a non-skilled/custodial/ residential level of care? For example:

The patient is discharged to a facility that is only certified with skilled beds but the patient does not qualify for a skilled level of care.

The Medicare certified nursing facility is licensed for both skilled and intermediate care beds, and the patient is transferred to intermediate care.

The patient resides at a Medicare certified SNF but only receives non-skilled services.

A: Code 04, discharged/transferred to an intermediate care facility (ICF) would be the appropriate patient status discharge code for all of the examples above.

Q: If a patient is discharged from a hospital based transitional care unit (i.e., skilled nursing unit) to the acute hospital under observation status, what is the discharge status for the TCU claim?

A: Use code 05, discharged/transferred to another type of health care institution not defined elsewhere in this code list.

Q: If a patient is discharged to home for the provision of home health services, but, the continuing care is either 1) not related to the condition or diagnosis for which the individual received inpatient hospital services or 2) is related, but, not provided within the post-discharge window, what is the correct patient status code to use?

A) Code 06 would be the appropriate patient discharge status code. In addition, the provider should append one of the following condition codes, as appropriate, to the claim:

- Condition code 42 – Continuing care not related (i.e. condition or diagnosis) to inpatient admission or;
- Condition code 43 – Continuing care not provided within prescribed post-discharge window.

Q: If a patient is discharged from an acute care hospital and PT/OT is arranged to be done in the home by a rehabilitation agency that is not affiliated with the home health care agency that made the arrangements, what is the appropriate code to use – 01 or 06?

A: If the therapy services are being provided under the home health benefit (e.g. Medicare Part A), use code 06; if the therapy is provided under the outpatient therapy benefit (e.g., Medicare Part B), use code 01.

Q: If a patient is discharged from acute hospital care but remains at the same hospital under hospice care, what status code should be used for the acute stay discharge?

A: Use code 51 Hospice - medical facility

Q: What discharge status code should be used when a patient is discharged to a chemical dependency treatment facility that is not part of a hospital?

A: If the chemical dependency treatment facility is not a psychiatric hospital or psychiatric distinct part unit of a hospital, and the patient is undergoing inpatient/residential treatment, use code 05, discharged/ transferred to another type of health care institution not defined elsewhere in this code list.

(**Note**: The NUBC has approved the establishment of a new code (70) to take effect April 1, 2008, for other types of health care facilities not defined elsewhere in the code list.)

Additional information

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

MLN Matters® Number: SE0801 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

Educational Events

Provider outreach and educational events – May-June 2014

Medicare's 'incident to' and physician signature requirements ACT (A/B)

When: Wednesday, May 14, 2014
Time: 1:30 p.m. -3:00 p.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/267732.asp

Internet-based PECOS class

When: Thursday, June 19
Time: 1 p.m. - 5:00 p.m. ET – Delivery language: English
Type of Event: Face-to-face
Location: Jacksonville, Fl
http://medicare.fcso.com/Events/266996.asp

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*.

MLN Connects™

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

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: February 27, 2014 – *http://go.usa.gov/Bjwz*
- CMS MLN Connects™ Provider eNews: March 6, 2014 – *http://go.usa.gov/KgZY*
- CMS MLN Connects™ Provider eNews: March 13, 2014 – *http://go.usa.gov/K83W*
- CMS MLN Connects™ Provider eNews: March 20, 2014 – *http://go.usa.gov/KEym*
- CMS MLN Connects™ Provider eNews: March 27, 2014 – *http://go.usa.gov/i93y6u5*

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

Contact CMS

The Region 4 office of the Centers for Medicare & Medicaid Services is located in Atlanta. The feedback email address is:

ROATLFM@CMS.HHS.GOV

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 number1-904-361-0407

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