Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers February 2013

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Doctors and patients benefit from electronic health record incentive program

In addition to the financial rewards they are receiving from the federal government, health care providers in Florida, Puerto Rico, and the U.S. Virgin Islands enrolled in the Medicare electronic health record incentive programs are already seeing improvements in the health of their patients.

In 2009, Congress passed and President Obama signed into law the Health Information for Clinical and Economic Health Act of 2009 (HITECH), which established a financial incentive program to encourage health professionals, hospitals, and critical access hospitals to convert patient record keeping from paper systems to computers, or electronic health records (EHR).

The incentive program, administered by the Centers for Medicare & Medicaid Services (CMS), pays cash bonuses to health providers as they implement certified EHR technology in their practices over three stages. To qualify, providers must be enrolled to serve Medicare patients.

While medical providers are getting bonuses for adopting technology, it may be their patients who are receiving bigger benefits. From increases in vaccines to prevent illness to the reduction of drug interactions, patients who see providers using EHRs are enjoying improved health thanks to the adoption of EHRs in their provider's practice.

Quality of care improvements

"The biggest difference is improvement of quality of care. By that, I mean patients are getting their flu vaccines, Tdap, shingles vaccine, pneumonia vaccines, mammograms, DEXA scans and colonoscopies," said Karl Hempel, MD, a physician who practices with Tallahassee Primary Care Associates (TPCA).

Dr. Hempel attributes this level of improvement to one of the "meaningful use" requirements established in the first phase of the EHR incentive program. For medical practices to establish "meaningful use" a percentage of patients must receive a clinical summary of their care. Dr. Hempel refers to his practice's clinical summaries as patient report cards.

"Every patient who comes in regardless of the reason gets a list of any recommended vaccines or procedures on a 'patient report card.' This report card is created by software that mines data in the electronic health records. This would take me 10-20 minutes or longer to look through a paper chart and provide these written recommendations for the patients. The patients needing vaccines receive them before I even enter the room," Dr. Hempel said.

TPCA was one of the first medical practices in Northern Florida enrolling in the Medicare EHR incentive program. In December 2011, the Center for the Advancement of Health

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Articles included in the *Medicare B 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.

About the *Medicare B Connection*

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website *http://medicare.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the Connection

Anyone may view, print, or download the Connection from our provider education website(s). Providers who cannot obtain the Connection from the Internet are required to register with us to receive a complimentary hardcopy.

Distribution of the Connection in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the Connection be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The Connection is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific *CPT*® and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.

In addition to the above, other sections include:

- . **Educational Resources**, and
- **Contact information** for Florida and the U.S. Virgin Islands.

The Medicare B Connection represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44.*

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html*.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (wavier of liability statement on file).

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the Contact Information section of this publication for the address in which to send written appeals requests.

2013 changes for electrophysiologic evaluation and ablation codes

The Centers for Medicare & Medicaid Services has modified the *Medicare Claims Processing Manual*, Chapter 4, Section 10.2.1 to account for coding changes to cardiac electrophysiologic evaluation and ablation codes by the American Medical Association's (AMA's) *CPT*® Editorial Panel. The *CPT*® Editorial Panel deleted *CPT*® codes *93651* and *93652*, effective January 1, 2013, and created new *CPT*® codes *93653, 93654, 93655, 93656*, and *93657*, effective January 1, 2013.

According the AMA's *Current Procedural Terminology*® (*CPT*®) Manual:

In many circumstances, patients with arrhythmias are evaluated and treated at the same encounter. In this situation, a diagnostic electrophysiologic study (EPS) is performed, induced tachycardia(s) are mapped, and on the basis of the diagnostic and mapping information, the tissue is ablated. When reporting the ablation procedure, the EPS may not be reported separately.

In November 2012, the AMA hosted an annual symposium to discuss many of the significant changes to *CPT*® 2013 codes and descriptors, as well as 2013 payment policy and relative value unit (RVU) changes to the Medicare physician payment schedule. One of the topics included changes to intracardiac electrophysiology ablations. The presentation slide that discussed these specific changes is available at *http://www.ama-assn.org/resources/doc/cpt/17-cardiology-brin.pdf*.

First Coast Service Options Inc. does not currently have a local policy related to this specific topic; therefore, claims should be coded based on *CPT*® guidelines. Although, the January 2013 update to the National Correct Coding Initiative supports these coding changes. These coding policies are based on coding conventions defined in the *CPT*® *Manual*.

Guidance for correct claim submission when secondary payers are involved

Provider types affected

This *MLN Matters*® special edition (SE) article is intended for providers, physicians, and suppliers who bill Medicare contractors (Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and carriers (hereafter referred to as Medicare contractors)) for services provided to Medicare beneficiaries.

Provider action needed

To ensure accurate claim submissions and timely payment, providers, physicians, and other suppliers should:

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer for related services.
- Use specific and correct diagnosis codes, especially for accident related claims.

Remember: A properly filed claim prevents Medicare contractors from inappropriately denying claims and expedites the payment process.

Background

Collect full beneficiary health insurance information

It is the responsibility of all Medicare providers, physicians, and other suppliers to identify the correct primary payer by asking their patients or patients' representative questions concerning the beneficiary's Medicare secondary payer (MSP) status. The model hospital admissions questionnaire, published by the Centers for Medicare & Medicaid Services (CMS), may be used as a guide to collect this information from beneficiaries. This tool is available online in the "MSP Manual" in Chapter 3, Section 20.2.1 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf*. Physicians and other suppliers may also use this questionnaire to ensure MSP information is captured for use at the time of billing, so that the appropriate primary payer is billed before Medicare as required by law.

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Guidance *(continued)*

Identify and bill the correct primary payer

Medicare regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items before submitting a claim to Medicare. When another insurer is identified as the primary payer, bill that insurer first. After receiving the primary payer remittance advice, then bill Medicare as the secondary payer, if appropriate. If a patient is seen for multiple services, each service should be billed to the appropriate primary payer.

Accident-related claims

If the beneficiary has an open MSP Liability (L), No-Fault (NF), or Workers' Compensation (WC) record, bill the L, NF, or WC insurer primary for accident-related claims first. **Do not** deny treatment.

To expedite processing and payment, the following steps should be followed:

1. Submit the accident related claim to the L, NF, or WC insurer first. If the insurer denies the claim, then bill Medicare for payment. It is important that you include all necessary MSP payment information, as found on the primary payer's remittance advice (e.g., claim adjustment reason code specifying reason for denial), on the claim sent to Medicare. If the L, NF, or WC insurer did not make payment for the accident related services, Medicare will need this information to process your claim accordingly. **If you follow these procedures, you do not need to wait 120 days to submit your claim to Medicare for payment.**
2. If the beneficiary has both a Group Health Plan (GHP) MSP coverage and L, NF, or WC coverage, you are required to submit a claim to the GHP insurer and the L, NF, or WC insurer before submitting the claim to Medicare. Once you receive the GHP remittance advice, include the GHP information along with the remittance advice information from the L, NF, and WC insurer with your claim to Medicare. If the claim is sent to Medicare without the GHP information, and there is an open GHP MSP record on file, Medicare will deny your claim.
3. In situations where there is no L, NF, or WC accident or injury, but the beneficiary has employer GHP coverage that is primary to Medicare, you must submit the claim to the GHP insurer first before submitting the claim to Medicare for secondary payment.

If you believe a claim was inappropriately denied:

- Ensure that you have submitted a correctly completed claim to the appropriate payer(s).
- Contact your Medicare contractor if you still have reason to believe a claim was denied inappropriately.
- You may need to provide information to your Medicare contractor that demonstrates why the claim was denied inappropriately.

For example, a diagnosis code may have been mistakenly applied to the beneficiary's L, NF, or WC MSP record. Indicate to the Medicare contractor that the service performed is not related to the accident or injury, and Medicare should adjust and pay the claim if it is a Medicare covered and payable service.

Contact the coordination of benefit contractor (COBC) at 1-800-999-1118 if a beneficiary's MSP record needs to be updated.

- The COBC collects, manages, and maintains other insurance coverage for Medicare beneficiaries.
- Providers, physicians, or other suppliers may request an update to an MSP record if they have the appropriate documentation to substantiate the change. The documentation may need to be faxed to the COBC at 734-957-9598, or the beneficiary may need to be on the line to validate the change.
- Please do not call the COBC to adjust claims or about mistaken payments. They will not be able to assist you.

Key points

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer(s) for related services.
- For multiple services, bill each responsible payer(s) separately. Do not combine unrelated services on the same claim to Medicare.

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Guidance *(continued)*

Consequently, if you render treatment to a beneficiary for accident related services and non-accident related services, do not submit both sets of services on the same claim to Medicare. Send separate claims to Medicare: one claim for services related to the accident and another claim for services not related to the accident.

- Providers, physicians, and other suppliers should always use specific diagnosis codes related to the accident or injury. Doing so will promote accurate and timely payments.
- Providers should report directly to the COBC any changes to beneficiary, spouse and/or family member's employment, accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information.

Additional information

- Specific claim-based issues or questions (including claim processing) should be addressed to the Medicare claim processing contractor at their toll-free number found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.
- If you need to report new beneficiary coverage that may be primary to Medicare or have questions regarding MSP status or claims investigation activities, contact the COBC's toll-free lines. For more information on contacting the COBC or the Medicare coordination of benefits process, visit the Medicare Coordination of Benefits Web page at *http://www.cms.gov/Medicare/Coordination-of-Benefits/COBGeneralInformation/index.html*.
- The *Medicare Learning Network*® (MLN®) has a *Medicare Secondary Payer Fact Sheet for Provider, Physician, and Other Supplier Billing Staff* (ICN 006903) at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MSP_Fact_Sheet.pdf*. This fact sheet is designed to provide education on the MSP provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the COBC.

MLN Matters® Number: SE1217
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

Update to claim processing instructions for non-physician practitioners

Note: This article was revised on December 19, 2012, to remove nurse practitioners and clinical nurse specialists from the next to last bullet point under *Background*. That bullet point only applies to physicians assistants (PAs). All other information remains the same. This information was previously published in the December 2012 *Medicare B Connection*, Page 7.

Provider types affected

This *MLN Matters*® article affects non-physician practitioners (NPPs), i.e., physicians assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), clinical psychologists (CPs), and clinical social workers (CSWs) submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8010 deletes and/or corrects obsolete and erroneous billing information in Chapter 12 of the *Medicare Claims Processing Manual* as it relates claim processing instructions for PAs, NPs, CNSs, CPs, and CSWs. Make sure that your billing staffs are aware of these changes.

