Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers June 2013

In this issue

Want to avoid receiving less reimbursement? It's time to get on board with EHR

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

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

Demonstrate meaningful use by October 1, 2014, to avoid negative payment adjustments beginning January 1, 2015.

According to CMS, negative payment adjustments will begin January 1, 2015. To avoid the adjustments, CMS highly encourages EPs to get started immediately and begin participation in the EHR program in 2013. EPs who first demonstrate meaningful use for a 90-day reporting period in 2013 may avoid payment adjustments in 2015.

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

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

Payment adjustments will be applied to the Medicare physician fee schedule amount for covered professional services furnished by the practice in 2015. Health practices which began participation in 2011 or 2012 and subsequently demonstrated meaningful use, are required to continue the demonstration for a full year in 2013.

Resources

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

Contents

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

Publication staff:
Terri Drury
Martin Smith
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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 at *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, Puerto Rico, 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 (waiver 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.

Quarterly update to the Correct Coding Initiative edits, version 19.2

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8298 which informs Medicare contractors about the release of the latest package of National Correct Coding Initiative (NCCI) edits, version 19.2, which will be effective July 1, 2013. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the national CCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology Manual*, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of CCI edits, version 19.2, effective July 1, 2013, will soon be available to CMS contractors via the CMS data center (CDC). A test file will be available to them on or about May 2, 2013, and a final file will be available to them on or about May 17, 2013.

Version 19.2 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/ Column 2 Correct Coding Edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for outpatient code editor (OCE). It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits.

CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website. The edits previously contained in the mutually exclusive edit file are **not** being deleted but are being moved to the Column One/Column Two Correct Coding edit file.

Additional information

The official instruction, CR 8298, 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/R2700CP.pdf*.

Refer to the CMS NCCI Web page for additional information at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

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: MM8298
Related Change Request (CR) #: CR 8298
Related CR Release Date: May 10, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2700CP
Implementation Date: July 1, 2013

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Ambulance

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8269 which informs Medicare contractors about changes to the ambulance fee schedule (AFS). Effective for claims with dates of service on and after October 1, 2013, payment for non-emergency basic life support (BLS) transports of individuals with end-stage renal disease (ESRD) to and from renal dialysis treatment facilities will be reduced by 10 percent. The reduced rate will be calculated and applied to Healthcare Common Procedure Code System (HCPCS) code A0428 when billed with destination modifier code "G" or "J", and the associated mileage, represented by HCPCS code A0425. A claim adjustment reason code of 45 (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement) and group code "CO" (contractual obligation) will be on the remittance advice notice for claims for which a Medicare contractor has applied the reduced AFS methodology. Make sure that your billing staffs are aware of these changes.

Background

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

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

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

Additional information

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

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

MLN Matters® Number: MM8269
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Related CR Transmittal #: R2703CP
Implementation Date: October 7, 2013

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Ambulatory Surgical Center

July 2013 update of the ambulatory surgical center payment system

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8328 which informs Medicare contractors about the changes to and billing instructions for various payment policies implemented in the July 2013 ambulatory surgical center (ASC) payment system update. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Key points of CR 8328

One new Healthcare Common Procedure Coding System (HCPCS) procedure code listed in the following is assigned for payment under the ASC payment system effective July 1, 2013.

HCPCS code	Effective date	Short descriptor	Long descriptor	ASC payment indicator
C9736	7/1/2013	Lap ablate uteri fibroid rf	Laparoscopy, surgical, radiofrequency ablation of uterine fibroid(s), including intraoperative guidance and monitoring, when performed	G2

The AMA releases category III *CPT*® codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2013 update, CMS is implementing six category III *CPT*® codes that the AMA released in January 2013 for implementation July 1, 2013. Two of the six category III *CPT*® codes are separately payable under the ASC payment system. The *CPT*® code, short descriptor, long descriptor, and payment indicator for these codes are shown in the following table:

CPT® code	Short descriptor	Long descriptor	ASC payment indicator
0331T	Heart symp image plnr	*Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment*	Z2
0332T	Heart symp image plnr spect	*Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT*	Z2

Payment rates for these services can be found in Addendum BB of the July 2013 ASC payment system update that is posted in the "Downloads" section *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

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

Payments for separately payable drugs and biologicals based on ASPs are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2013 ASC DRUG FILE. The updated payment rates, effective July 1, 2013, will be included in the July 2013 update of the ASC Addendum BB, which will be posted on the CMS website.

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

Two drugs and biologicals have been granted ASC payment status effective July 1, 2013. These items, along with their short and long descriptors, and ASC payment indicator (PI) assignments, are identified in the following table:

(continued on next page)

ASC *(continued)*

HCPCS code	Short descriptor	Long descriptor	ASC payment indicator
C9131*	In ado-trastuzumab emtansine	Injection, ado-trastuzumab emtansine, 1 mg	K2
Q4122	Dermacell	Dermacell, per square centimeter	K2

Note: The HCPCS code identified with an "*" indicates that this is both newly payable in the ASC payment system as well as being a new HCPCS code effective July 1, 2013.

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

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biologicals listed above) in the ASC payment system for July 1, 2013. These codes are listed in the following table are effective for services furnished on or after July 1, 2013.

HCPCS code	Short descriptor	Long descriptor	ASC payment indicator
Q2050*	Doxorubicin inj 10mg	Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg	K2
Q2051**	Zoldedronic acid 1mg	Injection, zoledronic acid, not otherwise specified, 1 mg	K2

*HCPCS code J9002 (Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg) will be replaced with HCPCS code Q2050 effective July 1, 2013. The payment indicator for HCPCS code J9002 will change to Y5 (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) effective July 1, 2013.

** HCPCS code J3487 (Injection, zoledronic acid (Zometa), 1 mg) and HCPCS code J3488 (Injection, Zoledronic Acid (Reclast), 1 mg) will be replaced with HCPCS code Q2051 effective July 1, 2013. The payment indicators for HCPCS codes J3487 and J3488 will change to Y5 (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) effective July 1, 2013.

Revised payment indicator for HCPCS codes Q4126 and Q4134, effective July 1, 2013

Effective July 1, 2013, the ASC payment indicators for HCPCS code Q4126 (Memoderm, dermaspan, tranzgraft or integuply, per square centimeter) and HCPCS code Q4134 (Hmatrix, per square centimeter) will change from PI=Y5 to PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list). For the remainder of CY 2013, HCPCS code Q4126 and HCPCS code Q4134 will be separately paid and the prices for these codes will be updated on a quarterly basis. These codes are listed in the following table and are effective for services furnished on or after July 1, 2013.

HCPCS code	Long descriptor	ASC payment indicator
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter	K2
Q4134	Hmatrix, per square centimeter	K2

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

The payment rates for two HCPCS codes were incorrect in the April 2013 ASC drug file. The corrected payment rates are listed in the following table and have been installed in the revised April 2013 ASC drug file, effective for services furnished on or after April 1, 2013, through June 30, 2013.

HCPCS code	Short descriptor	Corrected payment rate	ASC payment indicator
C9297	Omacetaxine mepesuccinate	$2.53	K2
C9298	Injection, ocriplasmin	$1,046.75	K2

Suppliers who received an incorrect payment for dates of service between April 1, 2013, and June 30, 2013, may request contractor adjustment of the previously processed claims.

(continued on next page)

ASC *(continued)*

Flublok (influenza virus vaccine)

Flublok (influenza virus vaccine) was approved by the FDA January 16, 2013, and is described by HCPCS code Q2033 (Influenza vaccine, recombinant himagglutinin antigens, for intramuscular use (Flublok)). CMS is assigning the ASC payment indicator "L1" (Influenza vaccine; pneumococcal vaccine; packaged item/service; no separate payment made.) to HCPCS code Q2033 effective July 01, 2013.

Fluarix quadrivalent (influenza virus vaccine)

Fluarix quadrivalent (influenza virus vaccine) was approved by the FDA, December 14, 2012, and is described by *CPT*® code *90686* (*Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use*). For the July 2013 update, CMS is revising the ASC payment indicator for *CPT*® code *90686* from "Y5" to "L1" ((Influenza vaccine; pneumococcal vaccine; packaged item/service; no separate payment made) effective January 1, 2013.)

Additional information

The official instruction, CR 8328, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2717CP.pdf*.

