Medicare B Connection

A Newsletter for MAC Jurisdiction 9 Providers

July 2013

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How does First Coast rate with you?

Register now for your chance to rate your satisfaction with us

Your opinions matter not only to First Coast Service Options but also to the Centers for Medicare & Medicaid Services. Together, we work with providers like you to continuously improve the Medicare program. As your Medicare administrative contractor (MAC), improving the quality of service we provide to you is our top priority, but we can't do it alone.

Teamwork is the key. The comments and suggestions you share through our provider feedback forums help us know not only what we are doing right but also what we can do better.

Now, we invite you and the other valued members of our provider community to rate your satisfaction with our performance in a in a brand-new way …

Introducing the MAC Satisfaction Indicator

The **MAC Satisfaction Indicator (MSI)** is an important new tool that will allow CMS to measure the level of satisfaction experienced by the providers and suppliers within each contractor's jurisdiction.

Each year, CMS will randomly select its MSI administration sample from a list of providers who have registered to become participants.

Your MSI participation will help us improve Medicare

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

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

Registration required

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

Your opinions do matter. Don't miss your chance to be among those selected to take part in the MSI survey and represent First Coast's provider community.

Let your voice be heard: *Register today*!

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Ready. SPOT, GO!

The Secure Provider Online Tool (the SPOT) offers faster access to claims information, benefit/eligibility data, payment history, and analytical data reports. Find out how to register plus more at *http://medicare.fcso.com/Help/256025.pdf*.

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.

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Articles included in the *Medicare B Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

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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 19.3

Provider types affected

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

What you need to know

This article is based on change request (CR) 8376, which informs Medicare contractors about the release of the latest package of National Correct Coding Initiative (NCCI) edits, version 19.3, which will be effective October 1, 2013. Make sure that your billing staffs are aware of these changes.

Background

The latest package of CCI edits, version 19.3, will be effective on October 1, 2013. 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.

Version 19.3 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.

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 8376, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2733CP.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 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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Implementation Date: October 7, 2013

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New waived tests

Provider types affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories submitting claims to Medicare claims administration contractors (Medicare contractors) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare carrier or A/B MAC for a *Current Procedural Terminology* (*CPT*®)

code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Caution – what you need to know

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *CPT*® codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and thus requiring certification) change each year. Change request (CR) 8301, from which this article is taken, informs carriers and MACs about the latest new *CPT*® codes that are subject to CLIA edits.

Go – what you need to do

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

Background

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The *CPT*® codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR 8301 (i.e., *CPT*® codes: *81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.

CPT® code	Effective date	Description
*82274*QW and G0328QW	01/3/2013	OSOM iFOB Test OSOM iFOBT Contol Kit
*87804*QW	02/13/2013	Henry Schein OneStep+ Influenza A&B Test
G0434QW	02/27/2013	American Screening Corporation Discover Drug Test Cards
G0434QW	02/27/2013	American Screening Corporation Discover Multi-panel Drug Test Cups
*81003*QW	03/15/2013	Moore Medical, mooremedical Urine Analyzer U120
*82055*QW	03/25/2013	Chematics Inc. Alco-Screen Saliva Alcohol Test

Additional information

The official instruction, CR 8301, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2745CP.pdf*.

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

MLN Matters® Number: MM8301
Related Change Request (CR) #: CR 8301
Related CR Release Date: July 24, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2745CP
Implementation Date: October 7, 2013

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Drugs and Biologicals

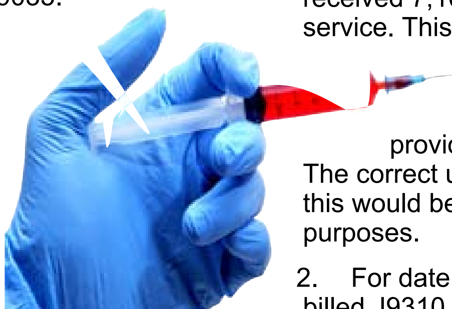
Converting dose to units billed for rituximab and bevacizumab

Provider types affected

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

What you need to know

This article informs you that the recovery auditors conducted complex reviews of claims billed for rituximab and bevacizumab. According to the Healthcare Common Procedure Coding System (HCPCS), rituximab is coded as J9310 and bevacizumab is coded as C9257 or J9035. Recovery auditors reviewed medical records to verify the exact number of milligrams (mg) administered and identify the correct number of units that should have been billed to Medicare.



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

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

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

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

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

Examples of findings

Rituximab

1. For date of service October 27, 2009, the provider billed J9310 for 71 units. Since J9310 has 1 unit equal to 100 mg, this would mean that the patient received 7,100 mg of rituximab for that date of service. This seemed abnormal and, therefore, a chart was requested. The medical record showed that the patient only received 710 mg and the provider billed an incorrect number of units. The correct units should be 7.1 units; however, this would be rounded up to 8 units for billing purposes.
2. For date of service April 29, 2010, the provider billed J9310 for 100 units. Since J9310 has 1 unit equal to 100 mg, this would mean that the patient received 10,000 mg of rituximab for that date of service. This seemed abnormal and, therefore, a chart was requested. The medical record showed that the patient only received 1,000 mg and the provider billed an incorrect number of units. The units were adjusted down to 10 units to reflect the proper dosage amount given.

Bevacizumab

1. A provider billed code J9035 for 1,300 units. Since J9035 has 1 unit equal to 10 mg, this would mean that the patient received 13,000 mg of bevacizumab for that date of service. It is unlikely a patient would receive 13,000 mg of bevacizumab in one day. The medical record showed that the patient only received 1,300 mg and the provider billed an incorrect number of units. Therefore, the correct number of units that should have been billed is 130 units.
2. For date of service October 6, 2010, the provider billed code J9035 for 1,600 units. Since J9035 has 1 unit equal to 10 mg, this would mean that the patient received 16,000 mg of bevacizumab for that date of service. It is unlikely a patient would receive 16,000 mg of bevacizumab in one

(continued on next page)

Converting *(continued)*

day. The medical record showed that the patient only received 1,600 mg and the provider billed an incorrect number of units. Therefore, the correct number of units that should have been billed is 160 units.

Additional information

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

Links to additional resources

National coverage determination (NCD) for bevacizumab

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

Supplementary *MLN Matters*® articles

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

Alpha-numeric HCPCS codes

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

Medicare manual references

- *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf*
- *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*

2013 Medicare Part B drug average sales price

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

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Durable Medical Equipment

Payment related to prior authorization for power mobility devices

Note: This article was revised June 28 to reflect the revised change request (CR) 8056 issued June 25. In this article, the CR release date, transmittal number and the Web address for accessing CR 8056 were revised. This information was previously published in the April 2013 *Medicare B Connection*, Pages 10-11.

Provider types affected

This *MLN Matters*® article is intended for Medicare fee-for-service (FFS) physicians/treating practitioners who prescribe power mobility devices (PMDs) for Medicare beneficiaries who reside in the demonstration states of California, Texas, Florida, Michigan, Illinois, North Carolina, and New York and submit a prior authorization request to DME Medicare administrative contractors for a PMD.

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

(continued on next page)

PMD *(continued)*

Background

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

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

In submitting the G9156 code, providers must also show a billed amount of $10 or the claim will reject.

If the G9156 is submitted with other codes, Medicare will split the claim. Thus, providers should submit the G9156 code on an assigned claim with no other codes.

Additional information

The official instruction, CR 8056, issued to your carrier and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1250OTN.pdf*.