Background

Key manual revisions/updates conveyed in CR 8010 are as follows:

- NPP assistant-at-surgery services should be billed with the "AS" modifier only.

(continued on next page)

Non-physician *(continued)*

- The health professional shortage area (HPSA) payment modifiers, "QB" and "QU" have been eliminated because they are no longer valid.
- The "AH" modifier for CPs and, the "AJ" modifier for CSWs have been eliminated because they are no longer necessary for identification purposes.
- The correct payment amount for the professional services of PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of what a physician is paid under the Medicare physician fee schedule (MPFS).
- Additionally, the correct payment amount for assistant-at-surgery services furnished by PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of 16 percent of what a physician is paid under the MPFS for surgical services.
- Procedures billed with the assistant-at-surgery physician modifiers 80, 81, 82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the assistant-at-surgery policy. Accordingly, Medicare will pay claims for procedures with these modifiers only if the services of an assistant-at-surgery are authorized.
- Medicare's policies on billing patients in excess of the Medicare allowed amount apply to assistant-at-surgery services.
- When a PA, NP, or CNS furnishes services to a patient during a global surgical period, Medicare contractors shall determine the level of PA, NP, or CNS involvement in furnishing part of the surgeon's global surgical package consistent with their current practice for processing such claims.
- Billing requirements and adjudication of claims requirements for global surgeries are under chapter 12, sections 40.2 and 40.4 of the "Medicare Claims Processing Manual."
- PAs must have their own "nonphysician practitioner" national provider identification (NPI) number. This NPI is used for identification purposes only when billing for PA services, because only an appropriate PA employer or a provider/supplier for whom the PA furnishes services as an independent contractor can bill for PA services.
- Specialty code 97 applies for PAs enrolled in Medicare. NPs enrolling in Medicare use specialty code 50 and CNSs use specialty code 89.

Additional information

The official instruction, CR 8010 issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2610CP.pdf*.

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

MLN Matters® Number: MM8010 *Revised*
Related Change Request (CR) #: CR 8010
Related CR Release Date: December 14, 2012
Effective Date: February 19, 2013
Related CR Transmittal #: R2610CP
Implementation Date: February 19, 2013

Consolidated Billing

Home health consolidated billing codes updated

Provider types affected

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

Provider action needed

This article announces that change request (CR) 8043 is a recurring update notification that provides the annual home health (HH) consolidated billing update, effective January 1, 2013. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key points

Effective January 1, 2013, the following HCPCS code is added to the HH consolidated billing supply code list:

- A4435 - Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each.

In addition, there are three codes on the supply code list for which long descriptions are being modified to remove the words "pad size". They are as follows:

- A6021 Collagen dressing, sterile, size 16 sq. in. or less, each
- A6022 Collagen dressing, sterile, size more than 16 sq. in. but less than or equal to 48 sq. in., each
- A6023 Collagen dressing, sterile, size more than 48 sq. in., each

Additional information

The official instruction, CR 8043, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2527CP.pdf*.

More information on HH consolidated billing is in the *Medicare Claims Processing Manual*, Chapter 10, Section 20, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf*.

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

MLN Matters® Number: MM8043
Related Change Request (CR) #: CR 8043
Related CR Release Date: September 7, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2527CP
Implementation Date: January 7, 2013

Drugs and Biologicals

April 2013 quarterly ASP Medicare Part B drug pricing files and revisions to prior files

Provider types affected

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

What you need to know

Medicare will use the April 2013 quarterly average sale price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 1, 2013, with dates of service April 1, 2013, through June 30, 2013.

Change request (CR) 8161, from which this article is taken, instructs Medicare contractors to implement the April 2013 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January, 2013, October 2012, July 2012, and April 2012 files. Make sure that your staffs are aware of these changes.

Background

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

The following table shows how the quarterly payment files will be applied:

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

Additional information

You can find the official instruction, CR 8161, issued to your FI, carrier, A/B MAC, DME MAC, and RHHI by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2624CP.pdf*.

If you have any questions, please contact your FI, carrier, A/B MAC, DME MAC, or RHHI 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: MM8161
Related Change Request (CR) #: CR 8161
Related CR Release Date: December 28, 2012
Effective Date: April 1, 2013
Related CR Transmittal #: R2624CP
Implementation Date: April 1, 2013

Durable Medical Equipment

2013 DMEPOS jurisdiction list

Provider types affected

This *MLN Matters*® article is intended for suppliers submitting claims to Medicare contractors (durable medical equipment Medicare administrative contractors (DME MACs), carriers, and Part B MACs) for DMEPOS services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8164 to notify suppliers that the spreadsheet containing an updated list of HCPCS codes for DME MAC, carrier, or B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staffs by showing the appropriate Medicare contractor to be billed for HCPCS codes appearing on the spreadsheet. The spreadsheet for the 2013 jurisdiction list is an Excel® spreadsheet and available under the Coding Category at *http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html*.

Note: The 2013 jurisdiction list was published in the January 2013 *Medicare B Connection*, Pages 14-22.

Additional information

You can find the official instruction, CR 8164, issued to your Medicare carrier, DME MAC, or B MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2637CP.pdf*. The Excel® spreadsheet for the 2013 jurisdiction list is also attached to CR 8164.

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

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Implementation Date: February 19, 2013

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CMS announces DMEPOS competitive bidding payment amounts for the round two and national mail-order competitions

The Centers for Medicare & Medicaid Services (CMS) announced the single payment amounts for the round two and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program.

The CMS Office of the Actuary estimates that the program will save the Medicare Part B trust fund $25.7 billion and beneficiaries $17.1 billion between 2013 and 2022. Scheduled to begin July 1, 2013, the pricing program will save Medicare beneficiaries in 91 major metropolitan areas on an average of 45 percent for certain DMEPOS items.

For additional information:

- *Press release*
- *Fact sheet*
- *CMS website*

Source: CMS PERL 201301-06

Payment related to prior authorization for power mobility devices

Provider types affected

This *MLN Matters*® article is intended for Medicare fee-for-service (FFS) physicians/treating practitioners who prescribe power mobility devices (PMDs) for Medicare

beneficiaries who reside in the demonstration states of California, Texas, Florida, Michigan, Illinois, North Carolina, and New York and submit a prior authorization request to DME Medicare administrative contractors for a PMD.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 8056 and outlines the requirements for the PMD demonstration prior authorization initiative.

Caution – what you need to know

If a physician/treating practitioner submits the initial prior authorization request, the physician/treating practitioner is entitled to a G-code (G9156) incentive payment. This incentive payment is for his/her initial prior authorization request for a beneficiary only. Only one G9156 code may be billed per beneficiary per PMD even if the physician/treating practitioner must resubmit the prior authorization request. The $10 incentive payment is issued to the physician/treating practitioner on a quarterly basis by a designated Medicare Payment Contractor that issues the incentive payments for all Medicare contractors.

Go – what you need to do

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

Background

The Centers for Medicare & Medicaid Services (CMS) has the authority under the Social Security Act (Section 1834(a)(15) see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) to develop and periodically update a list of durable medical equipment (DME) items which are subject to prior authorization before claim payment. Under demonstration authority CMS is proposing a three year prior authorization process for PMDs in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on beneficiary addresses, an initiative referred to hereafter as prior authorization. This initiative is designed as a tool to protect the Medicare Trust Fund by deterring fraudulent and abusive billing practices and make the physician or treating practitioner more accountable for the items he or she orders to prevent improper payments.

Under this PMD demonstration the physician/treating practitioner may submit the prior authorization request. If the prior authorization request is submitted by the physician/treating practitioner, the physician/treating practitioner may bill G9156. The physician/treating practitioner is entitled to a quarterly incentive payment of $10 for each G9156 code that meets all eligibility requirements. G9156 is submitted to the Medicare Administrative Contractor (A/B MACs) and/or carriers with the PMD prior authorization number. The $10 incentive payment is issued to the physician/treating practitioner on a quarterly basis.

In submitting the G9156 code, providers must also show a billed amount of $10 or the claim will reject. If the G9156 is submitted with other codes, Medicare will split the claim. Thus, providers should submit the G9156 code on an assigned claim with no other codes.

Additional information

The official instruction, CR 8056, issued to your carrier and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1182OTN.pdf*.

MLN Matters® article SE1231 outlines the parameters for the PMD demonstration project and may be reviewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1231.pdf*.

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

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Related Change Request (CR) #: CR 8056
Related CR Release Date: February 8, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1182OTN
Implementation Date: July 1, 2013

Evaluation and Management

Prepayment edit of evaluation and management (E/M) code *99291*

Recent data analysis pertaining to critical care services has identified that First Coast Service Options (First Coast) is at a high risk for claim payment error. The error is based on potential overutilization and/or abuse of code *99291*, which is defined in the *Current Procedural Terminology*® (*CPT*®) manual as follows:

- Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.

As outlined in the Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.12:

- Critical care is defined as the direct delivery by a physician(s) medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.
- Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.

Critical care services must be medically necessary and reasonable. Services provided that do not meet the requirements for critical care services or services provided for a patient who is not critically ill or injured in accordance with the above definitions and criteria but who happens to be in a critical care, intensive care, or other specialized care unit should be reported using another appropriate evaluation and management (E/M) code (e.g., subsequent hospital care, *CPT*® codes *99231-99233*).

Critical care is usually, but not always, given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care.

Critical care is a time-based service, and for each date and encounter entry, the physician's progress note(s) shall document the total time that critical care services were provided. The duration of critical care services to be reported is the time the physician spent evaluating, providing care and managing the critically ill or injured patient's care. That time must be spent at the immediate bedside or elsewhere on the floor or unit so long as the physician is immediately available to the patient. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

The *CPT*® critical care codes *99291* and *99292* are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. Non-continuous time for medically necessary critical care services may be aggregated. Reporting *CPT*® code *99291* is a prerequisite to reporting *CPT*® code *99292*. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician.

Based on a potential misunderstanding and/or misapplication of the requirements for providing critical care services, data indicates that providers may be billing for critical care based on the location of service rather than according to the patient's condition.

First Coast response

In response to the high risk for payment error, First Coast has implemented two prepayment review edits for claims submitted on or after February 18, 2013, which apply to all providers within First Coast's Florida jurisdiction. Below are summaries of how these edits will be applied:

- A 100 percent prepayment review edit will be applied to critical care services provided outside the following places of service: 21 (hospital), 22 (outpatient hospital), 23 (emergency room).
- A prepayment edit will be applied to all utilization outlier claims identified.