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

MLN Matters® Number: MM8328
Related Change Request (CR) #: CR 8328
Related CR Release Date: May 31, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2717CP
Implementation Date: July 1, 2013

Anesthesia

Pass-through payments for CRNA anesthesia services and related care

Provider types affected

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

Provider action needed

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

Background

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

(continued on next page)

CRNA *(continued)*

The Social Security Act, Section 1861(bb), defines the term "services of a certified registered nurse anesthetist" to mean "anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the state in which the services are furnished." In the calendar year 2013 physician fee schedule final rule, CMS amended the regulations at 42 CFR 410.69(b) by adding a definition of "Anesthesia and related care," which reads "Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished." Therefore, CMS is clarifying that effective January 1, 2013, in addition to anesthesia services, qualifying CAHs and rural hospitals can receive CRNA pass-through payments for services the CRNA is legally authorized to perform in the state in which the services are furnished.

Additional information

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

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

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

Drugs and Biologicals

Updates to Medicare coverage of hepatitis B vaccine and its administration

Medicare regulations cover hepatitis B vaccine and its administration if furnished to an individual who is at high or intermediate risk of contracting hepatitis B. The regulations were modified in 2012 to add "persons diagnosed with diabetes mellitus" under the high-risk group category for coverage under this benefit.

Change request 8275 makes the *Medicare Benefit Policy Manual* provisions consistent with these modified regulatory requirements.

Procedure to diagnosis editing

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

Diagnoses added to editing of hepatitis B

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

October 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, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME/MACs) and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed

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

Background

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

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

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

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

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

Additional information

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

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

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

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Durable Medical Equipment

July quarterly update for 2013 DMEPOS fee schedule

Provider types affected

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

Provider action needed

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

Background

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

Key points of CR 8325

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

Diabetic testing supplies

Effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the American Taxpayer Relief Act (ATRA), the fee schedule amounts for non-mail order diabetic supplies are adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established in implementing the national mail order competitive bidding program under Section 1847 of the Act. The national competitive bidding program for mail order diabetic supplies takes effect July 1, 2013. Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as described by the HCPCS codes below:

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

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DMEPOS *(continued)*

Also, the fee schedule amounts for non-mail order diabetic supplies listed above will be adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established under the national mail order competition for diabetic testing supplies each time the single payment amounts are updated, which can happen no less often than every three years as contracts are recompeted. The rules related to assignment of claims for non-mail order diabetic testing supplies are not affected by this new law.

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

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

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

Additional information

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

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

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

End-Stage Renal Disease

Revisions to the *Medicare Benefit Policy Manual* to reflect implementation of the ESRD PPS

Provider types affected

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

Provider action needed

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

Background

Effective January 1, 2011, CMS implemented the ESRD PPS, which provides a single payment to ESRD facilities, including hospital-based and independent facilities. The payment includes all items and services used in furnishing outpatient dialysis services including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services.

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

(continued on next page)

ESRD *(continued)*

Additional information

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

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

MLN Matters® article MM7064 "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services", explains PPS reimbursement for Part B ESRD services. The article is at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7064.pdf*.

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

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

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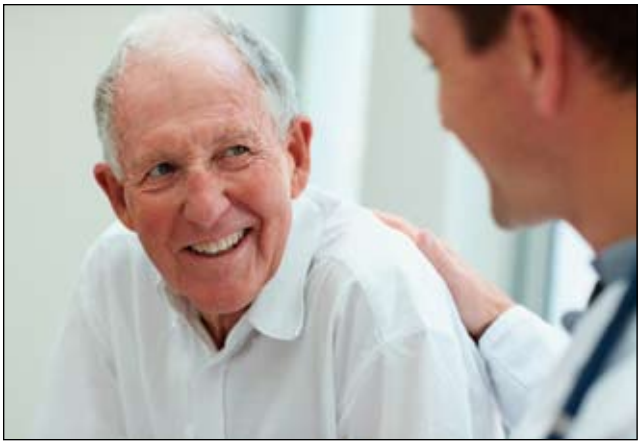
Evaluation and Management

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

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

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



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

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

- *CPT*® *99495* – Transitional care management services (moderate complexity):

(continued on next page)

TCM *(continued)*

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

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

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

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

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

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

CWF editing for billing of new patient visits by same physician or group practice within three years

Note: This article was revised June 4, 2013, to reflect the revised change request (CR) 8165 issued May 31. The article shows a revised list of new patient *Current Procedure Terminology* (*CPT®*) codes and an added list of established patient *CPT®* codes in the *Background* section. Also, the CR release date, transmittal number, and the Web address for accessing CR 8165 have been revised. All other information remains the same. This information was previously published in the May 2013 *Medicare B Connection*, Pages 7-8.

Provider types affected

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

Provider action needed

This article is based on CR 8165 which informs Medicare contractors about changes to Medicare's common working file (CWF) system that will detect erroneous billings when there are two new patient *CPT®* codes being billed within a three year period of time by the same physician or physician group. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

(continued on next page)

CWF *(continued)*

Background

The recovery auditors, under contract with the Centers for Medicare & Medicaid Services (CMS), are responsible for identifying and correcting improper payments in the Medicare fee-for-service payment process. The recovery auditors have identified claims with "new patient" evaluation and management (E&M) services to have improper payments, because the new patient services have been billed two or more times within a three-year period by the same physician or physician group. The *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.7 provides that "Medicare interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E&M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years. For example, if a professional component of a previous procedure is billed in a three year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit."

As a result of overpayments for new patient E&M services that should have been paid as established patient E&M services, CMS will implement changes to the CWF to prompt CMS contractors to validate that there are not two new patient *CPT*®s being paid within a three year period of time.

The new patient *CPT*® codes that will be checked in these edits include *99201-99205*, *99324-99328*, *99341-99345, 99381-99387, 92002*, and *92004*. The edits will also check to ensure that a claim with one of these new patient *CPT*® codes is not paid subsequent to payment of a claim with an established patient *CPT*® code (*99211-99215*, *99334-99337*, *99347-99350*, *99391-99397*, *92012*, and *92014*).

If Medicare discovers that a new patient code has been paid more than one time in a three-year period to the same physician, then Medicare contractors will consider this an overpayment and will take steps to recoup the payment. If the situation is detected prior to payment of a second claim, the second claim will be rejected.

Additional information

The official instruction, CR 8165 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1244OTN.pdf*.

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

MLN Matters® Number: MM8165 *Revised*
Related Change Request (CR) #: CR 8165
Related CR Release Date: May 31, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1244OTN
Implementation Date: October 7, 2013

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

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. Select from the following session dates: July 18, or August 15, 2013.

E/M interactive worksheet improves Medicare billing for providers

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

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

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

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

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

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

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

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

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

-Patricia Matthews-Davis
Jacksonville Spine Center

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

As an example, McConnell points to the review of systems (ROS) section of the worksheet. He explained that some patients present issues that cross over several medical systems. "You have to conjoin them," he said, noting one patient who presented concerns that were both psychiatric and neurological." To do this, there has to be some dialogue with us," he said, looking at Matthews-Davis.

In addition to working with the medical providers to improve medical documentation, Matthews-Davis also uses the E/M interactive worksheet for prepayment audits. "I have been using the interactive worksheet to audit our new providers' E/M service and have found it to be tremendously helpful. Having a copy of the worksheet with their documentation helps them see where changes are required and get a better understanding of how the guidelines work," she said.

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

Laboratory/Pathology

Coding requirements for laboratory specimen collection update

Provider types affected

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

What you need to know

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

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

Background

Current CMS instructions have a terminated code listed in the manual for the routine venipuncture for collection of specimens. CMS is releasing this update to these manual instructions to list the active code and address questions received from the laboratory industry. Since the fee schedules and systems were updated when the coding change occurred, there is no need to include any system or fee schedule updates.

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

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

- *36415*: Collection of venous blood by venipuncture
- P96I5: Catheterization for collection of specimen(s)"

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

Additional information

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

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

MLN Matters® Number: MM8339
Related Change Request (CR) #: CR 8339
Related CR Release Date: June 20, 2013
Effective Date: July 16, 2013
Related CR Transmittal #: R2730CP
Implementation Date: July 16, 2013

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Outpatient therapy services functional reporting testing period ended June 30

As required by Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012, the Centers for Medicare & Medicaid Services (CMS) implemented a new claims-based data collection system for outpatient therapy services by requiring reporting of functional limitations with 42 new nonpayable G-codes and seven new modifiers on specified claims for physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. The claims-based data collection system is effective for outpatient therapy services with dates of service on and after January 1, 2013.