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

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

MLN Matters® Number: MM8056 *Revised*
Related Change Request (CR) #: CR 8056
Related CR Release Date: April 5, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1250OTN
Implementation Date: July 1, 2013

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Evaluation and Management

Pulmonary procedures and evaluation and management services

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and non-physician practitioners submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors (MACs)) for pulmonary diagnostic procedures and evaluation and management services to Medicare beneficiaries.

What you need to know

Recovery auditors have identified overpayments associated with evaluation and management (E/M) services (*Common Procedure Terminology* (*CPT*®) *99211-99213*) for pulmonary diagnostic procedures. These overpayments occurred due to claims billed without modifier 25 on the same date of service as a pulmonary diagnostic, therapeutic, or monitoring procedure (*94010-94799*).

You and your staff should be familiar with the definitions of *CPT*® *99211-99213* and the correct use of modifier 25, when providing pulmonary diagnostic, therapeutic, or monitoring procedures.

Background

CPT® *99211-99213* – E/M services

- *CPT*® *99211* – Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.
- *CPT*® *99212* – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of three key

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DMEPOS *(continued)*

components. Usually the presenting problem(s) are self-limited or minor.

- *CPT® 99213* – Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes of face to face time are spent performing or supervising these services.

Definition of modifier 25: Significant, separately identifiable evaluation and management service by the same physician (or same qualified nonphysician practitioner) on the same day of the procedure or other service.

Billing considerations

- If a physician in attendance for a pulmonary function study obtains a history and performs a physical examination related to the pulmonary function testing, separate reporting of an E/M service is not appropriate.
- If a significant, separately identifiable E/M service is performed unrelated to the performance of the pulmonary function test, an E/M service may be reported with modifier 25.
- If the E/M was not separately identifiable, then the E/M service should not be billed.

Case studies

1. A provider billed *CPT®* code *94010* (breathing capacity test) with no modifier for date of service September 19, 2011. The same provider also billed *CPT®* code *99213* for the same patient on the same date of service without a modifier. *CPT®* code *99213* should not be billed if the E/M service was related to the code *94010*. Separate reporting of an E/M service is not appropriate because a health care professional in attendance for a pulmonary function study obtains a history and performs a physical examination related to the pulmonary function testing. If the E/M service was not related to the *94010*, then *99213* can be billed with modifier 25.
2. A provider billed *CPT®* code *94060* (evaluation of wheezing) with no modifier for date of service February 12, 2011. The same provider also billed *CPT®* code *99212* for the same patient on the same date of service without a modifier. *CPT®* code *99212* should not be billed if the E/M service was related to the code *94060*. Separate reporting of an E/M service is not appropriate because a physician in attendance for a pulmonary function study obtains a history and performs a physical examination related to the pulmonary function testing. If the E/M service was not related to the *94060*, then *99211* can be billed with modifier 25.

Use of *CPT®* modifier 25, significant evaluation and management service by same physician on date of global procedure

The *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.6, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*, requires that *CPT®* modifier 25 only be used on claims for E/M services, and only when these services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or other service. Medicare contractors pay for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier 25 is added to the E/M code on the claim.

Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified nonphysician practitioner in the patient's medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.

Additional information

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

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Billing for visits to patients in swing bed facilities

Provider types affected

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

What you need to know

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

Background

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

Through the review of previous CERT reports, CMS has learned that there have been a high percentage of errors occurring in billing for E/M services rendered in swing bed facilities. Some providers are inappropriately billing hospital visit codes for E/M services rendered in swing bed facilities (with nursing facility levels of care) when they should be billing nursing facility visit E/M codes. Physicians should bill hospital care codes when the facility is providing inpatient hospital care to the beneficiary and nursing facility care codes when the swing bed is being used to provide skilled nursing services. The *Current Procedure Terminology* (*CPT*®) codes involved include the following:

- *99221-99223* Initial hospital care
- *99231-99233* Subsequent hospital care
- *99238-99239* Hospital discharge day management

Example:

A 92 year old female was admitted to a hospital with swing bed approval for nursing facility care on April 30, 2010, and was discharged on May 6, 2010.

A physician billed *CPT*® code *99232* (Subsequent hospital care) for a date of service May 5, 2010, a day on which the facility was providing services at a skilled nursing level. The date of service (May 5, 2010), was during the stay for nursing facility care at a swing bed approved facility. Therefore, *CPT*® code *99232* was an overpaid claim.

Additional information

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

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

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Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our website feedback form, available at *http://medicare.fcso.com/Feedback/160958.asp*.

Hospital stays when elective surgery has been canceled

The Office of Inspector General (OIG) has identified inappropriate payments for inpatient hospital claims when the beneficiary was admitted for an elective surgery (e.g., cataract removal) but the surgery was canceled. However, the patient's symptoms must be severe enough to warrant an inpatient stay. Patients whose elective surgeries have been canceled, and who exhibit no other severe symptoms and receive no "intensive" inpatient services, would not meet the requirements for an inpatient stay.

Chapter 6, Section 6.5.2, of the *Medicare Program Integrity Manual* states that the review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Inpatient care, rather than outpatient care, is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay.

Additional information

Chapter 6, Section 6.5.2, of the *Medicare Program Integrity Manual* is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf#page=36*.

Special edition SE1037 (Guidance on Hospital Inpatient Admission Decisions) is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1037.pdf*.

Hospice

Hospice related services – Part B

Provider types affected

This *MLN Matters*® special edition (SE) article is intended for physicians submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors (MACs)) for services provided to Medicare beneficiaries who are in a hospice period of coverage.

What you need to know

This article informs you that recovery auditors conducted automated claim reviews of medical services provided as separate services, when the Centers for Medicare & Medicaid Services (CMS) regulation or policy, or local practice dictates that they should have been billed together, rather than individual services for Medicare patients in hospice care.

Provider action needed

CMS is publishing this article to alert providers that they should identify if a beneficiary is enrolled in hospice. Providers can ask the beneficiary or his/her legal representative if he or she is enrolled in hospice. This information should be documented in the beneficiary's medical record. Providers should educate beneficiaries and their families that once the beneficiary is enrolled in Hospice, they should contact the hospice provider to arrange for any care they need. If the hospice provider does not arrange the services the beneficiary needs, the beneficiary may be financially responsible for the services. The beneficiary and their family should also be aware

(continued on next page)

Hospice *(continued)*

that the beneficiary or his/her legal representative may revoke the election of hospice care at any time in writing. To revoke the election of hospice care, the beneficiary must file a document with the hospice that includes a signed statement that the beneficiary revokes the election for Medicare coverage of hospice care for the remainder of that election period and the effective date of that revocation. Note that a verbal revocation of benefits is **not** acceptable. The individual forfeits hospice coverage for any remaining days in that election period. A beneficiary may not designate an effective date of the revocation that is earlier than the date that the revocation is made.

Upon revoking the election of Medicare coverage of hospice care for a particular election period, a beneficiary resumes Medicare coverage of the benefits waived when hospice care was elected. A beneficiary may at any time elect to receive hospice coverage. For more information regarding hospice services, please see the references listed in the *Additional information* section of this article.

Services related to a hospice terminal diagnosis provided during a hospice period are included in the hospice payment and are not paid separately.

For beneficiaries enrolled in hospice, Medicare contractors should deny any Part B services furnished on or after January 1, 2002, that are submitted without either GV modifier (Attending physician not employed or paid under arrangement by the patients hospice provider) or GW modifier (Service not related to the hospice patients terminal condition). Contractors should deny services that are submitted with the GW modifier but for which, during medical review, the service is determined to be related to the terminal diagnosis. Contractors should deny services that are submitted with the GV modifier if it is determined that the physician services were furnished by hospice-employed physicians and nurse practitioners (NP) or by other physicians under arrangement with the hospice.