To address the issues identified and corresponding response, First Coast's Provider Outreach and Education (POE) department offered an educational session on February 20, 2013. A recording of this session is available at *http://medicare.fcso.com/Events/160889.asp*.

Expansion of Medicare telehealth services for calendar year 2013

Note: This article was revised **on February 7 and February 13, 2013**, to reflect revised change requests for (CR) 7900 issued on February 6 and February 12, 2013, respectively. The article was revised to show a revised transmittal numbers, release date, and Web address for accessing the CRs. Also, procedure code G0459 was added to the list of Medicare telehealth services for calendar year (CY) 2013 to allow telehealth services previously reported by procedure code 90862 to inpatients to continue to be reported and to change the implementation date to January 25, 2013. This information was previously published in the December 2012 *Medicare B Connection*, Pages 12-14.

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on CR 7900 which updates the list of Medicare telehealth services in the *Medicare Benefit Policy Manual* and the *Medicare Claims Processing Manual*.

Caution – what you need to know

In the CY 2013 physician fee schedule proposed rule with comment period, the Centers for Medicare & Medicaid Services (CMS) is proposing to add eight codes to the list of Medicare distant site telehealth services. Additionally, the 2013 Healthcare Procedural Coding System (HCPCS) update will replace several *Current Procedural Terminology*® (*CPT*®) codes related to psychotherapy services and a number of these services are on the list of approved telehealth services. Therefore, CR 7900 updates the list of approved telehealth services to reflect these code changes and it replaces several *CPT* codes related to psychotherapy services.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation *CPT*® codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners were instructed to bill a new or established patient office/outpatient visit *CPT*® code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits.

CMS has approved the use of a telecommunications system to substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. The conditions of payment for Medicare telehealth services, including qualifying originating sites and the types of telecommunications systems recognized by Medicare, are subject to the provisions of 42 CFR 410.78 (see *http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr410_main_02.tpl*). Payment for these services is subject to the provisions of 42 CFR 414.65 (see *http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl*).

In the calendar year 2013 PFS proposed rule with comment period, CMS is proposing to add eight codes to the list of Medicare distant site telehealth services. Additionally, the 2013 HCPCS update will replace several CPT procedure codes related to psychotherapy services, and a number of these services are on the list of approved telehealth services. The established policy for these telehealth services has not changed.

CMS is proposing to add the eight services contained in the following table to the list of Medicare telehealth services for CY 2013. CR 7900 instructs that the HCPCS codes for these services should be added to the list of Medicare telehealth services:

HCPCS code	Descriptor
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and brief intervention, 15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and intervention greater than 30 minutes

(continued on next page)

Telehealth *(continued)*

HCPCS code	Descriptor
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes.
G0444	Annual depression screening, 15 minutes.
G0445	High-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes.
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes.
G0447	Face-to-face behavioral counseling for obesity, 15 minutes.

CR 7900 also adds relevant policy instructions to the manuals regarding the addition of these codes.

The following *CPT*® codes should be added to the list of telehealth services to replace codes that will be deleted for CY 2013:

- *CPT*® codes *90832, 90833, 90834, 90836, 90837, 90838* to report individual psychotherapy services, reported with *CPT*® codes *90804-90809* prior to CY 2013
- *CPT*® codes *90791, 90792* to report psychiatric diagnostic interview examination, reported with *CPT*® code *90801* prior to CY 2013; and
- HCPCS code G0459 to report telehealth services previously reported by deleted *CPT*® code *90862* when furnished to inpatients. Services furnished to outpatients can be reported with appropriate E/M codes currently on the list of telehealth services.

CR 7900 revises the *Medicare Claims Processing Manual* (Chapter 12, Section 190.3 (List of Medicare Telehealth Services)) and the *Medicare Benefit Policy Manual* (Chapter 15, Section 270.2 (List of Medicare Telehealth Services)) which are included as attachments to CR 7900.

Additional information

Further information regarding telehealth services is available at *http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html*. You can also find information about submitting requests for adding services to the list of Medicare telehealth services at *https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Criteria.html*.

The official instruction, CR 7900, was issued to your FI, carrier, or A/B MAC via two transmittals. The first updates the *Medicare Benefit Policy Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R167BP.pdf*. The second transmittal updates the *Medicare Claims Processing Manual*, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2657CP.pdf*.

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

MLN Matters® Number: MM7900 *Revised*
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Related CR Transmittal #: R167BP and R2657CP
Implementation Date: No later than January 25, 2013

Laboratory/Pathology

HCPCS codes subject to and excluded from CLIA edits

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8162, which informs Medicare contractors about the new Healthcare Common Procedure Coding System (HCPCS) codes for 2013 that are both subject to and excluded from Clinical Laboratory Improvement Amendments (CLIA) edits. The CR also lists the HCPCS codes discontinued as of December 31, 2012.

Make sure that your billing staffs are aware of these CLIA-related changes for 2013 and that you remain current with CLIA certification requirements.

Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Medicare and Medicaid programs only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

The HCPCS codes that are considered a laboratory test under CLIA change each year. Contractors need to be informed about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

Discontinued codes

The following *Current Procedural Terminology*® (*CPT*®) codes were discontinued on December 31, 2012:

CPT®	Description
83890	*Molecular diagnostics; molecular isolation or extraction, each nucleic acid type (i.e., DNA or RNA)*
83891	*Molecular diagnostics; isolation or extraction of highly purified nucleic acid, each nucleic acid type (i.e., DNA or RNA)*
83892	*Molecular diagnostics; enzymatic digestion, each enzyme treatment*
83893	*Molecular diagnostics; dot/slot blot production, each nucleic acid preparation,*
83894	*Molecular diagnostics; separation by gel electrophoresis (e.g., agarose, polyacrylamide), each nucleic acid preparation*
83896	*Molecular diagnostics; nucleic acid probe, each*
83897	*Molecular diagnostics; nucleic acid transfer (e.g., southern, northern), each nucleic acid preparation*
83898	*Molecular diagnostics; amplification, target, each nucleic acid sequence*
83900	*Molecular diagnostics; amplification, target, multiplex, first 2 nucleic acid sequences*
83901	*Molecular diagnostics; amplification, target, multiplex, each additional nucleic acid sequence beyond 2 (list separately in addition to code for primary procedure)*
83902	*Molecular diagnostics; reverse transcription*
83903	*Molecular diagnostics; mutation scanning, by physical properties (e.g., single strand conformational polymorphisms [sscp], heteroduplex, denaturing gradient gel electrophoresis [DGGE], RNA'ASE a), single segment, each*
83904	*Molecular diagnostics; mutation identification by sequencing, single segment, each segment*
83905	*Molecular diagnostics; mutation identification by allele specific transcription, single segment, each segment*
83906	*Molecular diagnostics; mutation identification by allele specific translation, single segment, each segment*

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CLIA *(continued)*

CPT®	Description
83907	*Molecular diagnostics; lysis of cells prior to nucleic acid extraction (e.g., stool specimens, paraffin embedded tissue), each specimen*
83908	*Molecular diagnostics; amplification, signal, each nucleic acid sequence*
83909	*Molecular diagnostics; separation and identification by high resolution technique (e.g., capillary electrophoresis), each nucleic acid preparation*
83912	*Molecular diagnostics; interpretation and report*
83913	*Molecular diagnostics; RNA stabilization*
83914	*Mutation identification by enzymatic ligation or primer extension, single segment, each segment (e.g., oligonucleotide ligation assay [OLA], single base chain extension [SBCE], or allele-specific primer extension [ASPE])*
88384	*Array-based evaluation of multiple molecular probes; 11 through 50 probes*
88385	*Array-based evaluation of multiple molecular probes; 51 through 250 probes*
88386	*Array-based evaluation of multiple molecular probes; 251 through 500 probes*
0030T	*Antiprothrombin (phospholipid cofactor) antibody, each IG class*
0279T	*Cell enumeration using immunologic selection and identification in fluid specimen (e.g., circulating tumor cells in blood)*
0280T	*Cell enumeration using immunologic selection and identification in fluid specimen (e.g., circulating tumor cells in blood); interpretation and report*

New codes for 2013

In 2012, there were 101 new HCPCS codes for molecular pathology (i.e., *81200* through *81408*) that were subject to the CLIA regulations, were not payable by Medicare and were not included in the recurring update notification for 2012 (i.e., CR 7778). For 2013, these 101 molecular HCPCS codes have been placed on the Medicare clinical laboratory fee schedule. The 101 are included in the attachment to CR 8162.

The HCPCS codes listed below are new for 2013 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. The HCPCS codes listed below require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) must not be permitted to be paid for these tests.

The new *Current Procedural Terminology®* (*CPT®*) codes for 2013 are the following:

CPT®	Description
81201	*APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence*
81202	*APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants*
81203	*APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants*
81235	*EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 lrea deletion, L858R, T790M, G719A, G719S, L861Q)*
81252	*GJB2 (gap junction protein, beta 2, 26kDa; Connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence*
81253	*GJB2 (gap junction protein, beta 2, 26kDa; known familial variants*
81254	*GJB6 (gap junction protein, beta 6, 30 kDa, Connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309KB [DEL(GJB6-D13S1830)] and 232KB [DEL(GJB6-D13S1854)])*
81321	*PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis*
81322	*PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant*

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CLIA *(continued)*

CPT®	Description
81323	*PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant*
81324	*PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis*
81325	*PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis*
81326	*PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant*
81479	*Unlisted molecular pathology procedure*
82777	*Galectin-3*
86152	*Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood)*
86153	*Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required*
86711	*JC (John Cunningham) virus*
86828	*Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads; ELISA, flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I and Class II HLA antigens*
86829	*Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I or Class II HLA antigens*
86830	*Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class I*
86831	*Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class II*
86832	*Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); high definition qualitative panel for identification of antibody specificities (eg, individual antigen per bead methodology), HLA Class I*
86833	*Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); high definition qualitative panel for identification of antibody specificities (eg, individual antigen per bead methodology), HLA Class II*
86834	*Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); semi-quantitative panel (eg, titer), HLA Class I*
86835	*Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); semi-quantitative panel (eg, titer), HLA Class II*
87631	*Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 3-5 targets*
87632	*Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 6-11 targets*
87633	*Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 12-25 targets*
87910	*Infectious agent genotype analysis by nucleic acid (DNA or RNA); cytomegalovirus*
87912	*Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis B virus*
88375	*Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session*

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CLIA *(continued)*

Additionally, there were nine new *CPT*® codes for multi-analyte assays with algorithmic analyses (i.e., *81500* through *81512*, and *81599*) in 2013. The testing described by these codes is subject to the CLIA regulations; however, they are not payable by Medicare for CY 2013.