For functional reporting, the testing period ended June 30, 2013. During the testing period, claims without the required G-codes and severity/complexity modifiers will continue to be processed and adjudicated by your carrier or Part B Medicare administrative contractor. As of April 1, a remittance advice message has been alerting providers about missing information on select therapy claims. **Please note**: Institutional claims will not receive alert messages.

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

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

MM8166 "Outpatient Therapy Functional Reporting Non-Compliance Alerts"

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

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

Medicare Physician Fee Schedule Database

July update to the 2013 Medicare physician fee schedule database

Provider types affected

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

What you need to know

This article is based on change request (CR) 8291 and instructs Medicare contractors to download and implement a new Medicare physician fee schedule database. Payment files were issued to your contractor(s) based upon the 2013 MPFS final rule (published in the *Federal Register* on November 16, 2012) as modified by 1) the American Taxpayer Relief Act of 2012 (applicable January 1, 2013), and 2) the final rule correction notice (published in the *Federal Register* in April 2013).

This article details changes included in the July quarterly update to those payment files.

Background

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

Payment files were issued to your contractor(s) based upon the 2013 Medicare physician Fee Schedule (MPFS) final rule (published in the *Federal Register* on November 16, 2012) as modified by the American Taxpayer Relief Act of 2012 (applicable January 1, 2013; see *http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf*), and the final rule correction notice (published in the *Federal Register* in April 2013). For more information and access to the 2013 final rule, see the "Physician Fee Schedule" Web page available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*.

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MPFSDB *(continued)*

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

- Effective January 1, 2013, HCPCS codes *37211, 37212* and *92071* will have their bilateral indicators are being corrected to "1" = 150 percent payment adjustment applies if billed with modifier 50.
- Effective January 1, 2013, the TC component of the nerve conduction test (*95937*) will have its physician supervision of diagnostic procedures indicator changed to "7A" = "Supervision standards for level 77 apply. In addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill." ("77" = "Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under general supervision of a physician (TC only; PC always physician)"). (This change reflects the policy of Transmittal B-01-28, its effective date for the PT with ABPTS certification was July 1, 2001).
- Effective July 1, 2013, HCPCS Codes J3487, J3488, and J9002 will have their PROCSTAT indicators changed from "E" to "I" = "Not valid for Medicare purposes."
- Effective July 1, 2103, HCPCS Codes Q0090, Q2033, Q2051, Q2050, *0329T, 0330T, 0331T*, *0332T*, *0333T*, and *0334T* will be added to the fee schedule.
- Effective January 1, 2013, HCPCS Codes G0460, "Autologous PRP for ulcers", will be added to the fee schedule. (For more information, please reference *MLN Matters* article MM8213 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8213.pdf*)
- The following tables reflect additional changes made with their effective dates.

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

(continued on next page)

MPFSDB *(continued)*

HCPCS code	*0329T*	*0330T*	*0331T*	*0332T*	*0333T*	*0334T*
Site of service	9	9	9	9	9	9
Global surgery	YYY	YYY	YYY	YYY	YYY	YYY
Pre	0.00	0.00	0.00	0.00	0.00	0.00
Intra	0.00	0.00	0.00	0.00	0.00	0.00
Post	0.00	0.00	0.00	0.00	0.00	0.00
Physician	09	09	09	09	09	09
Diagnostic family imaging indicator	99	99	99	99	99	99
Non-facility PE used for OPPS payment amount	0.00	0.00	0.00	0.00	0.0	0.00
Facility PE used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00	0.00
MP used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00	0.00
Type of service	1	4	4	4	1	1
Long descriptor	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	Tear film imaging, unilateral or bilateral, with interpretation and report		Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	Visual evoked potential, screening of visual acuity, automated	Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (eg, CT or fluoroscopic)

(continued on next page)

MPFSDB *(continued)*

HCPCS code	G0460	Q0090	Q2033	Q2051	Q2050
Procedure status	C	N	X	E	E
Short descriptor	Autologous PRP for ulcers	Skyla 13.5mg	Influenza Vaccine, Flublok)	Zoledronic acid 1mg	Doxorubicin inj 10mg
Effective date	01/01/2013	07/01/2013	07/01/2013	07/01/2013	07/01/2013
Work RVU	0.00	0.00	0.00	0.00	0.00
Full non-facility PE RVU	0.00	0.00	0.00	0.00	0.00
Full facility PE RVU	0.00	0.00	0.00	0.00	0.00
	0.00	0.00	0.00	0.00	0.00
Multiple procedure indicator	0	9	9	9	9
Bilateral surgery indicator	0	9	9	9	9
Assistant surgery indicator	9	9	9	9	9
Co-surgery indicator	0	9	9	9	9
Team surgery indicator	0	9	9	9	9
PC/TC	0	9	9	9	9
Site of service	9	9	9	9	9
Global surgery	000	XXX	XXX	XXX	XXX
Pre	0.00	0.00	0.00	0.00	0.00
Intra	0.00	0.00	0.00	0.00	0.00
Post	0.00	0.00	0.00	0.00	0.00
Physician	09	09	09	09	09
Diagnostic family imaging indicator	99	99	99	99	99
Non-facility PE used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00
Facility PE used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00

(continued on next page)

MPFSDB *(continued)*

HCPCS code	G0460	Q0090	Q2033	Q2051	Q2050
MP used for OPPS payment amount	0.00	0.00	0.00	0.00	0.00
Type of service	1	9	V	1,9	1,9
Long descriptor	Autologous platelet rich plasma for chronic wounds/ ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment	Levonorgestrel- Releasing Intrauterine Contraceptive System (SKYLA), 13.5 mg	Influenza Vaccine, Recombinant Hemagglutin in Antigens, For Intramuscular Use (Flublok)	Injection, Zoledronic Acid, not otherwise specified, 1mg	Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg

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

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

Additional information

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

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

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

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Therapy Services

Multi-carrier system modifications to liability assignment regarding therapy cap claim denials

Provider types affected

This *MLN Matters*® article is intended for physicians, therapists, and other providers submitting professional claims to Medicare carriers or Medicare administrative contractors (MACs) for therapy services.

What you need to know

Section 603(c) of the American Taxpayer Relief Act of 2012 (ATRA) revised the payment liability for therapy limit denials. The law changes these denials from beneficiary liability to provider liability, effective January 1, 2013. As a result, when Medicare denies professional claims with dates of service (DOS) on or after January 1, 2013, that exceed the therapy caps and do not contain the GA modifier, the claims will be denied with a group code of CO (contractual obligation), instead of group code PR (patient responsibility). The assignment of the PR code will still occur for such claims denied that contain a DOS prior to January 1, 2013.

It is important to note that Medicare will not adjust claims with a DOS on or after January 1, 2013, that were denied with the incorrect group code of PR prior to the implementation of change request (CR) 8321. However, Medicare does require providers to refund any payments collected from beneficiaries that are associated with such denied claims and to take steps to avoid further collections from such beneficiaries based on the incorrect assigned liability on those denied claims.

Additional information

The official instruction, CR 8321, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1248OTN.pdf*.

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

MLN Matters® Number: MM8321
Related Change Request (CR) #: 8321
Related CR Release Date: June 14, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R1248OTN
Implementation Date: October 7, 2013

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Change to payment liability for therapy cap denials

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

Due to differing claim processing system constraints, this inaccurate RA reporting will be corrected beginning on different dates for different claim formats. For institutional claims, the correct liability will be reported beginning on June 24, 2013. For professional claims, the correct liability will be reported beginning on January 1, 2014.

Since Medicare’s payment amount for these claims is correct, Medicare administrative contractors will not adjust claims processed before these dates to correct the group code. To do so could create disruptions for providers’ accounts receivable. Instead, therapy providers should review any therapy cap denials for dates of service on or after January 1, 2013, to determine whether any payments have been collected from beneficiaries. Providers should refund any beneficiary payments they find for these services. Additionally, providers should cease to collect payments for therapy cap denials unless the beneficiary was appropriately notified via an advanced beneficiary notice of noncoverage (ABN).