Case studies

Example 1: A patient is enrolled in Hospice and goes to a physician's office for closed treatment of a metatarsal fracture, *CPT® 28470*.

Resolution: If the procedure is unrelated to the terminal diagnosis (non-hospice related), the physician's bill should contain GW modifier (Service not related to the hospice patients terminal condition). If this modifier is not appended, the procedure is related to the terminal diagnosis and should not be reimbursed under the Part B benefit. Thus, the claim is in error, since the services are considered included with payments under the hospice benefit.

Example 2: The patient is listed as being on hospice starting August 1, 2010, through August 31, 2010. Then a provider billed *CPT® 45378*, diagnostic colonoscopy with no modifiers August 3, 2010, to Part B.

Resolution: The billing of *CPT® 45378* would be incorrect since the beneficiary was enrolled in hospice and there can be no separate reimbursement unless the service was unrelated to the terminal diagnosis or the attending physician was otherwise entitled to separate reimbursement, which would be reflected by GV modifier (Attending physician not employed or paid under arrangement by the patients hospice provider) or GW modifier (Service not related to the hospice patients terminal condition). Contractors should also deny services that are submitted with the modifier but for which, during medical review, the service is determined to be related to the terminal diagnosis.

Additional information

To review the "Hospice Payment System Fact Sheet," go to: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospice_pay_sys_fs.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*.

To review the *Medicare Claims Processing Manual*, Chapter 11, Sections 10,40.1.3, 40.2 and 50 - Processing Hospice Claims, visit *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf*.

To review the *Medicare Benefit Policy Manual*, Chapter 9, Sections 10, 40.1.9 - Coverage of Hospice Services Under Hospital Insurance, go to *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf*.

To review *MLN Matters®* MM8142 on the "Hospice Monthly Billing Requirement," go to *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8142.pdf*.

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Surgery

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

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is publishing this article to remind providers of the global surgery period and to educate providers on how to correctly bill for additional/subsequent procedures performed in the 90-day global period. You and your billing staff should review and be familiar with the payment guidelines for evaluation and management (E/M) services provided during the global surgery period.

Background

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

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

In addition, where appropriate, modifier 79 (Unrelated procedure or service by the same physician during the postoperative period) may be used. CMS established modifier 79 to simplify billing for services provided to a patient by the same physician during the postoperative period that were unrelated to the original surgical procedure and not included in the payment for the surgical procedure.

Make certain you and/or your billing staff are **not** billing for E/M services that are already included in the payment for global surgery. Your staff may want to review the payment guidelines for E/M services provided during the global period of surgery. These instructions can be found in the *Medicare Claims Processing Manual*, Chapter 12, Section 40, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf*.

Additional information

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

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

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Co-surgery not billed with modifier 62

Provider types affected

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

What you need to know

Recovery auditors have identified significant payment errors because of failure to appropriately apply the co-surgeon modifier, used when two or more surgeons of different specialties contribute to one operative session and each separately submit claims to Medicare.

When two or more surgeons with different specialties submit claims for the same operative session for the same beneficiary and same date of service, all providers must use the co-surgeon modifier. When two different providers bill the same *CPT*® code, same patient and same date of service and one of the providers bills with modifier 62, the other provider must also bill with modifier 62. Note, however, that modifier 62 may only be used when the co-surgeons are of different specialties and are working simultaneously.

Background

The *Medicare Claims Processing Manual*, Section 40.8, Claims for Co-surgeons and Team Surgeons, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*, provides the following guidance:

Section 40.8. Claims for co-surgeons and team surgeons

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier 62 (two surgeons). Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant.

Billing instructions

The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons:

- **Modifier 62** – if two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier 62. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the Medicare fee schedule database (MFSDB).
- **Modifier 66** – if a team of surgeons (more than two surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier 66. Field 25 of the MFSDB identifies certain services submitted with a 66 modifier which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing "by report."
- **Different procedures require no modifier** – If surgeons of different specialties are each performing a different procedure (with different *CPT*® codes), neither co-surgery nor multiple surgeon rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services.

Payments

For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for each cosurgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "by report" basis.

Case examples from the recovery auditor review

- A provider bills for *CPT*® *61548* (*Hypophysectomy or excision of pituitary tumor*), and bills with modifier 62, for a patient on date of service March 8, 2012. A different provider bills for the same service for the same patient on the same date of service because he/she was the co-surgeon, yet did not bill with the modifier 62. The second surgeon was overpaid for failing to properly apply modifier 62.
- A provider bills for *CPT*® *49652* (*Laparoscopy, surgical repair, ventral, umbilical, spigelian or epigastric hernia*), and bills with modifier 62, for a patient July 2, 2011. A different provider bills for the same service for the same patient on the same date of service because he/she was the co-surgeon, yet did not bill with modifier 62. The second surgeon was overpaid for failing to properly apply modifier 62.

In both of these examples, providers should append the appropriate modifier to the claim line when they are the co-surgeon, operating on the same beneficiary, on same date of surgery.

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Co-surgery *(continued)*

Additional information

You may wish to review the *Medicare Claims Processing Manual*, Chapter 12, Section 40.8 (Claims for Co-Surgeons and Team Surgeons), which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

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

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Cataract removal – Part B

Provider types affected

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

What you need to know

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

Background

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

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

Codes involved with definition of each code

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

MPFSDB *(continued)*

CPT®	Definition of *CPT®* code
66982	*Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)*
66983	*Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)*
66984	*Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)*

Case studies

Recovery auditors presented the following examples to illustrate this policy:

Example 1: For date of service (DOS) October 20, 2009, the provider billed and received reimbursement for code *66852* LT modifier and also *66984* LT modifier. Since these codes are mutually exclusive of one another only one code should have been reimbursed. Per the *NCCI Policy Manual CPT®* codes describing cataract extraction (*66830-66984*) are mutually exclusive of one another. Only one code from this *CPT®* code range may be reported for an eye. Therefore Medicare recovered payment for *CPT®* code *66984*.

Example 2: For DOS November 23, 2010, the provider billed and received reimbursement for 2 units of *CPT®* code *66984* RT modifier. Since cataract removal can only occur once per eye for the same date of service this would be an overpayment. Medicare would adjust the units down to 1 unit for this claim line.

Additional information

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

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

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Guidance to reduce Mohs surgery reimbursement issues

Provider types affected

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

What you need to know

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

Background

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

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MOHS *(continued)*

MMS is a two-step process in which: 1) The tumor is removed in stages, followed by immediate histologic evaluation of the margins of the specimen(s); and 2) Additional excision and evaluation is performed until all margins are clear. Further, the physician performing MMS serves both as surgeon and pathologist; performing not only the excision but also the histologic evaluation of the specimen(s).

Specifically, the descriptions for these Mohs-specific *Current Procedural Terminology* (*CPT*®) codes are:

- *CPT*® code *17311*: Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks.

- *CPT*® code *17312*: Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure).
- *CPT*® code *17313*: Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks.
- *CPT*® code *17314*: Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure).
- *CPT*® code *17315*: Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure).

The identified coding problems

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

- **Example 1**: A physician billed *CPT*® code *17311* (MMS), while on the same date of service *CPT*® code *88305* (Surgical pathology, gross and microscopic examination) for the preparation and interpretation of the slides taken during the procedure, was separately billed for a specimen examination by a different practitioner without a modifier. *CPT*® code *17311* was, therefore, an overpaid claim.
- **Example 2**: A physician billed *CPT*® code *17313* (MMS) while on the same date of service *CPT*® code *88305* (Surgical pathology, gross and microscopic examination) for the preparation and interpretation of the slides during the procedure was separately billed for a specimen examination by a different practitioner without a modifier. *CPT*® code *17313* was, therefore an overpaid claim.