Hence, these nine codes were not included in CR 8162.

Additional information

The official instruction, CR 8162, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2639CP.pdf*.

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

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Implementation Date: April 1, 2013

Medicare Physician Fee Schedule Database

Emergency update to the 2013 Medicare physician fee schedule database

Provider types affected

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

Provider action needed

Payment files were originally issued to contractors based upon the calendar year (CY) 2013 Medicare physician fee schedule (MPFS) final rule, issued on November 1, 2012, and published in the *Federal Register* on November 28, 2012. This article is based on change request (CR) 8143 which informs Medicare contractors about the amendments to payment files to include corrections described in the CY 2013 MPFS final rule correction notice, as well as the statutory changes from the "American Taxpayer Relief Act of 2012", where the zero percent update to the 2013 conversion factor and the non-budget neutral geographic practice cost index (GPCI) work floor extenders will be effective January 1 for CY 2013. Make sure that your billing staffs are aware of these changes.

Background

Some physician work, practice expense, and malpractice relative value units (RVUs) published in the CY 2013 MPFS final rule have been revised to align their values with the CY 2013 MPFS final rule policies. These changes are discussed in the CY 2013 MPFS final rule correction notice and revised RVU values are found in Addendum B and Addendum C of the CY 2013 MPFS final rule correction notice. (These addenda are available as a download at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1590-FC.html*.) In addition to RVU revisions, changes have been made to some Healthcare Common Procedure Coding System (HCPCS) code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2013 MPFS final rule correction notice. Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2013 MPFS final rule correction notice public use data files.

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MPFSDB *(continued)*

Also, per CR 8143, Medicare contractors shall update their systems to add code G0459, "Telehealth inpt pharm mgmt", with an effective date of January 1, 2013, and your contractor was to implement this change no later than January 25, 2013.

Additional information

The official instruction, CR 8143 issued to your FI, carrier, RHHI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2651CP.pdf*.

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

MLN Matters® Number: MM8143
Related Change Request (CR) #: CR 8143
Related CR Release Date: February 1, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2651CP
Implementation Date: No later than January 25, 2013

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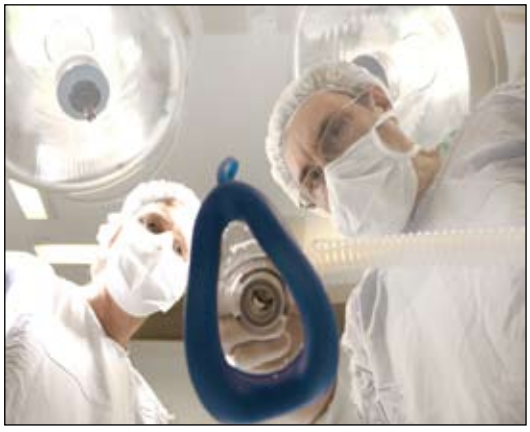
Surgery

Change of address for PTA of the carotid artery concurrent with stenting facility approval and recertification letter submission

Provider types affected

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



Provider action needed

This article is based on change request (CR) 8199, which updates the address identified in the national coverage determination (NCD) to which facilities must send their approval request letters and recertification letters. Make sure that your staffs are aware of this update.

Background

Effective March 17, 2005, facilities wishing to receive Medicare coverage for carotid artery stenting (CAS) procedures performed on patients at high risk for adverse events from carotid endarterectomy (CEA) were required to submit written documentation attesting to meeting the minimum facility standards identified in Section B4 of the NCD for percutaneous transluminal angioplasty (PTA) (See *Medicare National Coverage Determination Manual*, Section 20.7, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf*.) The NCD also requires facilities to submit recertification letters to CMS every two years. CR 8199 serves to update the address identified in the NCD to which the approval request letters and recertification letters must be sent. The address has been changed to:

PTA *(continued)*

Director, Coverage and Analysis Group
7500 Security Boulevard, Mailstop S3-02-01
Baltimore, MD 21244

All other aspects of this NCD remain the same.

Additional information

The official instruction, CR 8199, issued to your FI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R151NCD.pdf*.

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

MLN Matters® Number: MM8199
Related Change Request (CR) #: CR 8199
Related CR Release Date: February 8, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R151NCD
Implementation Date: March 11, 2013

Bariatric surgery for the treatment of morbid obesity NCD and addition of laparoscopic sleeve gastrectomy

Note: This article was revised on January 30, 2013, to reflect the revised change request (CR) 8028 issued on January 29. In the article, the CR release date, implementation date, and transmittal numbers, and Web addresses for accessing the transmittals are revised. All other information remains the same. This information was previously published in the November 2012 *Medicare B Connection*, Pages 19-20.

Provider types affected

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

What you need to know

This article is based on CR 8028, which provides that, effective for claims with dates of service on or after June 27, 2012, Medicare contractors acting within their respective jurisdictions may determine coverage of stand-alone LSG for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions are satisfied:

- The beneficiary has a body-mass index (BMI) ≥ 35 kg/m2
- The beneficiary has at least one co-morbidity related to obesity
- The beneficiary has been previously unsuccessful with medical treatment for obesity

You may bill stand-alone LSG with healthcare common procedure coding system (HCPCS) code *43775* (Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy), which appears on the October 2012 Medicare physician fee schedule update.

Effective for discharges on or after June 27, 2012, inpatient hospital claims may be submitted with stand-alone LSG International Classification of Diseases (ICD-9) procedure code 43.82 (Laparoscopic sleeve gastrectomy covered at contractor's discretion).

Please make sure that your billing staffs are aware of this change.

(continued on next page)

Bariatric *(continued)*

Background

In 2006, the Centers for Medicare & Medicaid Services (CMS) released a final national coverage determination (NCD) on bariatric surgery for the treatment of morbid obesity (see the "NCD Manual," Section 100.1, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part2.pdf*). For Medicare beneficiaries who have a body mass index (BMI) ≥ 35 kg/m2, at least one co-morbidity related to obesity, and who have been previously unsuccessful with medical treatment for obesity, the following procedures were determined to be reasonable and necessary:

- Open and laparoscopic Roux-en-Y Gastric Bypass (RYGBP)
- Laparoscopic Adjustable Gastric Banding (LAGB)
- Open and laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS)

In addition, the NCD stipulates that the above bariatric procedures are to be covered only when performed at facilities that are:

- Certified by the American College of Surgeons (ACS) as a Level 1 Bariatric Surgery Center, or
- Certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE) (Program Standards and requirements in effect on February 15, 2006).

Due to lack of evidence at the time, the 2006 NCD specifically did not cover open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding. In 2009, CMS updated the NCD to include type 2 diabetes mellitus as a co-morbidity.

In September 2011, CMS re-opened the NCD to determine whether new and emerging evidence supported inclusion of LSG as a reasonable and necessary bariatric surgery under Sections 1862 (a)(1)(A) and 1862 (a)(1)(E) of the Social Security Act. Open sleeve gastrectomy was not considered and remains non-covered.

Effective for claims with dates of service on or after June 27, 2012, Medicare contractors acting within their respective jurisdictions may determine coverage of stand-alone LSG for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions are satisfied:

- The beneficiary has a body-mass index (BMI) ≥ 35 kg/m2
- The beneficiary has at least one co-morbidity related to obesity
- The beneficiary has been previously unsuccessful with medical treatment for obesity

Note: Medicare contractors will not search their files to reprocess claims processed prior to implementation of CR 8028. However, upon implementation, the contractors will adjust claims that you bring to their attention.

Additional information

The official instructions regarding this change, CR 8028, was issued to your FI, carrier, or A/B MAC via two transmittals. The first transmittal revises the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R150NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2641CP.pdf*.

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

MLN Matters® Number: MM8028 *Revised*
Related Change Request (CR) #: CR 8028
Related CR Release Date: January 29, 2013
Effective Date: June 27, 2012
Related CR Transmittal #: R150NCD, R2641CP
Implementation Date: February 28, 2013

General Coverage

New IUR will help reduce overpayments caused by incorrect POS billing

Provider types affected

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

What you need to know

The Medicare physician fee schedule includes two payment amounts depending on whether a service is performed in a facility setting, such as an outpatient hospital department or ambulatory surgical center, or in a non-facility setting, such as a physician's office. The payments to physicians are higher when the services are performed in non-facility settings. The higher payments are designed to compensate physicians for the additional costs incurred to provide the service at an office location as opposed to a facility location. In order for the physician to receive the higher non-facility practice expense payment, the service must meet the requirements of 42 CFR 414.22(b)(5)(i)(B).

Background

The Office of Inspector General identified incorrect place of service billing by physicians as a payment error in an audit report (see A-01-11-00508). This report stated, "Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare contractors. The correct place-of-service code ensures that Medicare does not reimburse a physician incorrectly for the overhead portion of the payment if the service was performed in a facility setting." This report also states that several Medicare contractors overpaid physicians who did not correctly identify the place of service on their claims.

To ensure proper payment, CWF will create an IUR for all claims where the dates of service, the beneficiary information, and procedure, are all the same and billed with a physician place of service code 11 - office, and a facility code for inpatient hospital – 21, and ambulatory surgical center (ASC) – 24, that is posted due to an update from CMS. An IUR is a message from CWF to a MAC, carrier or fiscal intermediary, as applicable, to review claims for accuracy.

Additional information

The official instructions, CR 7892, issued to your MAC or carrier regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1170OTN.pdf*.