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

Vision

Ocular photodynamic therapy with verteporfin for macular degeneration

Provider types affected

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

What you need to know

This article is based on change request (CR) 8292, which instructs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) will expand coverage of ocular photodynamic therapy (OPT) (*CPT*® *67221*/*67225*) with verteporfin (HCPCS J3396) for "wet" age-related macular edema (AMD). CMS is revising the requirements for testing to permit either optical coherence tomography (OCT) or fluorescein angiogram (FA) to assess treatment response. All other coverage criteria would continue to apply.

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

Background

CMS received a formal written request from the American Academy of Ophthalmology (AAO) to review and update national coverage determination (NCD) 80.3.1 (Ocular Photodynamic Therapy (OPT) with verteporfin) since this coverage decision was from 2004, prior to the emergence of targeted anti-VEGF intravitreal treatments. These newer therapies have largely supplanted OPT as initial management of AMD and OPT is largely relegated to patients in whom the newer therapies have failed. When the policy was written, an initial FA was ordered to determine if the lesions were considered classic choroidal neovascular (CNV) lesions. Then the patients were followed monthly with additional FAs to determine the need for retreatment. The NCD requirement for follow-up FA with OPT with verteporfin is no longer supportable for these "end-stage" patients. (**Note**: The request specifies Section 80.3.1 of the *NCD Manual*, but the requirement for follow-up FA also appears in Sections 80.2, 80.2.1, and 80.3 of the *NCD Manual*).

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

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

Additional information

The official instruction, CR 8292, was issued to your FI, carrier and A/B MAC via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2728CP.pdf*. The second transmittal updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R155NCD.pdf*.

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

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

Wound Care

Autologous platelet-rich plasma for chronic non-healing wounds

Note: This article was revised May 24, 2013, to add a descriptor for code G0460 and June 13, 2013, to reflect changes made to CR 8213 to delete a reference to "randomized clinical trial." Also, the CR release date, transmittal numbers and the Web address for accessing the CR were also revised. This information was previously published in the March 2013 *Medicare B Connection*, Pages 29-33.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

Background

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

Since 1992, the Centers for Medicare & Medicaid Services (CMS) has issued national non-coverage determinations for platelet-derived wound healing formulas intended to treat patients with chronic, non-healing wounds. In December 2003, CMS issued a national non-coverage determination specifically for the use of autologous PRP in treating chronic non-healing cutaneous wounds except for routine costs when used in accordance with the clinical trial policy defined in Section 310.1 (Routine Costs in Clinical Trials (Effective July 9, 2007)) of the *National Coverage Determinations (NCD) Manual*. Currently, as of March 2008, CMS has non-coverage determinations for the use of autologous blood-derived products for the treatment of acute wounds where PRP is applied directly to the closed incision site, and for dehiscent wounds, as well as non-coverage for chronic, non-healing cutaneous wounds.

On October 4, 2011, CMS accepted a formal request to reopen and revise Section 270.3 of the *Medicare NCD Manual*, which addresses autologous blood-derived products for chronic non-healing wounds. The request was for a reconsideration of the coverage of autologous PRP for the treatment of the following chronic wounds: diabetic, venous, and/or pressure ulcers. It was requested that CMS cover PRP through an NCD with data collection as a condition of coverage; and requested that this would provide a practical means by which CMS could obtain the necessary data to evaluate the performance of PRP and to confirm the outcomes presented in their request.

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

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

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

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

(continued on next page)

Wound *(continued)*

The clinical study must address:

- Prospectively, do Medicare beneficiaries, with chronic non-healing diabetic, venous and/or pressure wounds, who receive well-defined optimal usual care along with PRP therapy, experience clinically significant health outcomes compared to patients who receive only well-defined optimal usual care for such wounds; as indicated by addressing at least one of the following:
  a. Complete wound healing?
  b. Ability to return to previous function and resumption of normal activities?
  c. Reduction of wound size or healing trajectory which results in the patient's ability to return to previous function and resumption of normal activities?

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

- Its principal purpose is to test whether PRP improves the participants' health outcomes
- It is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use
- It does not unjustifiably duplicate existing studies
- Its design is appropriate to answer the research question being asked in the study
- It is sponsored by an organization or individual capable of executing the proposed study successfully
- It is in compliance with all applicable federal regulations concerning the protection of human subjects found at 45 CFR Part 46
- All of its aspects are conducted according to appropriate standards of scientific integrity set by the International Committee of Medical Journal Editors (*http://www.icmje.org*);
- It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with evidence development (CED);
- It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR §312.81(a) and the patient has no other viable treatment options;
- It is registered on the ClinicalTrials.gov website (*http://www.clinicaltrials.gov/*) by the principal sponsor/investigator prior to the enrollment of the first study subject;
- Its study protocol:
  a. Specifies the method and timing of public release of all pre-specified outcomes to be measured, including the release of outcomes that are negative or that the study is terminated early;

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

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

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

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

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

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Wound *(continued)*

Coding and payment details

Healthcare Common Procedure Coding System (HCPCS) codes

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

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

Medicare contractors will return to provider/return as unprocessable your PRP claims that do not include **all** these diagnosis coding and additional billing requirements:

Should they return your PRP claims for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only in the context of an approved clinical study, they will use the following messages: these diagnosis coding and additional billing requirements:

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

Type of bill

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

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

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

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

- CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present";
- RARC N428 – "Service/procedure not covered when performed in this place of service"; and
- Group code: CO

Place of service (POS) professional claims

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

- CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service";
- RARC N428 – "Service/procedure not covered when performed in this place of service"; and
- Group code: CO.

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

Additional information

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

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Wound *(continued)*

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

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

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

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

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General Coverage

Use of a rubber stamp for signature

Provider types affected

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

What you need to know

For medical review purposes, the Centers for Medicare & Medicaid Services (CMS) requires that services ordered/provided be authenticated by a handwritten or electronic signature. With few exceptions, stamped signatures are not acceptable as described in Chapter/Section 3.3.2.4 of the *Medicare Program Integrity Manual*. Change request (CR) 8219 adds another exception to that manual. Under the added exception, CMS will permit the use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.

Additional information

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

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

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

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Claim status category and claim status codes update

Provider types affected

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

Provider action needed

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

All code changes approved during the June 2013 committee meeting will be posted on or about July 1, 2013, at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes*. Make sure that your billing staffs are aware of these changes.

Background

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

The national Code Maintenance Committee meets three times each year (February, June, and October) in conjunction with the Accredited Standards Committee (ASC) x12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry six months for implementation of the newly added or changed codes. Therefore, on the date of implementation of CR 8320 (October 7, 2013), your Medicare contractor must:

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

Additional information

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

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

MLN Matters® Number: MM8320
Related Change Request (CR) #: CR 8320
Related CR Release Date: May 24, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2713CP
Implementation Date: October 7, 2013

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The role of clearinghouses in the ICD-10 transition

Practices preparing for the October 1, 2014, ICD-10 deadline are looking for resources and organizations that can help them make a smooth transition. It is important to know that while clearinghouses can help, they cannot provide the same level of support for the ICD-10 transition as they did for the version 5010 upgrade. ICD-10 describes a medical diagnosis or hospital inpatient procedure and must be selected by the provider or a resource designated by the provider as their coder, and is based on clinical documentation.

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

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

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

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

Keep up to date on ICD-10

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

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

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Fraud

Seniors and caregivers urged to join the fight against fraud

New health care summaries help seniors identify improper payments

In mailboxes across the country, people with Medicare will soon see a redesigned statement of their claims for services and benefits that will help them better spot potential fraud, waste, and abuse. These newly redesigned *Medicare summary notices* are just one more way the Obama Administration is making the elimination of fraud, waste, and abuse in health care a top priority. Because of actions like these and new tools under the Affordable Care Act, the number of suspect providers and suppliers thrown out of the Medicare program has more than doubled in 35 states.

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

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

Update on CMS anti-fraud efforts

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

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

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

Full text of the *CMS press release* (issued June 6).

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

What is Medicare Fraud?

Fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. Learn more at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf*.

Incentive Programs

CMS updates 2014 eligible professional clinical quality measures

The Centers for Medicare & Medicaid Services (CMS) recently updated 2014 clinical quality measures (CQMs) and corresponding specifications for electronic reporting for eligible professionals (EPs) participating in Medicare incentive programs.

Beginning in 2014, the CQM specifications will be used for multiple programs, such as the physician quality reporting system, to align the EHR incentive programs and reduce the burden on providers to report quality measures.

CMS strongly encourages the implementation and use of the updated 2014 CQMs for EPs since they include new codes, logic corrections, and clarifications. In 2014, all providers participating in Medicare incentive programs will be required to report on the 2014 CQMs finalized in the stage 2 rule.