Coding and documentation guidance to help prevent reimbursement problems

The majority of skin cancers can be managed by simple excision or destruction techniques. The medical record of a patient undergoing MMS should clearly show that this procedure was chosen because of the complexity (e.g. poorly defined clinical borders,

(continued on next page)

MOHS *(continued)*

possible deep invasion, prior irradiation), size or location (e.g. maximum conservation of tumor-free tissue is important). Medicare will consider reimbursement for MMS for accepted diagnoses and indications, which you must document in the patient's medical record as being appropriate for MMS and that MMS is the most appropriate choice for the treatment of a particular lesion.

Additionally, you should be aware of Mohs Medicare coverage limitations: 1) Only physicians (MD/DO) may perform MMS; 2) The physician performing MMS must be specifically trained and highly skilled in MMS techniques and pathologic identification; and 3) As mentioned above, if the surgeon performing the excision using MMS does not personally provide the histologic evaluation of the specimen(s), the *CPT*® codes for MMS cannot be used, rather the codes (*11600-11646*) for the standard excision of malignant lesions should be chosen.

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

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

You must describe the histology of the specimens taken in the first stage. That description should include depth of invasion, pathological pattern, cell morphology, and, if present, perineural invasion or presence of scar tissue. For subsequent stages, you may note that the pattern and morphology of the tumor (if still seen) is as described for the first stage; or, if differences are found, note the changes. There is no need to repeat the detailed description documented for the first stage, presuming that the description would fit the tumor found on subsequent stages.

Additional information

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

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

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

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp*. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

National coverage determination for transcatheter aortic valve replacement

Note: This article was revised July 12 to reflect the revised change request (CR) 8255 issued July 11. The article has been updated to clarify that the addition of "CT" with the registry number is only for paper claims. Also, Web addresses for the articles related to CRs 7897 and 8168 are now in this article. The CR release date, transmittal number and the Web address for accessing CR 8255 are revised. This information was previously published in the May 2013 *Medicare B Connection*, Pages 11-12.

Provider types affected

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

Provider action needed

CR 8255 is being issued to require that claims for TAVR carry an approved clinical trial number, effective for claims processed on or after July 1, 2013. Given that TAVR is covered only under coverage with evidence development (CED), the Centers for Medicare & Medicaid Services (CMS) has ensured that the approved clinical trials and approved registry have obtained valid numbers from *http://www.clinicaltrials.gov* and that those numbers are maintained at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html*. See the *Background* and *Additional information* sections of this article for further details regarding these changes. Please make sure that your billing staffs are aware of these changes.

Background

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

TAVR (also known as TAVI or transcatheter aortic valve implantation) is a new technology for use in treating aortic stenosis. A bioprosthetic valve is inserted percutaneously using a catheter and implanted in the orifice of the native aortic valve. The procedure is performed in a cardiac catheterization lab or a hybrid operating room/cardiac catheterization lab with advanced quality imaging and with the ability to safely accommodate complicated cases that may require conversion to an open surgical procedure. The interventional cardiologist and cardiac surgeon jointly participate in the intra-operative technical aspects of TAVR.

CR 8255 requires that claims for TAVR carry an approved clinical trial number. Specific claims processing instructions are as follows:

- For professional claims processed on or after July 1, 2013, Medicare expects this numeric, 8-digit clinical trial (CT) registry number to be preceded by the alpha characters of "CT" in Field 19 of paper Form CMS-1500 claims or entered similarly **but without the** "CT" prefix in the electronic 837P in Loop 2300 REF01 (REF01=P4).
- Professional claim lines for *0256T, 0257T, 0258T, 0259T, 33361, 33362, 33363, 33364, 33365*, and *0318T* must have the CT registry number, a Q0 modifier, and a secondary diagnosis code of V70.7 (ICD-10=Z00.6). Such claims lines will be returned as unprocessable if the CT registry number, the modifier Q0, or the V70.7 (ICD-10=Z00.6) is not present.

Claims for TAVR submitted without the CT registry number will be returned as unprocessable with the following messages:

- **Claims adjustment remarks code (CARC) 16**: "Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)";
- **Remittance advice remarks code (RARC) MA50**: "Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.";
- **RARC MA130**: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."; and
- Group code-contractual obligation (CO).

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

- **CARC 4**: "The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.";
- **RARC N29**: "Missing documentation/orders/notes/summary/report/chart.";
- **RARC MA130**: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."; and
- Group code-contractual obligation (CO).

For claims processed on or after July 1, 2013, the claim lines for *0256T, 0257T, 0258T, 0259T*, *33361, 33362, 33363, 33364, 33365*, and *0318T* will be

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NCD *(continued)*

returned as unprocessable when billed without secondary diagnosis code V70.7 (ICD-10=Z00.6) with the following messages:

- CARC 16: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)";
- RARC M76: "Missing incomplete/invalid diagnosis or condition.";
- RARC MA130: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/ correct information."; and
- Group code-contractual obligation (CO).

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

Additional information

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

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

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

You may also want to review two related TAVR articles MM8168 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8168.pdf*) and MM7897 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7897.pdf*).

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

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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.

General Coverage

Revised CMS-1500 paper claim form: Version 02/12

The National Uniform Claim Committee (NUCC), an industry organization in which The Centers for Medicare & Medicaid Services (CMS) participates, maintains the CMS-1500 claim form and periodically revises it according to industry needs. The NUCC recently revised this form (version 02/12). The NUCC changed the form to adequately accommodate and implement ICD-10-CM diagnosis codes, although the form does include other changes as well. More information is available on the NUCC website.

On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised CMS-1500 claim form, version 02/12, OMB control number, 0938-1197. The CMS-1500 claim form is the required format for submitting claims to Medicare on paper.

Features of the revised form

The revised form, among other changes, notably adds the following functionality:

- Indicators for differentiating between ICD-9-CM and ICD-10-CM diagnosis codes.
- Expansion of the number of possible diagnosis codes to 12.
- Qualifiers to identify the following provider roles (on item 17):
  - Ordering
  - Referring
  - Supervising

Instructions for completing the revised form

CMS is updating the *Medicare Claims Processing Manual* (Publication 100-04) Chapter 26 to instruct contractors and providers regarding how to complete the revised form. CMS will post this information on the CMS website when it is available.

Tentative timeline for implementing the revised form for Medicare claims

Medicare anticipates implementing the revised CMS-1500 claim form (version 02/12) as follows:

- January 6, 2014: Medicare begins receiving and processing paper claims submitted on the revised CMS-1500 claim form (version 02/12).
- January 6 through March 31, 2014: Dual use period during which Medicare continues to receive and process paper claims submitted on the old CMS-1500 claim form (version 08/05).
- April 1, 2014: Medicare receives and processes paper claims submitted only on the revised CMS-1500 claim form (version 02/12).

These dates are tentative and subject to change. CMS will provide more information as it is available.

Note: The Administrative Simplification Compliance Act (ASCA) requires that Medicare claims be sent electronically unless certain exceptions are met. Some Medicare providers qualify for these exceptions and send their claims to Medicare on paper. For more information about ASCA exceptions, please contact the Medicare contractor who processes your claims. Claims sent electronically must abide by the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The current standard adopted under HIPAA for electronically submitting professional health care claims is the 5010 version of the ASC X12 837 Professional Health Care Claim standard and its implementation specification, Technical Report 3 (TR3). More information about the ASC X12 and TR3 is available on the ASC X12 website.