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

MLN Matters® Number: MM7892
Related Change Request (CR) #: CR 7892
Related CR Release Date: January 31, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1170OTN
Implementation Date: July 1, 2013

Summary of policies in 2013 MPFS final rule and the telehealth originating site facility fee payment amount

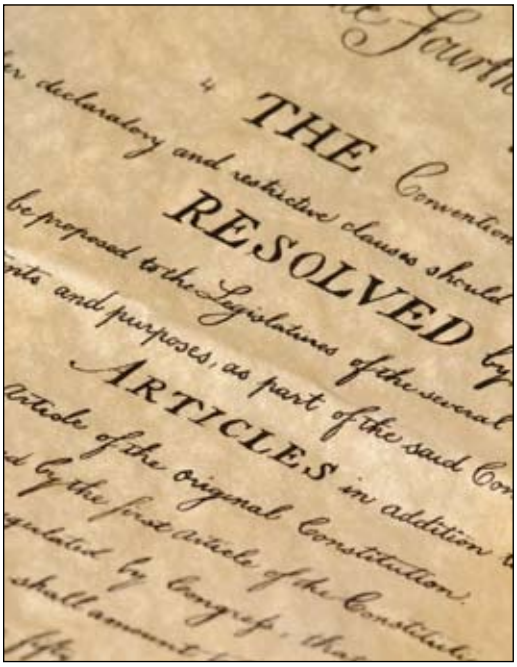
Note: This article was revised on February 7, 2013, to reflect the revised change request (CR) 8191 issued on February 6. The transmittal number, CR release date, Web address for the CR, and the implementation date were revised. All other information remains the same. This information was previously published in the January 2013 *Medicare B Connection*, Pages 43-45.

Provider types affected

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

What you need to know

Change request (CR) 8191, from which this article is taken, summarizes the policies in the calendar year (CY) 2013 Medicare physician fee schedule (MPFS) final rule and announces the telehealth originating site facility fee payment amount. Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians' services for the subsequent year. You should make sure that your staffs are aware of these changes.



Background

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2012, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) who are paid under the MPFS in CY 2013.

The final rule addresses:

- Medicare public comments on payment policies that were originally displayed on July 6, 2012, and published in the *Federal Register* on July 30, 2012: "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013;" and
- Interim final values established in the CY 2013 MPFS final rule with comment period (originally displayed on November 1, 2012, and published in the *Federal Register* on November 16, 2012). It assigns interim final values for new and revised codes for CY 2013; and requests comments on these values, which it will accept until December 31, 2012.

Since publication of the final rule, Congress has averted the statutorily required reduction in Medicare's physician fee schedule through the American Taxpayer Relief Act of 2012. A separate CR addresses revisions required by that legislation.

Summary of policies in the CY 2013 MPFS

1. Payment increases to primary care physicians in 2013

The 2013 MPFS includes a new policy to pay a physician or non-physician practitioner to coordinate a patient's care in the 30 days following a hospital or skilled nursing facility (SNF) stay. CMS believes that recognizing the work of community physicians and practitioners in treating a patient following discharge from a hospital or nursing facility will ensure better continuity of care for these patients, and help reduce patient readmissions.

2. Implementation of the physician value-based payment modifier

The rule's changes in care coordination payment and other changes are expected to increase payment to family practitioners by seven percent and other primary care practitioners between three and five percent.

The 2013 MPFS continues the careful implementation of the physician value-based payment modifier by phasing in application of the modifier and enabling physicians in larger groups to choose how to participate. The value

(continued on next page)

Policies *(continued)*

modifier provides differential Medicare payments to physicians based on a comparison of the quality and cost of care furnished to beneficiaries.

The statute allows CMS to phase in the value modifier over three years, from 2015 to 2017. For 2015, the final rule applies the value modifier to groups of physicians with 100 or more eligible professionals, a change from the proposed rule, which would have set the group size at 25 or above. This change was adopted to gain experience with the methodology and approach before expanding to smaller groups.

The final rule also provides an option for these groups of physicians to choose how the value modifier is calculated based on whether they participate in the Physician Quality Reporting System (PQRS). For physicians and groups of physicians who elect to participate in 2015, common sense incentives will improve the care that beneficiaries receive; physicians with higher quality and lower costs will be paid more, and those with lower quality and higher costs will be paid less. The performance period for the application of the value modifier in CY 2015 was previously established as CY 2013 in the CY 2012 MPFS final rule, which you can find at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*.

3. Aligning quality reporting across programs

The 2013 MPFS continues CMS' efforts to align quality reporting across programs in order to reduce burden and complexity. It makes changes to the PQRS and the Electronic Prescribing (eRx) Incentive Program (the two quality reporting programs applicable to the MPFS) and updates the Medicare Electronic Health Records (EHR) Incentive Pilot Program.

These changes will simplify reporting and align the various programs' quality reporting approaches so they support the National Quality Strategy.

4. Enhancing the Physician Compare website

The 2013 MPFS lays out the next steps to enhance the Physician Compare website, including posting names of practitioners who (as part of the Million Hearts campaign) successfully report measures to prevent heart disease. Please note that these are recommended measures under PQRS as well.

5. Expanding access to services that non-physicians practitioners can provide

The 2013 MPFS expands access to services that can be provided by non-physician practitioners. It allows Medicare to pay: 1) certified registered nurse anesthetists (CRNAs) for providing all services that they are permitted to furnish under state law (i.e. to the full extent of their state scope of practice); and 2) For portable X-rays ordered by nurse practitioners (NPs), physician assistants (PAs) and other non-physician practitioners.

6. Payment for molecular pathology services

The 2013 MPFS explains how Medicare will pay for molecular pathology services—the next innovation of clinical laboratory tests that will foster the development of personalized medicine. These tests will be paid under the clinical laboratory fee schedule (CLFS), with the 2013 payment set by the gap filling method.

7. Face-to-face encounter as a condition of payment for certain items

The 2013 MPFS requires a face-to-face encounter as a condition of payment for certain durable medical equipment (DME) items for orders written on, or after, July 1, 2013.

8. Implementation of a claims-based data collection strategy

Section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) requires CMS to implement a claims-based data collection strategy on January 1, 2013; to gather information on: 1) Beneficiary function and condition, 2) Therapy services furnished, and 3) Outcomes achieved. CMS will use this information to assist in reforming the Medicare payment system for outpatient therapy services.

Details about this data collection can be found in CR 8005. You can find the associated *MLN Matters*® articles, MM8005, "Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services – Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf*.

9. Multiple procedure payment reduction (MPPR)

Also for CY 2013, a multiple procedure payment reduction (MPPR) will apply a 25 percent reduction to the technical component (TC) of the second and subsequent diagnostic cardiovascular service, and a 20 percent reduction to the TC of the second and subsequent diagnostic ophthalmology service; furnished by the same physician (or physicians in the same group practice) to the same beneficiary, on the same day. CR 7848

(continued on next page)

Policies *(continued)*

discusses this 2013 MPPR in full detail, and you can find the associated *MLN Matters*® article: MM7848, "Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7848.pdf*.

10. Telehealth originating site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20. For telehealth services provided on or after January 1 of each subsequent CY, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act.

The MEI increase for 2013 is 0.8 percent. Therefore, for CY 2013, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser, of the actual charge, or $24.43 as described by Healthcare Common Procedure Coding System (HCPCS) code Q3014. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

More information on CY 2013 changes in telehealth can be found in CR 7900. You can review the associated *MLN Matters*® article: MM7900, "Expansion of Medicare Telehealth Services for Calendar Year (CY) 2013," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7900.pdf*.

Additional information

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

The official instruction, CR 8191, issued to your FI, carrier, or A/B MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2653CP.pdf*.

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

MLN Matters® Number: MM8191 *Revised*
Related Change Request (CR) #: CR 8191
Related CR Release Date: February 6, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2653CP
Implementation Date: January 25, 2013

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Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at *http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html.* Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU.

Medicare Remit Easy Print enhancement

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who use Medicare Remit Easy Print (MREP) software.

What you need to know

Change request (CR) 8149, from which this article is taken, instructs the relevant Medicare contractor, Viable Information Processing Systems (ViPS), to add an enhancement to Medicare Remit Easy Print (MREP) software so that it is compatible with additional personal computer operating systems.

Background

The Centers for Medicare & Medicaid Services (CMS) offers free software (Medicare Remit Easy Print (MREP)) to view and print HIPAA-compliant electronic remittance advice (Transaction 835 - Health Care Claim Payment/Advice). CMS believes that making the software compatible with multiple operating systems would make it more acceptable to users and providers/suppliers and help the transition from paper to electronic remittance advice (ERA).

Therefore, as part of the regular software enhancement process (designed to meet the changing needs of providers/suppliers to help you transition to ERA), CR 7218 (published on November 12, 2010) instructed ViPS to make the MREP compatible with Microsoft Windows 7 (32 or 64 bit), Vista (32 or 64 bit), and XP (32 or 64 bit) operating systems. (You can find the related *MLN Matters*® article, MM7218 (Medicare Remit Easy Print (MREP) Enhancement), at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7218.pdf*.)

In response to reports of user issues with MREP, CR 8149, from which this article is taken, instructs ViPS to analyze and resolve (effective July 1, 2013) the finding that a ".NET Framework is required by MREP but is incompatible with Windows 7."

Your carrier, B MAC, or DME MAC will notify you (effective July 1, 2013) of the enhancement in MREP software once the resolutions are implemented.

Additional information

The official instruction, CR 8149, issued to your carrier, B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1163OTN.pdf*.

If you have any questions, please contact your carrier, B MAC, or DME 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: MM8149
Related Change Request (CR) #: CR 8149
Related CR Release Date: January 18, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1163OTN
Implementation Date: July 1, 2013

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EHR *(continued from front page)*

IT named Dr. Hempel a "Meaningful Use Vanguard" for his practice's effort in converting patient records to electronic health records.

What is "meaningful use?"

"Meaningful use" is defined as the extent to which a provider uses electronics records to conduct their clinical practice such as issuing prescriptions or ordering medical tests, tracking patient health status, or submitting clinical quality measures through electronic systems.

"Providing a clinical summary is one of the requirements for meaningful use," says Kenneth Dunn, Meaningful Use Manager for the South Florida Regional Extension Center (SFREC).

"These summaries are helping to improve compliance with taking medication. With the Medicare population, the summaries are also excellent information for family members and care givers to review with patients after they return home."

The SFREC received a grant from the Department of Health and Human Services in 2010 to assist over 3,000 health care providers with adoption of EHRs in their practice.

Mr. Dunn says the process is not complicated as some practices would believe at the outset. "Most meaningful use measures are already being collected. What changes is how the data is being collected. EHR improves the way offices collect and recall patient information eliminating several steps in the process," Dunn said.

Mr. Dunn points to the administrative improvements offices experience once they implement EHRs. "Many practices who implement EHR are eliminating follow up appointment cards by recording the date and time for their next appointment on the clinical summary," he said.