Clinical quality measures, or CQMs, are tools that measure and track the quality of healthcare services provided by EPs, eligible hospitals and critical access hospitals. CQMs measure different aspects of patient care including: health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care coordination, patient engagements, population and public health, and clinical guidelines.

More information is available on the *EHR incentive programs website*.

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

PV-PQRS registration system opens July 15

The physician value (PV)-Physician Quality Reporting System (PQRS) registration system is a new application to serve the physician value modifier and PQRS programs. The PV-PQRS registration system will be open July 15 to October 15, 2013, and will allow the following:

- Physician group practices to select their calendar year (2013 PQRS group reporting mechanism, and if applicable, elect quality tiering to calculate their 2015 value-based payment modifier; and
- Individual eligible professionals to select the administrative claims reporting mechanism for CY 2013.

Note: An individuals authorized access to the CMS computer services (IACS) account is required to access the PV-PQRS registration system. You can now sign up for a new IACS account or modify an existing IACS account on the *CMS applications portal*.

For more information

Visit the *physician feedback program website* for more information on the value-based payment modifier.

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

General Information

Enrollment denials when overpayment exists

Provider types affected

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

What you need to know

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

Background

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

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

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

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

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

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

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

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

Additional information

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

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

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Expedited determinations for provider service terminations

Provider types affected

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

What you need to know

Medicare beneficiaries, or a representative acting for a beneficiary, can appeal their provider service terminations to a quality improvement organization (QIO) through the expedited determinations process. You have provider responsibilities in this process which, if not completed correctly, could impact your reimbursement. CR 7903, from which this article is taken, provides new information to the *Medicare Claims Processing Manual*; in accordance with *42 Code of Federal Regulations* (CFR), Part 405 Medicare program, expedited terminations: final rule (final rule), published November 26, 2004. The manual addition ensures consistency with provisions of the final rule and clarifies operating instructions.

Background

Excerpts from these manual changes are summarized below.

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

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

Skilled nursing facilities (SNF), including services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy). For example, a beneficiary exhausts their SNF Part A 100-day benefit, but remains in the facility under a private pay stay and receives covered physical and occupational therapy under Medicare Part B. A Notice of Medicare Non-Coverage (NOMNC) must be delivered by the SNF at the end of a Part A stay or when all of the Part B therapies are ending.

Note: SNFs includes beneficiaries receiving Part A and B services in swing beds.

Care settings in which NOMNC delivery does not apply

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

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

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

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Enrollment *(continued)*

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

Terminations *(continued)*

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

NOMNC preparation and delivery

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

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

There are some exceptions to these required delivery timeframes:

1. You may deliver the NOMNC earlier than two days preceding the end of covered services; however, its delivery should be closely tied to the impending end of coverage;
2. You should not routinely give the notice at the time services begin, unless the services are expected to last fewer than two days; and
3. You should deliver the NOMNC sooner than two days or the next to last visit before coverage ends when a beneficiary receiving home health services is unexpectedly found to no longer be homebound, and thus ineligible for covered home health care.

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

You may deliver NOMNC to representatives whom the beneficiary has authorized and appointed to act on their behalf during the appeal process. A beneficiary may designate an appointed representative via the "Appointment of Representative" form, the CMS-1696 which can be found at *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf*. You should inform the representative of the beneficiary's right to appeal a coverage termination decision, and include the following information:

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

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

If you choose to communicate the information in writing, a hard copy of the NOMNC must be sent to the representative by certified mail, return receipt

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Terminations *(continued)*

requested, or any other delivery method that can provide signed verification of delivery (e.g. FedEx, UPS). You should keep in mind that the burden is on you to demonstrate that timely contact was attempted with the representative and that the notice was delivered. The date that someone at the representative's address signs (or refuses to sign) the receipt is considered the date received. Place a copy of the annotated NOMNC in the beneficiary's medical file.

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

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

Amending the NOMNC date

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

Beneficiary responsibilities

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

The beneficiary: 1) Must be available to answer questions or supply information requested by the QIO; 2) May (but is not required to) supply additional information to the QIO that he or she believes is pertinent to the case; and 3) Must obtain a physician certification stating that failure to continue (home health or CORF services only) is likely to place his or her health at significant risk.

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

Note: You may not bill a beneficiary who has timely filed an expedited determination for disputed services until the review process (including a reconsideration by a QIO, if applicable) is complete.

If the beneficiary makes an untimely request (by not meeting the timeliness requirements described above), the QIO will accept the request for review, but is not required to complete the review within its usual 72-hour deadline. Beneficiaries have up to 60 days from the effective date of the NOMNC to make an untimely request to a QIO. When the beneficiary is still receiving services, the QIO must make a determination and notify the parties within 7 days of receipt of the request. When the beneficiary is no longer receiving services, the QIO will make a determination within 30 days of the request.

You should also be aware that the coverage protections discussed above will not apply to a beneficiary who makes an untimely request to the QIO.

Provider responsibilities

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

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

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

- A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered;
- A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review; and
- The facts specific to the beneficiary's discharge and provider's determination that coverage should end.

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Terminations *(continued)*

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

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

Please note that an HHA is not required to make a separate trip to the beneficiary's residence solely to deliver a DENC. Upon notification from the QIO of a beneficiary's request for an expedited determination, an HHA may telephone the beneficiary to provide the information contained on the DENC, annotate the DENC with the date and time of telephone contact, and file it in the beneficiary's records. A hard copy of the DENC should be sent to the beneficiary via tracked mail or other personal courier method by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. The burden is on the provider to demonstrate that timely contact was attempted with the beneficiary and that the notice was delivered.

Effect of QIO determination on continuation of care

If the QIO decision extends coverage beyond a point covered by the physician's orders (either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care) providers cannot deliver care. In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue, and be given the opportunity to reinstate orders. The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider. The expedited determination process does not override regulatory or state requirements that physician orders are required for a provider to deliver care.

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

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

> **Example 1**: If covered home health care continues following a favorable QIO decision for the beneficiary, the HHA would resume issuace of home health advance beneficiary notices (HHABN) as warranted for the remainder of this home health episode. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA even though Medicare will not pay, an HHABN with option box 1(use when item (s) and/or services (s) may be provided that will not be paid for by Medicare) must be issued to the beneficiary since this would be an initiation of non-covered care.
>
> **Example 2**: If covered SNF care continues, following a favorable QIO decision for the beneficiary, but later ends due to the end of Medicare coverage; and the patient wishes to continue receiving uncovered care at the SNF, a skilled nursing facility advance beneficiary notice (SNFABN) must be issued to the beneficiary.

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

> **Example when one notice is required**: The following is an example of an instance in which only one notice may be required when Medicare covered care is ending: A beneficiary is receiving CORF services, and all covered CORF care is ending. A NOMNC must be delivered at least two days, or two visits, prior to the end of coverage. If the beneficiary does not wish to continue the CORF services, an ABN should not be given.
>
> **Example when two notices are required**: The following is an example of an instance in which two notices may be required when Medicare covered care is ending: A beneficiary's Part A stay is ending because a skilled level of care is no longer medically necessary and the beneficiary wishes to remain in the SNF receiving custodial-level care. The beneficiary must receive the NOMNC two days prior to the end of coverage and a SNFABN must also be delivered before custodial level care begins.
>
> **Example when no notice is required**: As mentioned above, it is also possible that no notice is required when Medicare coverage is ending. The following is an example of such an instance: A beneficiary exhausts the 100 day benefit in a SNF. In this instance, neither the NOMNC nor the SNFABN should be delivered, although the latter can be issued voluntarily, as a courtesy to the beneficiary.

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Terminations *(continued)*

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

Additional information

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

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

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Prompt payment interest rate revision

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

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

The new rate of 1.75 percent is in effect through December 31, 2013.

Interest is not paid on:

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

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

Source: Publication 100-04, Chapter 1, Section 80.2.2

Update to *Program Integrity Manual* regarding reconsideration requests

Provider types affected

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

What you need to know

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

- Sections 15.25.1.2 and 15.25.2.2 (Reconsideration Requests) are revised as follows: Consistent with 42 CFR 498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request of a provider enrollment denial or revocation at any time prior to the hearing officer's (HO's) decision. The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:
  - The initial determination itself,
  - The findings on which the initial determination was based,
  - The evidence considered in making the initial determination, and
  - Any other written evidence submitted under 42 CFR 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

Additional information

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

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

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Update to Chapter 15 of the *Program Integrity Manual*

Note: This article was revised May 20, 2013, to reflect a updated change request (CR). The CR removed changes that were made to Section 15.5.20 of the PIM. The CR release date, transmittal number and link to the transmittal were also changed. All other information remains the same. This information was previously published in the March 2013 *Medicare B Connection*, pages 46-47.