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

Place of service coding for physician services in an outpatient setting

Provider types affected

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

What you need to know

Recovery auditors have identified that some physicians were incorrectly reporting place of service as office (11) when the services were provided in an outpatient hospital (22) setting, resulting in incorrect reimbursement.

In addition, outpatient hospital claims were identified reporting the same surgical *Current Procedural Terminology* (*CPT®*) codes for the same patient and same date of service as professional claims with a reported place of service (11) office.

All surgical *CPT®* codes (*10000-60000*) were included in the analysis. The greatest number of improper payments for CPT® codes related to the integumentary system (10000 series).

You and your billing staff should be familiar with place of service codes used to specify the place of service (outpatient hospital setting (22) or office setting (11)) where services were rendered. Reporting the incorrect place of service code can affect reimbursement, resulting in an over/underpayment.

Background

To account for the increased expense that physicians incur by performing services in their offices, Medicare Part B reimburses physicians at a higher rate for surgical procedures performed in their offices.

However, when physicians perform these services in facility settings such as an outpatient facility, Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate.

An improper payment exists when physicians bill these services with an incorrect place of service based on the setting in which the services were rendered.

Billing examples

Example 1: An 84 year old female has an outpatient hospital claim paid for services provided on March 7, 2008. Reported on the outpatient hospital claim is *CPT®* code *62311* (*Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast of diagnostic or therapeutic substance(s), epidural or subarachnoid; lumbar, sacral*).

A professional claim is identified for the same patient, same date of service, and same surgical *CPT®* code *62311* with place of service office (11).

The correct place of service for this date of service is outpatient hospital (22).

The professional claim for *CPT®* code *62311* is adjusted to pay at the facility rate by applying the correct place of service code 22. The allowed amount the provider for *CPT®* code *62311* for the facility rate is $73.01. The new provider paid amount is $58.41. This results in a total recovery amount of $89.76.

Example 2: An 88 year old female has an outpatient hospital claim paid for services provided March 12, 2008. Reported on the outpatient hospital claim is *CPT®* code *11100* (*Biopsy of skin; single lesion*).

A professional claim is identified for the same patient, same date of service, and same surgical *CPT®* code *11100* with place of service office (11).

The correct place of service for this date of service is outpatient hospital (22).

The professional claim for *CPT®* code *11100* is adjusted to pay at the facility rate by applying the correct place of service code 22. The allowed amount for *CPT®* code *11100* for the facility rate is $41.86. The new provider paid amount is $33.49. This results in a total recovery amount of $33.14.

Additional information

The *Medicare Claims Processing Manual*, Chapter 12, Section 20.4.2 (Site of Service Payment Differential), which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*, provides further guidance on this matter.

The Office of the Inspector General has performed audits related to place of service errors. For example, their report titled "Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Years 2005 and 2006; 06-17-2009" is available at *http://oig.hhs.gov/oas/reports/region1/10800528.asp*.

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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Add-on codes without primary codes

Provider types affected

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

Provider action needed

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

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

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

Example:

A provider submitted a claim with *CPT*® code *26863* for one unit for date of service May 5, 2010, without billing for the primary *CPT*® code *26862*. Add-on codes billed without their primary codes are considered an overpayment. Overpayment for add-on *CPT*® code *26863* was retracted as a billing error.

- Add-on *CPT*® code *26863* description: Fuse/graft added joint – Arthrodesis, interphalangeal joint with or without internal fixation; with autograft, each additional joint. List separately in addition to code for primary procedure.
- Primary *CPT*® code *26862* description: Fusion/graft of finger – Arthrodesis, interphalangeal joint, without internal fixation; with autograft. This is a parent *CPT*® code and can be reported with add-on *CPT*® code *26863*.

Additional information

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

You can review the *Medicare Claims Processing Manual* (Chapter 12, Section 30.6.12(I) Critical Care Services Provided by Physicians in Group Practice(s)) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*.

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

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Duplicate claims – outpatient

Provider types affected

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

What you need to know

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

Provider action needed

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

Background

An issue may exist when duplicate services are billed and reimbursed under Medicare. Outpatient claims submitted by a facility for the same service to a particular individual on a specified date of service that was included in a previously submitted claim will be audited for duplicate payments. Exact duplicate data fields submitted for outpatient facility claims including same beneficiary, same provider, same dates of service, same types of services, same place of service, same procedure codes, and same billed amount will be audited for duplicate payments.

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

- HCPCS - A codes - ambulance/transportation services
- HCPCS - B&C codes - enteral and parenteral therapy
- HCPCS - D codes - dental procedures
- HCPCS - E codes - durable medical equipment
- HCPCS - G&H codes - temporary procedures and professional services and mental health
- HCPCS - J codes - drugs administered other than oral method
- HCPCS - L codes - orthotic procedures
- HCPCS - M-P codes - medical services & pathology/laboratory
- HCPCS - Q-R-S codes - temporary codes
- HCPCS - V codes - vision codes
- *CPT*® *00100-01999 (*anesthesia)
- *CPT*® *90281-99607* (excluding E/M *99201-99499*) (medicine)
- *CPT*® *80047-89356* (lab & path)
- *CPT*® *70010* to *79999* (radiology)
- *CPT*® *10021* to *69990* (surgery)

Case studies

Example 1: A provider received duplicate payments of $87.45 April 13, 2012, and May 5, 2012, for *CPT*® *71020* (chest X-ray) with billed date of service of March 26, 2012. Both claims were billed for same patient, same provider, and same date of service, same charge, same *CPT*® code, and same units, without a modifier. The duplicate billing increased the subscriber's liability by $53.00.

Resolution: Billing of modifier 76 (repeat procedure or service by the same physician or other qualified health care professional) or 77 (repeat procedure or service by another physician or other qualified health care professional) should be used to report the performance of multiple diagnostic services on the same day if these were not actually duplicate claims.

Example 2: A provider received duplicate payments of $64.19 February 22, 2012, and April 20, 2012, for *CPT*® *77080* (Dual-energy X-ray absorptiometry (DXA), bone density axial) with billed date of service of January 31, 2012. Both claims were billed for the same patient, same provider, and same date of service, same charge, same *CPT*® code, and same units, without a modifier.

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

Additional information

The most current *MLN*® article MM8121 about the "Clarification of Detection of Duplicate Claims Section

(continued on next page)

Preventing duplicate claim denials

Effective July 1, 2013, new claim system edits may result in additional duplicate claim denials to your practice. Please share this information with your billing companies, vendors and clearing houses. The Centers for Medicare & Medicaid Services (CMS) has instructed Medicare contractors to enhance claim system edits to include same claim details in its history review of duplicate procedures and/or services. The edits will search within paid, finalized, pending and same claim details in history. This means that unless applicable modifiers are included in your claim, the edits will detect duplicate and repeat services within the same claim and/or based on a claim previously submitted.

To minimize a potential increase in duplicate claim denials, please review your billing software and procedures to ensure that you are billing correctly. Some services on a claim may appear to be duplicates when, in fact, they are not. Please ensure appropriate use of condition codes and/or modifiers to identify procedures and services that are not duplicates. A complete list of condition codes and modifiers can be found in the *Current Procedural Terminology* (*CPT*®) codebook. The following are a few examples of modifiers that may be used, as applicable, to identify repeat or distinct procedures and services on a claim:

- Modifier 76 may be used to indicate a repeat procedure or service by the same provider, subsequent to the original procedure or service.
- Modifier 91 may be used to indicate repeat clinical diagnostic laboratory tests. This modifier is added only when additional test results are medically necessary on the same day.
- Modifier 59 may be used, as applicable, to identify procedures or services that are normally reported together but are appropriate to be billed separately under certain circumstances. Modifier 59 indicates a procedure or service by the same provider, distinct or independent from other services, performed on the same day.