"Physicians are no longer working with the "super bill." They are able to select from the E/M codes within the patient visit. Once the data is collected it's in the system requiring little or no additional administrative steps for billing staff to handle."

While improvements in the quality of care for patients and administrative efficiencies in their offices are getting notice, health care practices are also benefitting in a big way from incentive payments from CMS for converting to electronic health records.

Provider incentive payments

Since January 2011, 180,000 health care providers have received $10.3 billion in payments for participating in the EHR incentive programs. This includes nearly 14 thousand individual providers and 91 hospitals in Florida. Individual health practitioners eligible for the program include physicians, dental practitioners, podiatrists, optometrists and chiropractors. These providers in Puerto Rico and the U.S. Virgin Islands are eligible; however, hospitals in these locations are prohibited from receiving the EHR incentives.

Under rules established by CMS, each eligible health professional (EP) can receive payments of $18,000 this year and up to $44,000 over five years under the Medicare EHR incentive program. Additional cash incentives are available for providers of health services in a health professional shortage area. Eligible providers may still register for the incentive programs and earn up to $39,000 in payments for participation for 2013-2016.

To receive incentive payments in 2013 and avoid pay cuts in 2015, providers must also attest to demonstrated "meaningful use" of certified EHR technology. Beginning in 2015, health professionals enrolled in Medicare who do not successfully demonstrate "meaningful use" of electronic health records in their clinical practice could see Medicare a reduction in payment for services to Medicare beneficiaries.

"The biggest difference, with EHR, is improvement of quality of care."

- Karl Hempel, MD,

Tallahassee Primary Care Associates

For more information about getting started in the incentive program, *click here*.

CMS has also initiated an incentive program for hospitals to implement electronic health records. Hospitals could earn between $2 million and $6 million in payments through 2015. Ninety-one Florida hospitals have received payments through the EHR incentive program. Hospitals in U.S. held territories including Puerto Rico and the U.S. Virgin Islands are not eligible for the incentives.

More information about Medicare electronic health record incentives is available on the First Coast Service Options Inc. website at *http://medicare.fcso.com/EHR/index.asp*.

Sources

- The Centers for Medicare & Medicaid Services - EHR Incentive Program

  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

- Community Health Centers Alliance

  http://www.chcalliance.org/

- South Florida Regional Extension Service

  http://www.southfloridarec.org/

- Tallahassee Primary Care Associates

  http://www.tallahasseeprimarycare.com/

Standard operating rules for code usage in remittance advice

Provider types affected

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

What you need to know

Change request (CR) 8182, from which this article is taken, instructs your Medicare contractor to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set for code usage in electronic funds transfer (EFT) and electronic remittance advice (ERA) by January 1, 2014.

Background

The Health Insurance Portability and Accountability Act (HIPAA) amended Title XI of the Social Security Act by adding Part C (Administrative Simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to: "Public Law 104-191, Health Insurance Portability and Accountability Act of 1996," which you can find at *http://aspe.hhs.gov/admnsimp/pl104191.htm#1173*.)

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions and by mandating the adoption of a set of operating rules for each of the HIPAA transactions. In December 2011 Congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to electronic data interchange (EDI) from paper has been slow and "disappointing." (You can find a copy of this testimony at *http://www.ncvhs.hhs.gov/*.

Note: The same rules will also apply to standard paper remittance (SPR), as Medicare reports the same standard codes in both electronic and paper formats of remittance advice.

The EFT and ERA operating rule set includes the following rules:

(Please note that CR 8182 focuses only on rule numbers 3 and 4)

1. Phase III CORE 380 EFT Enrollment Data Rule
2. Phase III CORE 382 ERA Enrollment Data Rule
3. Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule
4. CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule
5. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule
6. Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule

HIPAA initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim/line has been adjudicated, and now the ERA/EFT operating rules under the Affordable Care Act are mandating a standard use of those standard codes. The ERA/EFT operating rules mandate consistent and uniform use of remittance advice (RA) codes (group codes, claim adjustment reason codes (CARC) and remittance advice remark codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up
- Faulty electronic secondary billing
- Inappropriate write-offs of billable charges
- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay.

(continued on next page)

Remittance *(continued)*

Business scenarios

The CORE Phase III ERA/EFT operating rules define four business scenarios, and specify the maximum set of the standard codes that a health plan may use. This list will be updated and maintained by a CORE task group when the two code committees update the lists and/or when there is need for additional combinations based on business policy change and/or federal/state mandate.

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for each business scenario is specified in the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule), that is an attachment to CR 8182. This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published four times a year) in the future.

Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

Scenario 1: Additional information required - missing/invalid/incomplete documentation

This scenario refers to situations in which additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario 2: Additional information required – missing/invalid/incomplete data from submitted claim

This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario 3: Billed service not covered by health plan

This scenario refers to situations in which the billed service is not covered by the health plan.

Scenario 4: Benefit for billed service not separately payable

This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

Finally, by October 7, 2013, the Medicare Remit Easy Print (MREP) and PC Print software will be modified as necessary.

Additional information

The official instruction, CR 8182, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1187OTN.pdf*. You will find a copy of the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule) as an attachment to that CR.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DME 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: MM8182
Related Change Request (CR) #: CR 8182
Related CR Release Date: February 8, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1187OTN
Implementation Date: October 7, 2013

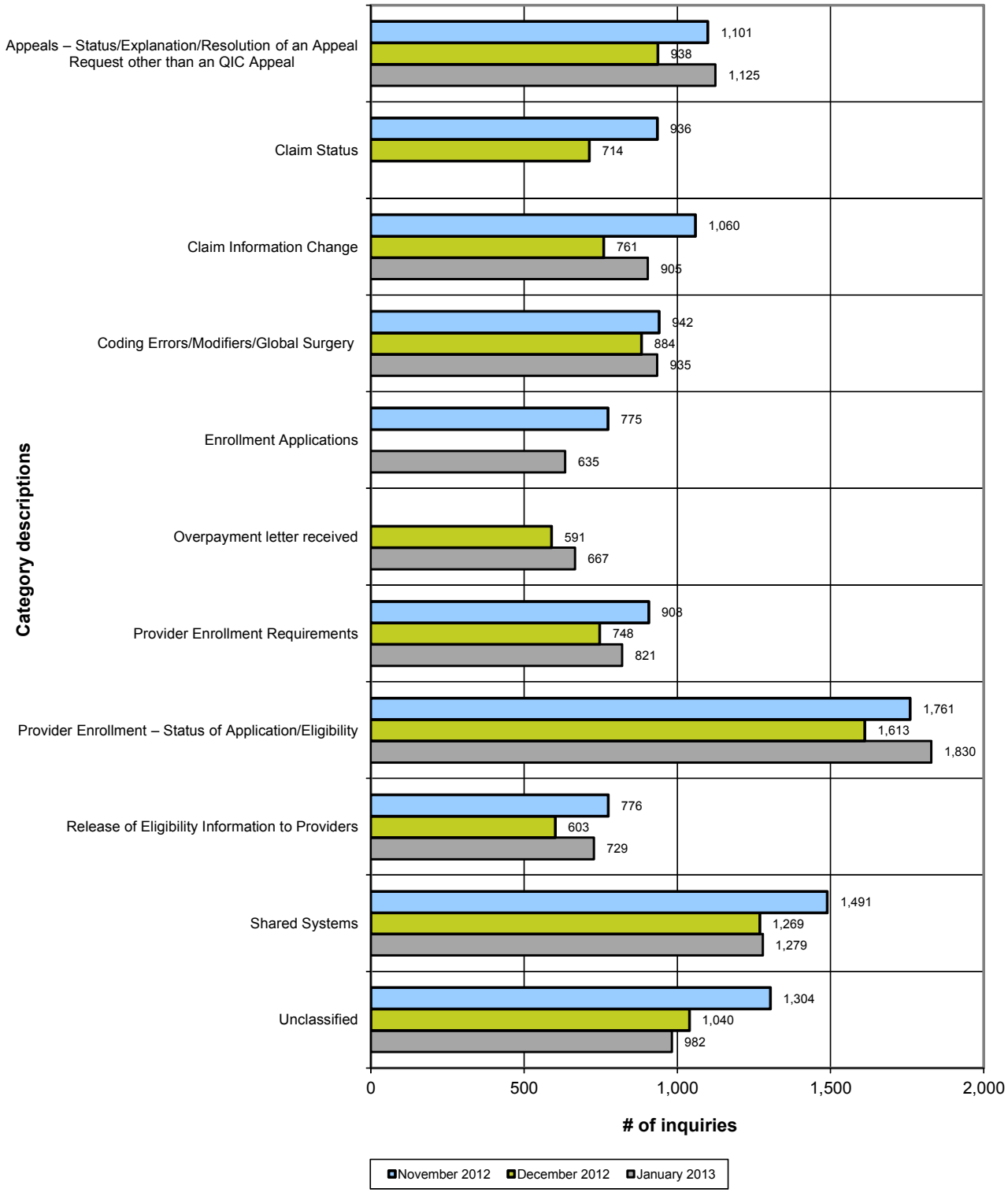
Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended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

Top inquiries, denials, and return unprocessable claims

The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during November 2012-January 2013.