Provider types affected

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

Provider action needed

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

Key points

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

1. **Owning and managing individuals**: If your Medicare contractor is unsure as to whether the officers and directors/board members of the enrolling provider or supplier's corporate owner/parent also serve as the enrolling provider or supplier's officers and directors/board members, your contractor will contact you for clarification.
2. **If there is a change in correspondence or special payments address/change of electronic funds transfer (EFT) information**: Your Medicare contractor may confirm the change with the contract person listed.
3. **Rejections**: Your Medicare contractor may reject an application that was signed more than 120 days prior to the date on which the contractor received the application—assuming the provider or supplier failed to furnish a new, appropriately-signed certification statement within 30 days of the contractor's request to do so.
4. **Timeframe**: Absent a CMS instruction or directive to the contrary, your Medicare contractor will send a rejection letter no later than five business days after the contractor concludes that the provider or supplier's application should be rejected.
5. **Be aware**: If your contractor rejects an application, it will either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.
6. **Potential identity theft or other fraudulent activity**: In conducting the verification activities described in Section 15.7.5 of Chapter 15, if the contractor believes that a case of identity theft or other fraudulent activity likely exists, the contractor will notify its provider enrollment operations group business function lead (PEOG BFL) at CMS immediately.
7. **Non-certified suppliers and individual practitioners**: Absent a CMS instruction or directive to the contrary, an approval letter under Section 15.9.1 of Chapter 15 will be sent no later than five business days after the contractor concludes that the provider or supplier meets all Medicare requirements and that his/her/its application can be approved.
8. **Unsolicited additional information**: Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request; rather, it is considered to be and will be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first will be processed to completion prior to the second one being processed to completion.
9. **Miscellaneous policies**: In situations where a provider with multiple PTANs is to be deactivated for non-billing, the contractor will only deactivate the non-billing PTAN(s).
10. **Partnerships**: Only partnership interests in the enrolling provider need be disclosed in Section 5 of the Form CMS-855. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in Section 5.

(continued on next page)

Update *(continued)*

11. **Processing and approval of corrective action plans (CAPs)**: The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request. If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless stated otherwise in another CMS directive or instruction – the effective date is based on the date the supplier came into compliance with all Medicare requirements.

Additional information

You can find the official instruction, CR 8155, issued to your carrier, FI, A/B MAC, or RHHI by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R462PI.pdf*. The entire revised Chapter 15 of the PIM is attached to that CR.

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

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

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

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.

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.

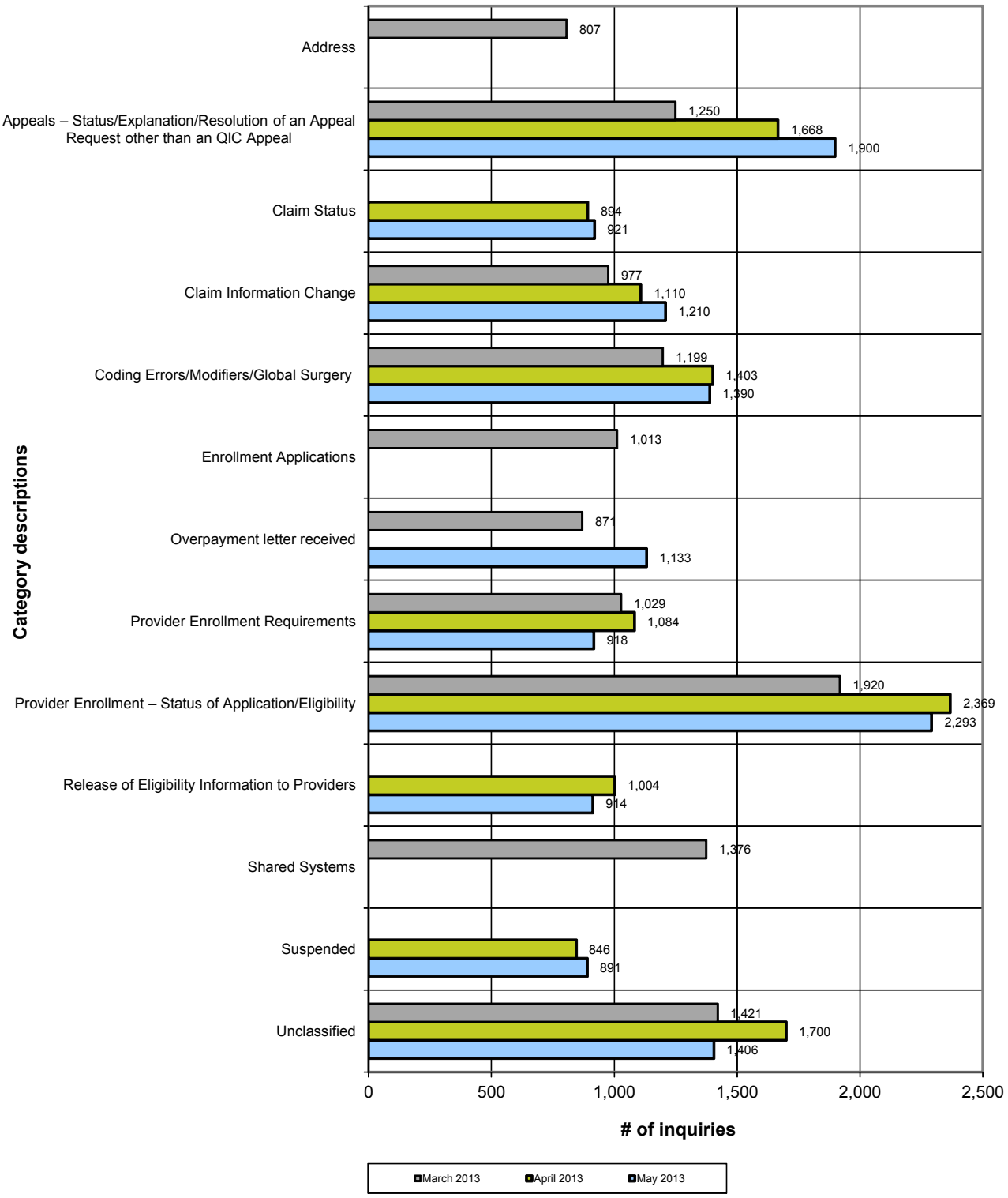
CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at *http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html*.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

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 March-May 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 March-May 2013