Note: Procedures, services and modifiers submitted on your claim should be supported by documentation in the patient's medical record.

Sources: CMS *MLN Matters*® *MM8121*, *CMS Internet-only manual (IOM), Publication 100-04, Chapter 1, Section 120-Detection of duplicate claims*, and the *American Medical Association's (AMA) 2013 Current Procedural Terminology* (*CPT*®) codebook.

Duplicate *(continued)*

of the CMS Internet Only Manual" is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8121.pdf*.

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

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Issues completing the PWK fax/mail coversheet

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

PWK issues

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

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

Reminders

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

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

New fax coversheet to precede all EDI enrollment forms

To streamline the submission process, improve office workflow, and enhance efficiency, First Coast Service Options Inc. (First Coast) has implemented a new receipt process for EDI (electronic data interchange) forms. First Coast's EDI department has introduced a new electronic fax image interface process. This process will require all EDI forms to be preceded with the required fax cover sheet effective immediately. This includes enrollment and DDE (data direct entry) forms and ASCA (Administrative Simplification Compliance Act) information. The fax cover sheet provides detailed information about the fax transmission and provides routing and linking of documentation received depending on the information on the cover sheet.

You will not be able to create your own coversheet. You will need to use the interactive fax coversheet from our website. Simply type the requested information into the interactive fields on the form, print it, and fax it along with your EDI form(s). **Note**: The fax coversheet may not be altered in any way except entering information into the appropriate fields.

The EDI department will process all accurate and complete EDI forms in the order in which they are received. Once processed, notification will be sent to the provider containing the information on how the form was processed and the details regarding the status. Additionally, to ensure timely notification your email address will be required on the original EDI enrollment form(s) and DDE form(s) received so we can email this information to you. Any EDI form that is incomplete or unable to be processed for any reason will be returned to the provider indicated on the form.

Click *here* to access the EDI fax coversheet.

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.*

Update: Demand letters and claim cancellations for items or services provided to incarcerated beneficiaries

Recently, the Centers for Medicare & Medicaid Services (CMS) initiated recoveries from providers and suppliers based on data that indicated a beneficiary was incarcerated on the date of service. Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated when the items and services were furnished. A beneficiary may be "incarcerated" even when the individual is not confined within a penal facility, such as a beneficiary who is on a supervised release, on medical furlough, residing in a halfway house, or other similar situation.

Medicare identified previously paid claims that contain a date of service partially or fully overlapping a period when a beneficiary was apparently incarcerated based on information CMS receives from the Social Security Administration (SSA). As a result, a large number of overpayments were identified, demand letters released, and, in many cases, automatic recoupment of overpayments made. CMS has since learned that the information related to these periods of incarcerations was, in some cases, incomplete for CMS purposes.

CMS is actively reviewing these data and will be taking action to improve the process used to identify periods of incarceration. As part of this effort, CMS is working to quickly identify claims that resulted in our recent recovery actions and take steps, as appropriate, to correct any inappropriate overpayment recoveries.

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

Revised actions required for providers and beneficiaries

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

Source: CMS PERL 201307-05

Are you ready to transition to ICD-10?

The Centers for Medicare & Medicaid Services (CMS) will host a presentation by Sue Bowman from the American Health Information Management Association (AHIMA), Thursday, August 22, 1:30-3 p.m. ET.

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

Other topics covered include:

- Similarities and differences from ICD-9
- Coding
- Basics of finding a diagnosis code
- Unspecified codes
- External cause of injury codes
- Type of encounter

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

Share your ICD-10 transition experience

First Coast Service Options Inc. wants to highlight stories of providers who have already started their ICD-10 transition plan.

If you would like to share your story, let us know. *Click here* and briefly **tell us how your organization is preparing for ICD-10**. We would like to share your story with your peers in Florida, Puerto Rico, and the US Virgin Islands. Be sure to check the "General" radio button on the feedback form.

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

Innovative providers use PDS reports to improve billing practices

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

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

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

"Using the trends spotted with the PDS report, we changed our process to improve our claims."

-Joe Scialdone,
Escambia County Medical Services

Joe Scialdone regularly uses PDS reports to improve billing operations for Escambia County Emergency Medical Services.

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

Improving the bottom line

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

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

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

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

Other online tools

In addition to PDS reports, First Coast offers providers other *online tools* for providers to improve their billing practices. Providers may use *comparative billing reports (CBR)* and the *evaluation and management (E/M) interactive worksheet*.

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

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

Medicare enrollment for 'mass immunizers'

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

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

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

Such suppliers must meet the following requirements:

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

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

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

- The effective date provision in 42 CFR § 424.520(d) does not apply to the enrollment of mass immunizers. This is because the individual/entity is not enrolling as a physician, non-physician practitioner, physician group or non-physician practitioner group.
- In Section 4 of the Form CMS-855, the supplier need not list each off-site location (e.g., county fair, shopping mall) at which it furnishes services. It need only list its base of operations (e.g., county health department headquarters, drug store location).

For more information on mass immunization roster billing, refer to:

- Publication 100-02, *Benefit Policy Manual*, *Chapter 15, Section 50.4.4.2*
- Publication 100-04, *Claims Processing Manual*, *Chapter 18, Sections 10 through 10.3.2.3*

Note: Section 10.3.1 outlines the requirements for submitting roster bills.

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

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

Rate your satisfaction with your MAC

Your opinion counts

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

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

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

Let your voice be heard.

Update to Chapter 15 of the *Program Integrity Manual*

Provider types affected

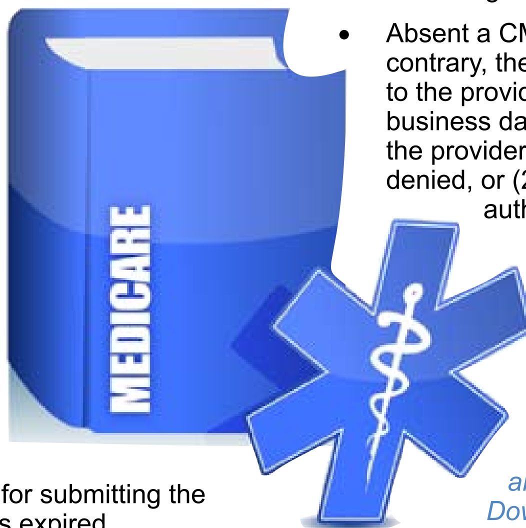
This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs) and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8341, which incorporates certain provider enrollment policy and operational clarifications into Chapter 15 of the *Program Integrity Manual* (*PIM*).

Background

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



- If a contractor returns an enrollment revalidation application, the contractor shall – unless an existing Centers for Medicare & Medicaid Services (CMS) instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.
- If a contractor returns a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider resubmits the revalidation application and the contractor returns it again, rejects it, or denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.
- If the contractor rejects or denies a revalidation application, the contractor shall – unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's Medicare billing privileges under 42 CFR 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.
- If the contractor rejects or denies a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider resubmits the revalidation application and the contractor rejects it again, returns it, or denies it, the contractor shall – unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.
- Absent a CMS instruction or directive to the contrary, the contractor shall send a denial letter to the provider or supplier (1) no later than five business days after the contractor concludes that the provider or supplier's application should be denied, or (2) if the denial requires prior CMS authorization, no later than five business days after CMS notifies the contractor of such authorization.