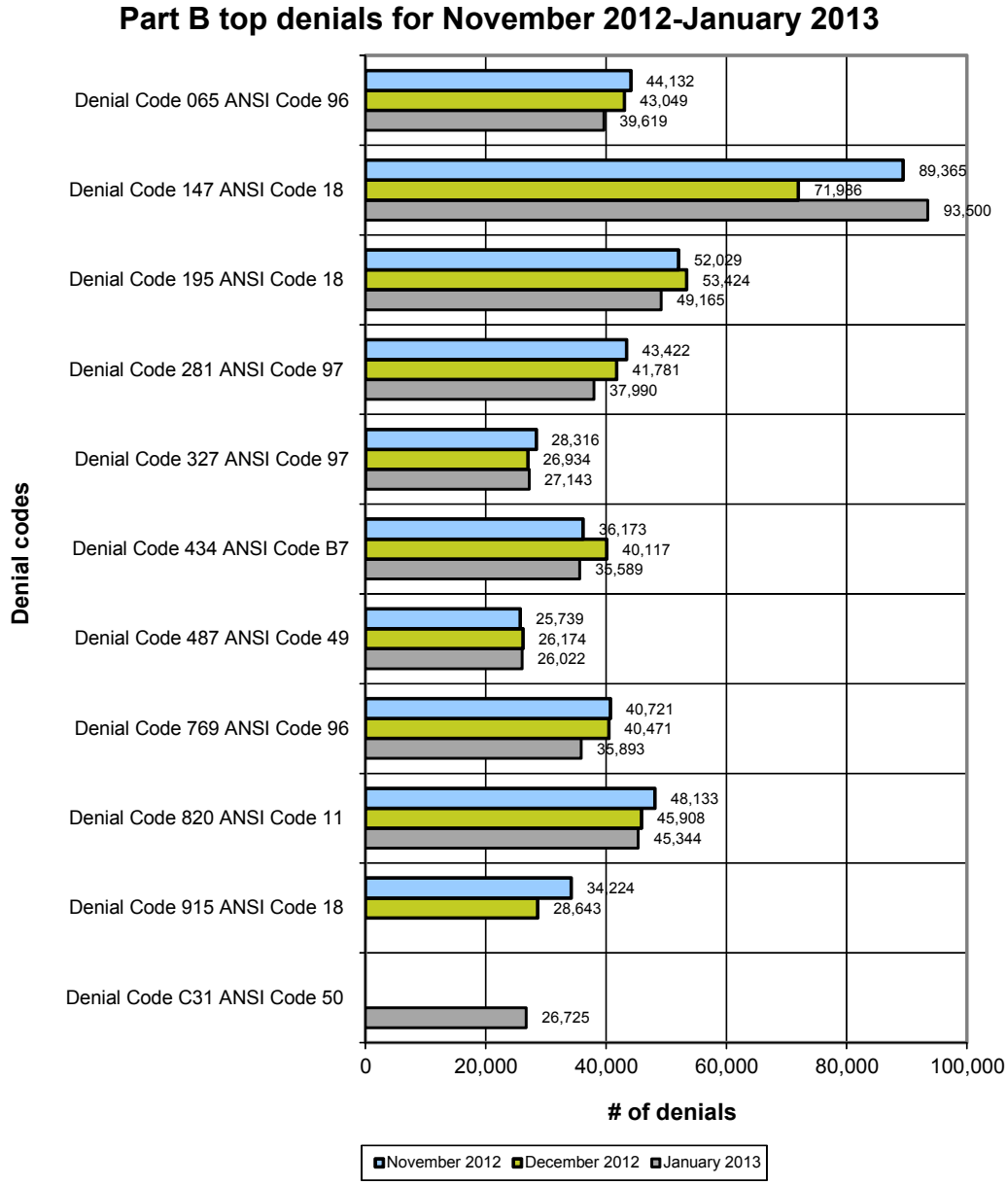
For tips and resources to help providers avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Part B top inquiries for November 2012-January 2013



(continued on next page)

Top *(continued)*



What to do when your claim is denied

Before contacting customer service, check claim status though the IVR. The IVR will release necessary details around claim denials.

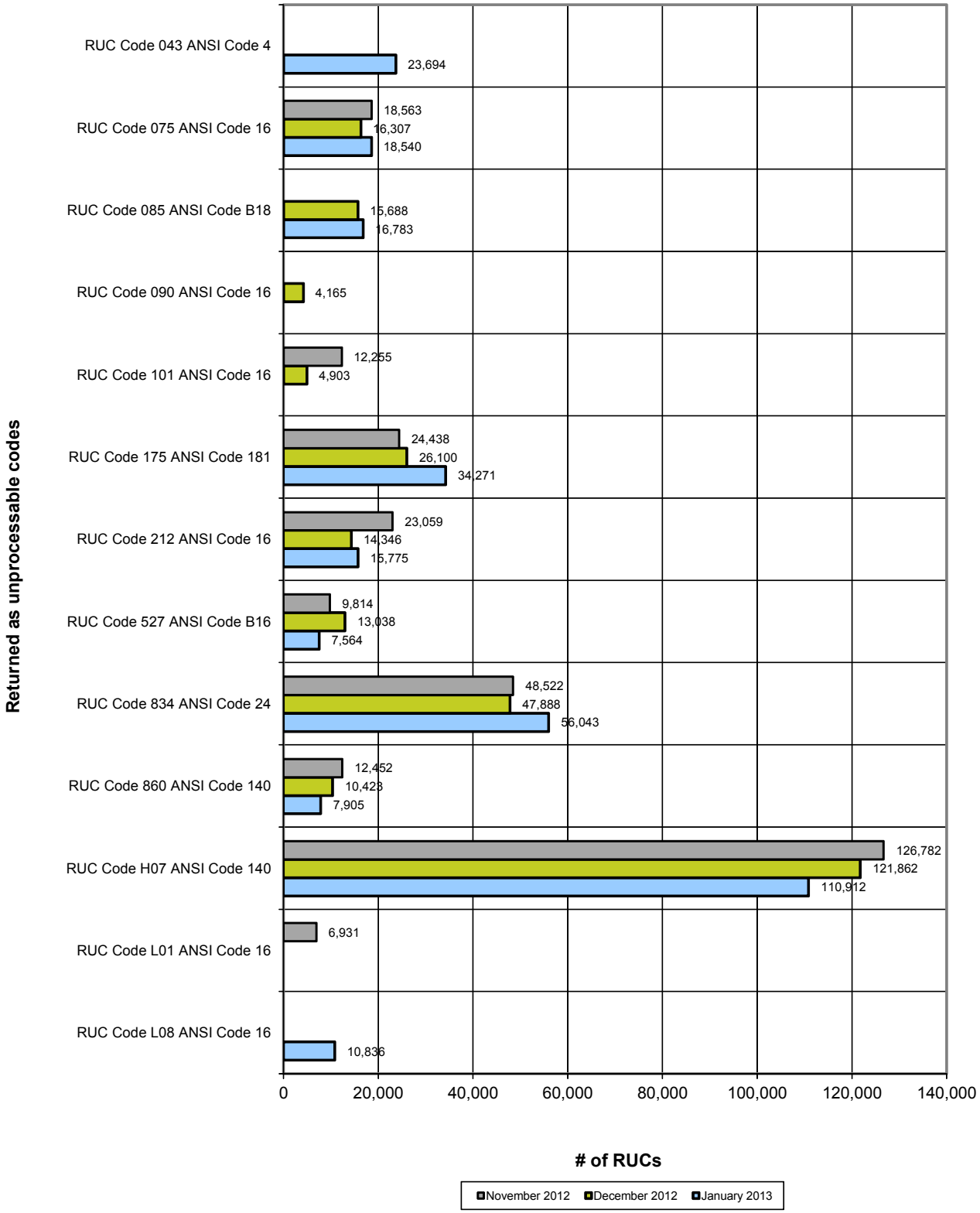
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

Refer to the *Claim completion FAQs*, *Billing issues FAQs*, and *Unprocessable FAQs* on the First Coast Medicare provider website for additional information on why claims may deny and how to correct this.

You may also refer to the *Top Part B claim denials* and *RUCs* tip sheets for tips and resources on correcting and avoiding certain claim denials.

Top *(continued)*

Part B top return as unprocessable claims for November 2012-January 2013



This section of *Medicare B 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.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the First Coast eNews mailing list. Simply go to *http://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

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Advance beneficiary notice

Modifier GZ must be used when 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 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 must append the billed service with modifier GA or GZ.

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? First Coast's LCD lookup, available at *http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp*, helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your Internet connection, the LCD search process can be completed in less than 10 seconds.

Revisions to LCDs

J2505: Pegfilgrastim (Neulasta®) – revision to the LCD

LCD ID number: L29254 (Florida)
LCD ID number: L29463 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pegfilgrastim (Neulasta®) was most recently revised October 1, 2010. Since that time, the LCD was revised based on an external reconsideration request. The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add ICD-9-CM codes 209.31-209.36 and 209.75 for HCPCS code J2505.

Effective date

This LCD revision is effective for services rendered **on or after February 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

J9045: Carboplatin (Paraplatin®, Paraplatin-AQ®) – revision to the LCD

LCD ID number: L29089 (Florida)
LCD ID number: L29104 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for carboplatin (Paraplatin®, Paraplatin-AQ®) was most recently revised October 1, 2009. Since that time, the LCD was revised based on an external reconsideration request. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for off-labeled indications was updated to add "Thymic carcinoma". The "ICD-9 Codes that Support Medical Necessity" section of the LCD was updated to add ICD-9-CM diagnosis code 164.0 for HCPCS code J9045. 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 February 21, 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

J9181: Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) – revision to the LCD

LCD ID number: L29169 (Florida)
LCD ID number: L29423 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) was most recently revised October 1, 2011. Since that time, the LCD was revised based on an external reconsideration request. The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add ICD-9-CM codes 209.31-209.36 and 209.75 for HCPCS code J9181. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add the following indications:

- For Merkel cell carcinoma in combination with carboplatin or cisplatin as a consideration for adjuvant treatment with or without radiation therapy for N+ disease
- For Merkel cell carcinoma in combination with carboplatin or cisplatin as treatment for distant metastatic disease or disseminated recurrence with or without surgery or radiation therapy

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 February 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

J9265: Paclitaxel (Taxol®) – revision to the LCD

LCD ID number: L29249 (Florida)
LCD ID number: L29460 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for paclitaxel (Taxol®) was effective for services rendered on or after February 02, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD was revised based on an external reconsideration request. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for off-labeled indications was updated to add "Thymic carcinoma." The "ICD-9 Codes that Support Medical Necessity" section of the LCD was updated to add ICD-9-CM diagnosis code 164.0 for HCPCS code J9265. 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 February 21, 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

93975: Duplex scanning – revision to the LCD

LCD ID number: L29159 (Florida)
LCD ID number: L29420 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for duplex scanning was most recently revised October 1, 2011. Since that time, the LCD was revised based on an external reconsideration request. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add the following indication for *CPT®* codes *93975* and *93976*: "To evaluate patients diagnosed with hypertensive and normotensive renovascular disease with impaired renal function." The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add ICD-9-CM diagnosis code ranges 403.90-403.91 and 585.1-585.5 for *CPT®* codes *93975* and *93976*. 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 February 21, 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

Additional Information

11730: Surgical treatment of nails – billing and coding clarification

LCD ID number: L29318 (Florida)
LCD ID number: L29395 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for surgical treatment of nails was revised and will be effective for services rendered on or after February 11, 2013. An article related to the revision of this LCD was previously published in the *December 2012 Connection on page 70*. The article provided information related to a zone program integrity contractor (ZPIC) analysis which determined that podiatrists in Florida are billing for avulsion of the nail services more frequently than current peer-reviewed literature supports. Therefore, LCD language was added to the "Limitations of Coverage" and "Utilization Guidelines" sections of this LCD, stating that services performed more often than every 12 weeks on the same digit are considered to be not medically reasonable and necessary and will be denied. In addition, language was added to the "Documentation Requirements" section of the LCD stating that the medical record must identify the specific digit(s) on which the procedure was performed. To further clarify the language in the LCD, the "Coding Guidelines" attachment states that the nail on which the procedure is performed must be reported on the claim using one of the following modifiers to identify the digit in order for payment to be considered.