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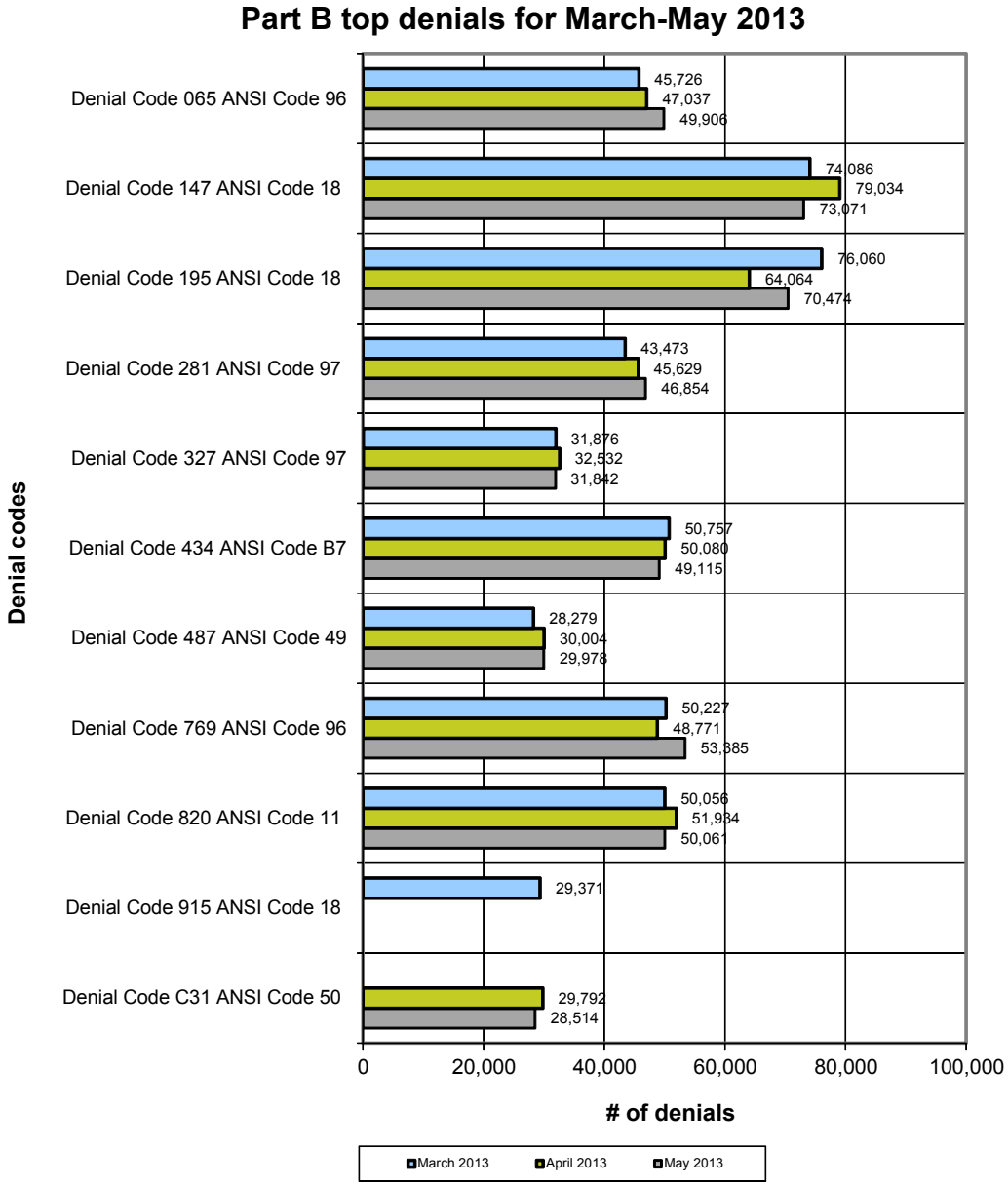
Top *(continued)*



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.

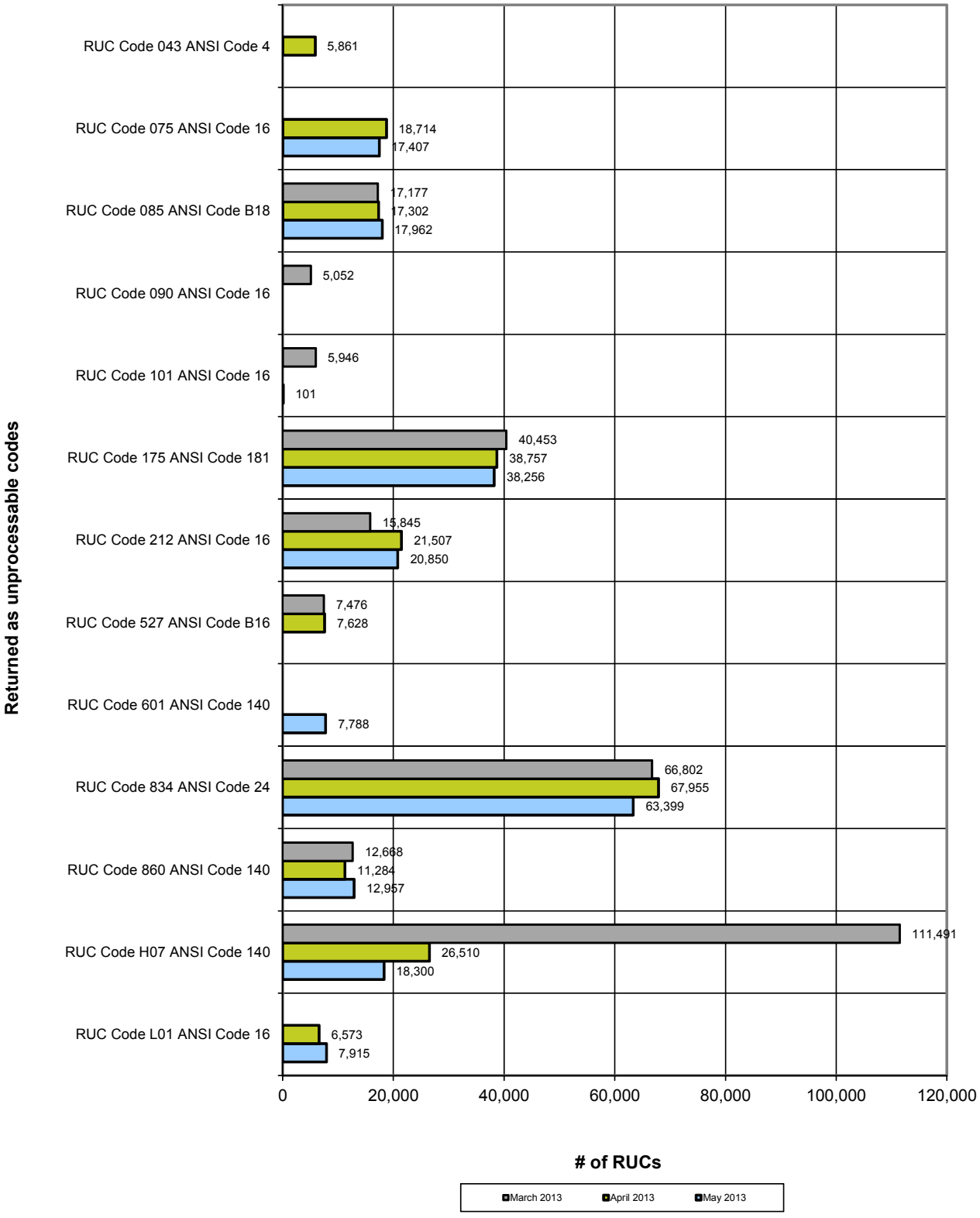
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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 March-May 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

Contents

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

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

LCD ID number: L32100 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates intravenous (IV) and monoclonal antibodies in the treatment of osteoporosis and their other indications was most recently revised September 1, 2012. Since that time, based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8286, transmittal 2695, dated May 2, 2013 (Quarterly HCPCS Drug/Biological Code Changes), CR 8291, transmittal 2708, dated May 17, 2013 (July Update to the CY 2013 Medicare Physician Fee Schedule Database [MPFSDB]), and CR 8328, transmittal 2717, dated May 31, 2013 (July 2013 Update of the Ambulatory[ASC] Payment System), the status indicators for HCPCS codes J3487 and J3488 were changed to an "I" (not valid for Medicare purposes). HCPCS codes J3487 and J3488 were replaced with new HCPCS code Q2051. Therefore, the "*CPT*®/HCPCS Codes" and "ICD-9 Codes that Support Medical Necessity" sections of the LCD were updated to remove HCPCS codes J3487 and J3488 and add HCPCS code Q2051.

Effective date

This LCD revision is effective for services rendered **on or after July 1, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

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

LCD ID number: L29157 (Florida)
LCD ID number: L29419 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for doxorubicin, liposomal (Doxil/Lipodox) was most recently revised January 1, 2013. Since that time, based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8286, transmittal 2695, dated May 2, 2013 (Quarterly HCPCS Drug/Biological Code Changes), CR 8291, transmittal 2708, dated May 17, 2013 (July Update to the 2013 Medicare physician fee schedule database [MPFSDB]), and CR 8328, transmittal 2717, dated May 31, 2013 (July 2013 Update of the ambulatory [ASC] payment system), the "Indications and Limitations of Coverage and/or Medical Necessity" and "*CPT*®/HCPCS Codes" sections of the LCD were revised to remove HCPCS code J9002 (Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg) and replace it with HCPCS code Q2050 (Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg).

Effective date

This LCD revision is effective for services rendered **on or after July 1, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

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 February 21, 2013. Since that time, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add diagnosis codes 608.89 (Other specified disorders of male genital organs, other) and 608.9 (Unspecified disorder of male genital organs) for *CPT*® codes *93975* and *93976*.