Additional information

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

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

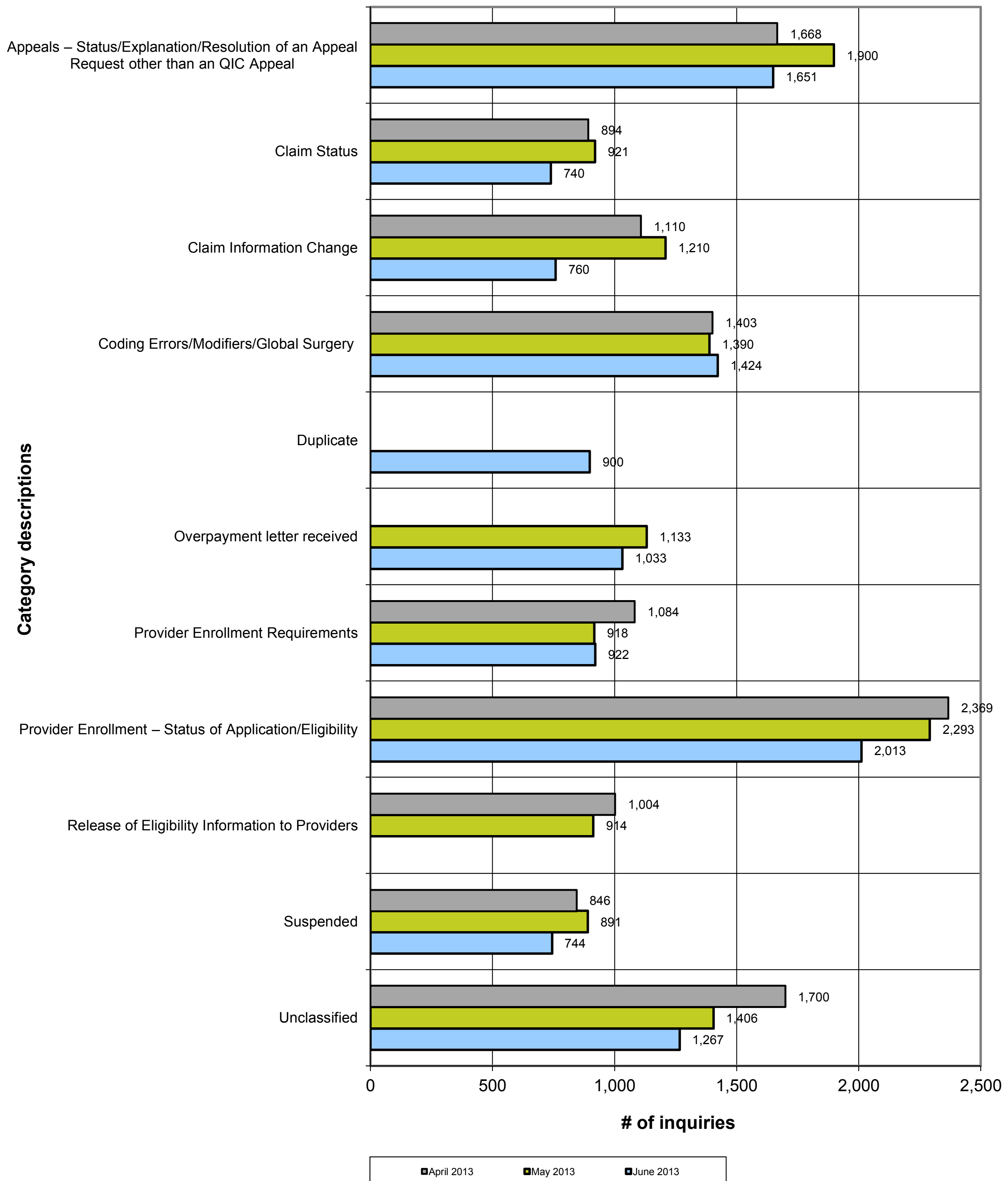
MLN Matters® Number: MM8341
Related Change Request (CR) #: CR 8341
Related CR Release Date: July 5, 2013
Effective Date: October 8, 2013
Related CR Transmittal #: R474PI
Implementation Date: October 8, 2013

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

Top inquiries, denials, and return unprocessable claims

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



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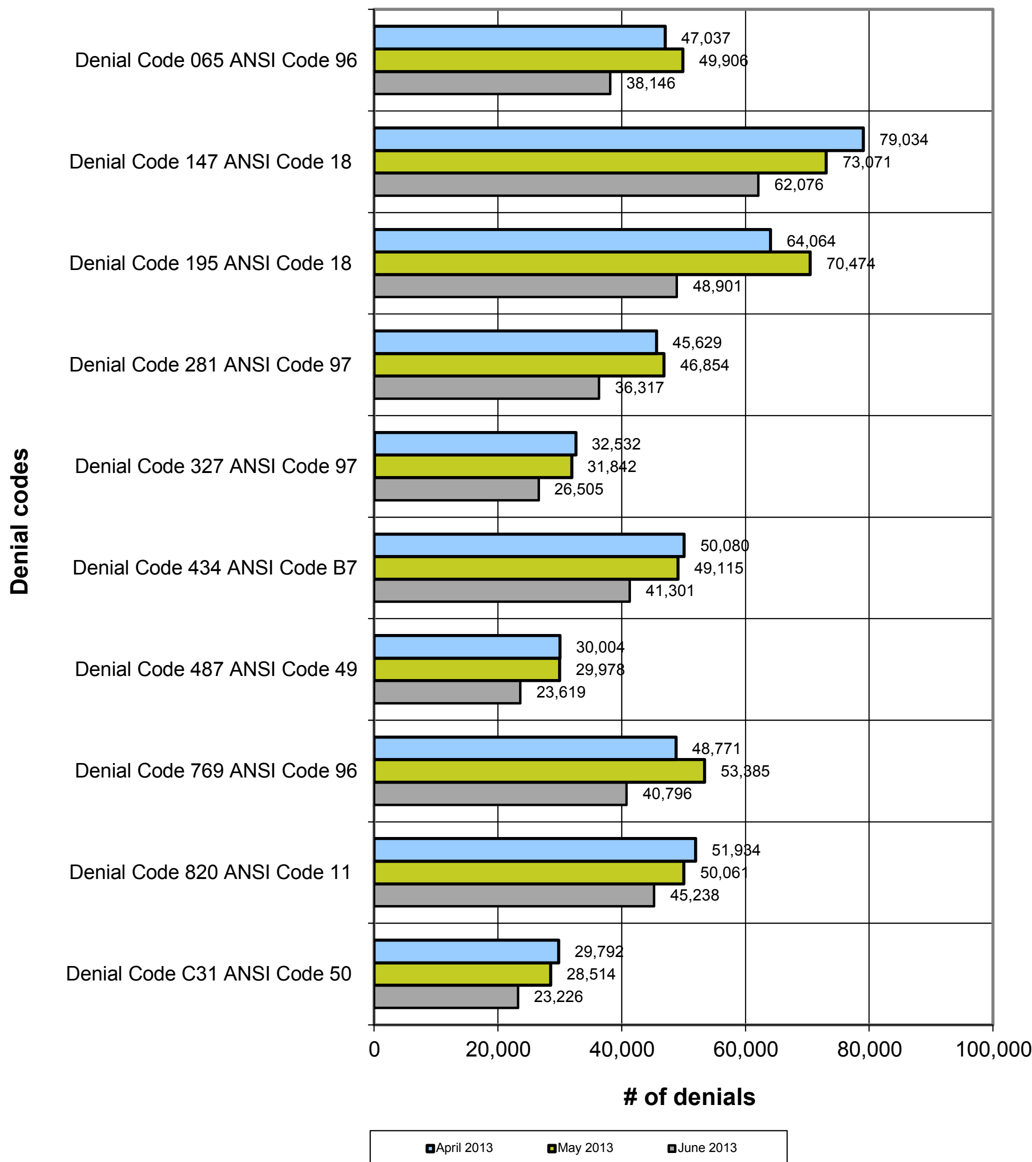
Part B top denials for April-June 2013



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.