TA - Left foot, great toe
T1 - Left foot, second digit
T2 - Left foot, third digit
T3 - Left foot, fourth digit
T4 - Left foot, fifth digit
T5 - Right foot, great toe
T6 - Right foot, second digit
T7 - Right foot, third digit
T8 - Right foot, fourth digit
T9 - Right foot, fifth digit

FA - Left hand, thumb
F1 - Left hand, second digit
F2 - Left hand, third digit
F3 - Left hand, fourth digit
F4 - Left hand, fifth digit
F5 - Right hand, thumb
F6 - Right hand, second digit
F7 - Right hand, third digit
F8 - Right hand, fourth digit
F9 - Right hand, fifth digit

(continued on next page)

11730 *(continued)*

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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

Incorrect denial of claims for *CPT®* codes *95885-95887*

Effective date: July 1, 2013
Implementation date: July 1, 2013

First Coast Service Options Inc. (First Coast) has discovered that providers may be receiving inappropriate denials. As a result of a processing issue, *Current Procedural Terminology®* (*CPT®*) codes *95885, 95886*, and *95887* when billed with *CPT®* code *95907, 95908, 95909*, *95910, 95911, 95912*, or *95913* may have been denied in error. The result is an underpayment for claims with dates of service **on or after January 1, 2013**. This processing issue was corrected on **January 30, 2013**.

No action is required by providers at this time

First Coast is working to identify all services that have been denied in error and will make the appropriate adjustments. First Coast requests that providers do not submit appeal or reopening requests; it is unnecessary to call the customer services lines in regards to these incorrect denials. First Coast apologizes for any inconvenience this may have caused to impacted providers.

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 enhancements*" page. 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.

Educational Events

Upcoming provider outreach and educational events
March 2013

Medicare Part B changes and regulations

When: Wednesday, March 20
Time: 11:30 a.m.-1:00 p.m.

Place of service coding (POS) for physician services

When: Wednesday, March 27
Time: 11:00 a.m.-noon

Note: Unless otherwise indicated, all First Coast educational offerings are considered to be "ask-the-contractor" events, "webcast" type of event, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at *www.fcsouniversity.com*, log on 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 User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. 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 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 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues 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 the First Coast Medicare training website, 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. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

Additional Resources

CMS Medicare Provider e-News

The Centers for Medicare & Medicaid Services (CMS) Medicare Provider e-News is an official *Medicare Learning Network*® (*MLN*)-branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate. To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to the latest e-News:

- 'CMS Medicare FFS Provider e-News': January 31, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/Enews-2013-01-31.pdf*
- 'CMS Medicare FFS Provider e-News':February 7, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-07-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': February 14, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-17-eNews.pdf*

Source: CMS PERL 201301-06, 201302-01, 201302-02

Preventive Resources

Seniors among groups hardest hit by flu this season

It has been recognized for many years that people 65 years and older are at greater risk of serious complications from influenza compared with young, healthy adults. A high percentage of seasonal influenza-related deaths and hospitalizations occur each year in people 65 years and older.

Due to the severe impact the current influenza season is having on people 65 and older in the United States, the Centers for Disease Control and Prevention (CDC) is increasing communications to clinicians caring for seniors as well as people 65 and older. The CDC is particularly concerned that these high-risk persons both seek care and receive treatment for influenza infection with antiviral medications promptly.

Dr. Alicia Fry, with CDC's Influenza Division, reminds everyone to take everyday actions to keep from getting sick with the flu. "The most important of these everyday actions is staying away from others who are or may be sick," Fry says. "There is a lot of flu out there right now," says Fry. "So if your grandchildren or other family members are sick with flu-like symptoms, consider waiting to see them until they recover."

Additional information

Review the published material in its entirety at:

- *2012-2013 CDC Influenza Update for Geriatricians and Other Clinicians Caring for People 65 and Older*
- *Flu Season Continues; Seniors Hit Hard*
- *Seniors among Groups Hardest Hit by Flu this Season*

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

Free online adult vaccine finder

The *HealthMap Vaccine Finder*, managed by HealthMap, a division of Boston Children's Hospital and Harvard Medical School, lists more than 50,000 locations across the country that offer flu vaccination. Consumers can search for places they can get a flu vaccination within or near their ZIP code. Over 125,000 consumers have already used this helpful site since August 2012. The website has now expanded to include 10 adult vaccines.

How to register your location

If you are interested in letting the public know about vaccines offered at your practice or clinic, you may register your location at *https://flushot.healthmap.org/admin/signup/*. Once you have registered on the site, you may upload your information for consumers to access about vaccination locations in your area. You may also add other consumer-friendly information such as office hours, contact information, and patient age requirements. The use of the website is free to consumers as well as to providers of adult immunization services.

Note: In 2012, Google passed the baton to HealthMap when they retired Google's Flu Vaccine Finder. Google has worked closely with HealthMap as they've created the new HealthMap Vaccine Finder. If you have previously provided data to Google Flu Vaccine Finder, you will need to register and upload your location data to HealthMap.

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

Providers advised to review the use of insulin pens

According to CMS, patients continue to be placed at risk of blood-borne pathogen exposure through inappropriate use of insulin pens by more than one patient. CMS cited the example of a facility in Buffalo, New York, which mailed letters to 1,915 patients informing them of a potential exposure from another patient's insulin pen.

According to the Food and Drug Administration, insulin pen cartridges may contain blood after a single injection. Once injected, the pens potentially become contaminated from the back flow of blood into the insulin reservoir. The pens are designed for use by one patient, though they contain multiple doses of insulin.

CDC recommendations

The Centers for Disease Control and Prevention (CDC) recommends the following steps to prevent transmission of blood-borne infections with the use of insulin pens:

- Insulin pens containing multiple doses of insulin are meant for single use only. Even when the needle is changed, the pens must never be used for more than one person.
- Labeled each pen with the patient name or other identifiers to verify that the correct pen is being used.
- Regularly review policies and procedures and educate care giving staff about the safe use of insulin pens.
- Promptly notify and offer appropriate follow-up care including blood-borne pathogen testing for any patients exposed to multiple use of insulin pens.

For more information, see the here is the link to the *CMS advisory letter on use of insulin pens*.

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

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

Mail directory

Claims submissions

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating providers
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare secondary payer
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD claims
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

Communication

Redetermination requests
Medicare Part B claims review
P.O. Box 2360
Jacksonville, FL 32231-0018

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of Information Act
Freedom of Information Act requests
P.O. Box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
CGS Administrators, LLC
P.O. Box 20010
Nashville, Tennessee 37202

Electronic media claims (EMC)

Claims, agreements and inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting charge issues:
Processing errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

Refund verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare claims for Railroad retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse
First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Phone numbers

Providers

Toll-Free
Customer Service:
1-866-454-9007

Interactive Voice Response (IVR):
1-877-847-4992

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Medicare websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor
http://medicare.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

First Coast Service Options Inc.
P. O. Box 45098
Jacksonville, FL 32232-5098

Flu rosters

First Coast Service Options Inc.
P. O. Box 45031
Jacksonville, FL 32232-5031

Electronic data interchange (EDI)

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

Part B debt recovery, MSP inquiries and overpayments, and cash management

First Coast Service Options Inc.
P.O. Box 45013
Jacksonville, FL 32232-5013

Provider enrollment

Where to mail provider/supplier applications
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
CGS Administrators, LLC
P.O. Box 20010
Nashville, Tennessee 37202

Redeterminations

First Coast Service Options Inc.
P. O. Box 45024
Jacksonville, FL 32232-5091

Redetermination overpayment

First Coast Service Options Inc.
P. O. Box 45091
Jacksonville, FL 32232-5091

Freedom of Information Act requests (FOIA)

First Coast Service Options Inc.
P. O. Box 45073
Jacksonville, FL 32232-5073

Congressional inquiries

First Coast Service Options Inc.
Attn: Carla-Lolita Murphy
P. O. Box 2078
Jacksonville, FL 32231-0048

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Medicare claims for railroad retirees

Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse

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

Local coverage determinations

First Coast Service Options Inc.
P. O. Box 2078
Jacksonville, FL 32231-0048

Post pay medical review

First Coast Service Options Inc.
P. O. Box 44288
Jacksonville, FL 32231-4288

Overnight mail and/or other special courier services

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

Medicare websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor
http://medicare.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

Email address:
AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Addresses

Claims
Additional documentation
General mailing
Congressional mailing
First Coast Service Options Inc.
P.O. Box 45036
Jacksonville, FL 32232-5036

Redeterminations
First Coast Service Options Inc.
P.O. Box 45056
Jacksonville, FL 32232-5056

Redeterminations on overpayment
First Coast Service Options Inc.
P.O. Box 45015
Jacksonville, FL 32232-5015

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.
P.O. Box 45092
Jacksonville, FL 32232-5092

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

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

Electronic Data Interchange (EDI)
First Coast Service Options Inc.
P.O. Box 44071
Jacksonville, FL 32231-4071

Flu vaccinated list
First Coast Service Options Inc.
P.O. Box 45031
Jacksonville, FL 32232-5031

Local coverage determinations
First Coast Service Options Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048

Debt collection
Overpayments, questions about Medicare as a secondary payer, cash management
First Coast Service Options Inc.
P.O. Box 45040
Jacksonville, FL 32232-5040

Overnight mail and other special handling postal services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare contractors 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.
1-877-715-1921

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

Interactive voice response (IVR)
1-877-847-4992

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

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

Website for Medicare

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

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to First Coast Service Options Inc. account # (use appropriate account number). Do not fax your order; it must be mailed.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2012 through September 2013.	40300260	$33		
2013 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2013, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)

Medicare B Connection

First Coast Service Options Inc.
P.O. Box 2078 Jacksonville, FL. 32231-0048

Attention Billing Manager