Effective date

This LCD revision is effective for claims processed **on or after June 12, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Gemcitabine (Gemzar®) – revision to the LCD

LCD ID number: L29182 (Florida)
LCD ID number: L29432 (Puerto Rico/U.S. Virgin Islands)

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

Effective date

This LCD revision is effective for services rendered **on or after June 18, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Noncovered services – revision to the LCD

LCD ID number: L29288 (Florida)
LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised June 4, 2013. Since that time, fluarix quadrivalent was approved by the Food and Drug Administration (FDA) effective for services rendered on or after December 14, 2012, therefore, *CPT*® code *90686* was removed from the "Local Noncoverage Decisions-Drugs and Biologicals" section of the LCD. This LCD revision is effective for claims processed **on or after July 1, 2013**, for services rendered **on or after January 1, 2013**.

Based on change request 8338, transmittal 2718, dated June 7, 2013 (July 2013 Update of the Hospital OPPS), the descriptor was revised for HCPCS code C9734. Therefore, for consistency the descriptor for HCPCS code C9734 was also changed in the Part B LCD. This LCD revision is effective for services rendered **on or after July 1, 2013**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Vinorelbine tartrate (Navelbine®) – revision to the LCD

LCD ID number: L29306 (Florida)
LCD ID number: L29486 (Puerto Rico/U.S. Virgin Islands)

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

Effective date

This LCD revision is effective for services rendered **on or after June 18, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Additional Information

C9285/J3490: Synera™ topical patch

Synera™ (lidocaine 70 mg/tetracaine 70 mg) topical patch (HCPCS codes C9285/J3490) is indicated for use on intact skin to provide local dermal analgesia for superficial venous access and superficial dermatological procedures such as excision, electrodessication and shave biopsy of skin lesions. Based on literature review and review of the Food and Drug Administration (FDA) approval letter/clinical pharmacology information it has been determined that Synera™ topical patch is not separately payable and therefore, is not considered medically reasonable and necessary.

Minimum criteria for reimbursement of diagnostic ultrasound tests

First Coast Service Options Inc. (First Coast) recognizes that the miniaturization of electronic devices and advances in technology will lead to the increasing availability of certain real time images to clinicians. Such images may or may not be associated with improved test performance and added value to diagnostic/ therapeutic interventions. These evolving devices can range in complexity and capability from lightweight pocket-sized units completely contained within the examiner's hand to complex equipment systems where only the probe itself is hand-held.

The appropriate assignment of a specific ultrasound *Current Procedural Terminology* (*CPT*®) code(s) is not determined by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure. While Medicare does not endorse any particular machine or device, professional organizations are available to address the functionality of particular machines and accredit laboratories that perform ultrasound studies. *CPT*® has guidelines addressing radiology coding and descriptors for procedures please see the 2013 *CPT*® book, radiology section, subsection, diagnostic ultrasounds page(s) 394-395. According to *CPT*® standards physicians and allied personnel are required to code to specificity and should only submit codes that are clearly separately reportable.

To be reimbursable by Medicare, a diagnostic ultrasound test must meet at least these minimum criteria (**this is not an all-inclusive list**):

- It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.
- It is expected that these services would be performed as indicated by current medical literature and/or current standards of practice.

(continued on next page)

Ultrasound *(continued)*

- It must be billed using the *CPT*® code that accurately describes the service performed including the intent of the code based on American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) established average intra service time and practice expense.
- The technical quality of the exam must be in keeping with accepted national standards and not require a follow-up ultrasound examination to confirm the results.
- The study must be done for an accepted clinical indication by a properly trained examiner and interpreted by qualified individuals within their scope of practice (weekend courses may not demonstrate expertise)
- The medical necessity, images, findings, interpretation and report must be documented in the medical record.
- An examination that does not meet the standards required for a complete diagnostic ultrasound examination will not be recognized as a valid diagnostic ultrasound service and will be non-covered.

Studies that do not meet these minimum criteria, regardless of the equipment used, should not be billed under diagnostic ultrasound codes or other *CPT*® codes. For example:

- An emergency room "quick look" ultrasound to assess the chest for the presence of fluid, etc., may be useful as an extension of the physical examination. However, it does not meet the above standards and should not be coded as *CPT*® code *76604* (*Ultrasound, chest, (includes mediastinum) real time with image documentation*).

The assignment of a specific ultrasound *CPT*® code is not determined by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure.

Interventional pain management procedures address a range of interventions, some with X-ray based imaging included in the procedure or separately coded when indicated. There are certain scenarios in which First Coast may or may not cover ultrasound imaging for *CPT*® code *76942* (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*) in the following clinical instances (this is not an all- inclusive list). For example:

- An orthopedic surgeon, rheumatologist, or other physician/NPP performing a routine arthrocentesis of the knee for diagnosis and/or therapy (visco supplementation, corticosteroid injection) does not meet the guidelines for this procedure code. Also, LCD 29307 – Viscosupplementation Therapy for Knee, specifically non-covers ultrasound imaging for viscosupplementation.
- Many episodes of care would not meet the intent of the code or meet the reasonable and necessary threshold for coverage (such as podiatrist or other provider treating Morton's neuroma, physician/NPP doing trigger point injections, nerve injections, physician/NPP treating symptomatic varicose veins, etc.)
- Ultrasound guidance for needle placement may be payable when clinical circumstance warrants, such as a procedure where anatomy/organ evaluation is necessary; joint procedure where risk of osteomyelitis is significant; and the medical necessity of the service is clearly documented in the medical record (the unique patient has indications that are medically reasonable and necessary, and the images, findings, interpretation and report are separately documented in the medical record).

It is the expectation that physicians utilizing ultrasound guidance for standard office based needle procedures, either not code separately or bill the unlisted code (*76999 Unlisted ultrasound procedure (eg, diagnostic, interventional*) with an appropriate fee.

- *CPT*® code *76942* was weighted by the (RUC) to address physician work, practice expense & physician liability. The intra-service time of *CPT*® code *76942* is 30 minutes.
- Of note, **a large joint arthrocentesis is rated for five minutes of intra-service time**.
- Not all marginal improvements in the technical aspects of a procedure add complete value (are reasonable and necessary and/or are the established standard of care) nor are such improvements completely addressed in *CPT*® and the associated Medicare physician fee schedule.

(continued on next page)

Ultrasound *(continued)*

CPT® codes *76881* (*Ultrasound, extremity, nonvascular, real-time with image documentation; complete*) and *76882* (*Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific*) describe an ultrasound imaging procedure for the evaluation of muscles, tendons, joints, and/or soft tissue structures generally after a standard radiograph does not determine the diagnosis and other imaging is not indicated (MRI etc.). Use of these procedures codes with aspiration and/or injection procedures would not be expected unless a separate musculoskeletal diagnostic evaluation is indicated and documented as reasonable and necessary.

- Of note, *CPT®* codes *76881* and *76882* are generally paid if coded and billed correctly by qualified physicians and all other requirements of the Medicare program are satisfied though coverage (the medical record supports the medical necessity of the services). These two codes have 15 minutes intra service time and 11 minutes intra service time respectively unless a separate musculoskeletal diagnostic evaluation is indicated and documented as reasonable and necessary.

Per the *Code of Federal Regulations* (CFR) Section 410.32, all diagnostic tests must be ordered by the physician/nonphysician practitioner who is treating the patient, that is, the physician/nonphysician practitioner who furnishes a consultation or treats a patient for a specific medical problem and who uses the results in the management of the patient's specific medical problem. Tests not ordered by the physician/nonphysician practitioner who is treating the patient are not reasonable and necessary.

The provider is responsible for ensuring the medical necessity of the diagnostic radiology procedure(s) and maintaining the medical record, which must be available to First Coast Medicare upon request. Diagnostic radiology procedures, including ultrasound, are medically reasonable and necessary only if the outcome will potentially impact the diagnosis or clinical course of the patient. It is also expected that ultrasound services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Educational Events

Upcoming provider outreach and educational events
July - August 2013

Medifest 2013 Tallahassee; Building a stronger Medicare community through education

When: Tuesday-Wednesday, July 24-25
Time: 8:00 a.m.-4:30 p.m.
Type of event: Face-to-face

Prepayment medical review of hospital claims – inpatient DRGs

When: Wednesday, August 14
Time: 11:30 a.m.-1:00 p.m.

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

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

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

Pending request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Denied request for lack of response:
Submit as 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.
Medicare EDI
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.
Medicare EDI
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