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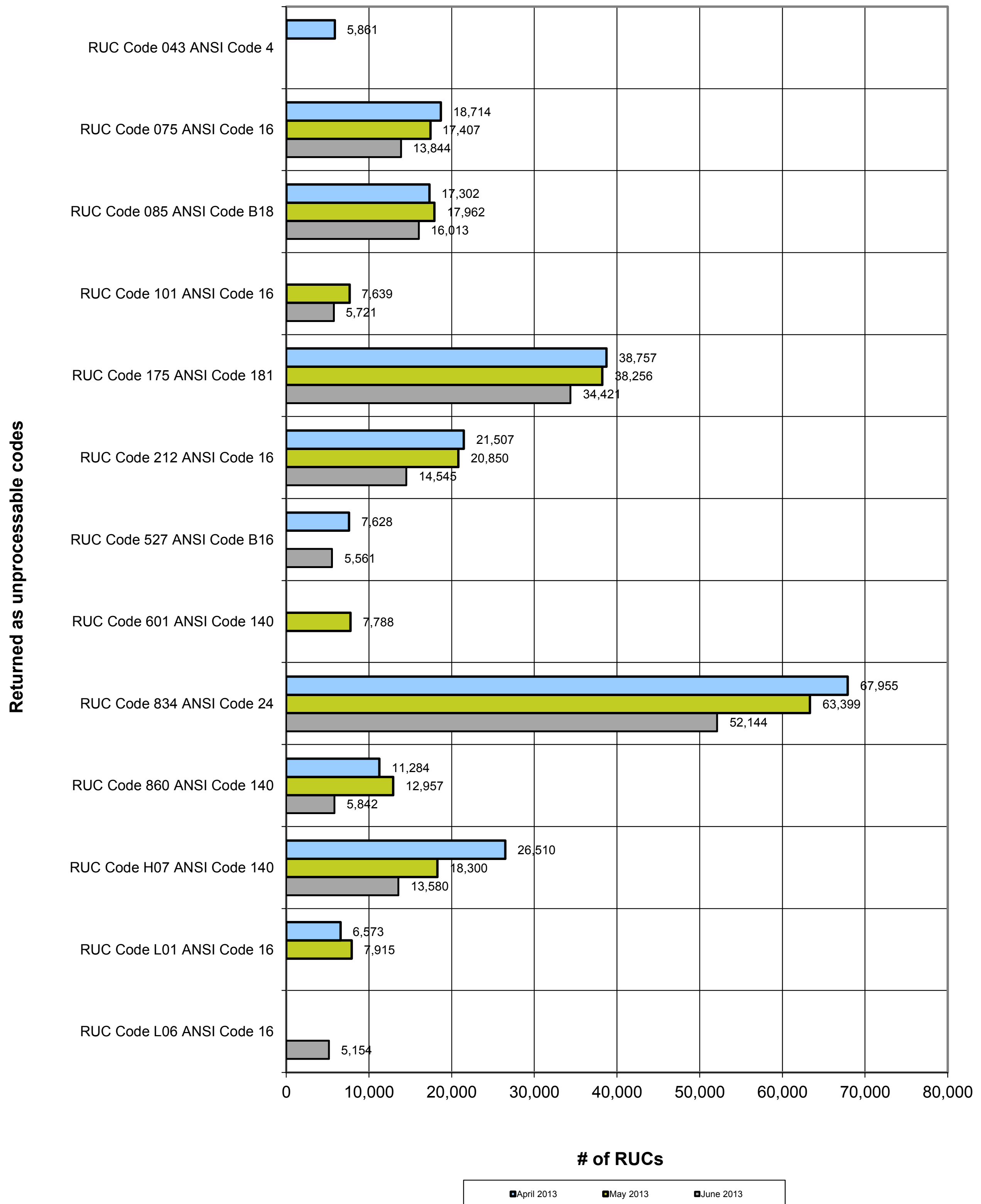

This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage Web page at *http://medicare.fcso.com/Landing/139800*.asp for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

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

More information

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

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

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Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

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

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Looking for LCDs?

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

Revisions to LCDs

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

LCD ID number: L29086 (Florida)
LCD ID number: L29101 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was most recently revised July 2, 2013. Since that time, the LCD has been revised to add diagnosis code V58.65 (Long-term [current] use of steroids) under the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after July 22, 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*.

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

LCD ID number: L29086 (Florida)
LCD ID number: L29101 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was most recently revised January 1, 2012. Since that time, the LCD has been revised to add rIsedronate sodium (Atelvia) under 'Frequency Standards' in the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD and under the 'Utilization Guidelines' section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after July 2, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Myocardial imaging, positron emission tomography (PET) scan – revision to the LCD

LCD ID number: L29231 (Florida)
LCD ID number: L29455 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for myocardial imaging, positron emission tomography (PET) scan was most recently revised June 4, 2013. Since that time, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add ICD-9-CM diagnosis codes 413.0 (Angina decubitus) and 413.9 (Other unspecified angina pectoris).

Effective date

This LCD revision is effective for services rendered **on or after July 15, 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*.

Ocular photodynamic therapy (OPT) with verteporfin

LCD ID number: L29239 (Florida)
LCD ID number: L29372 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ocular photodynamic therapy (OPT) with verteporfin was most recently revised April 23, 2012. Since that time, based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8292, transmittals 155 and 2728, dated June 14, 2013, the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the LCD were updated to add verbiage to allow subsequent follow-up visits with either fluorescein angiogram (FA) (*CPT*® code *92235*) or optical coherence tomography (OCT) (*CPT*® code *92133* or *92134*) prior to treatment.

Effective date

This LCD revision is effective for claims processed **on or after July 16, 2013**, for services rendered **on or after April 3, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

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

Now you can find the fee schedule information you need faster than ever before with First Coast's redesigned fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp*. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Educational Events

Upcoming provider outreach and educational events August 2013

Prepayment medical review of hospital claims – inpatient DRGs

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

Internet-based PECOS class

When: Thursday, August 15
Time: 8:00 a.m.-noon
Type of event: Face-to-face

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 MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) MLN Connects™ Provider eNews (previously "'CMS Medicare FFS 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 eNews 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 eNews:

- 'MLN Connects™ Provider eNews': June 27, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-27Enews.pdf*
- "MLN Connects™ Provider eNews': July 4, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-04-Enews.pdf*
- 'MLN Connects™ Provider eNews': July 11, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-11-Enews.pdf*
- 'MLN Connects™ Provider eNews': July 18, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-18Enews.pdf*

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

The new First Coast University

Come see our online Medicare training and resources

Experience the redesigned *First Coast University*, where you have fast and easy access to what's new, what's coming, and what's happening now with Medicare provider education. Best of all, you don't need to sign into your *First Coast University* account to explore educational opportunities available to providers within our jurisdiction.

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

First Coast University: Your Gateway to Medicare Knowledge

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

- Explore First Coast's Medicare educational events calendar and register for classes and seminars that will help you learn more about the Medicare program and find ways to improve the accuracy and efficiency of your Medicare billing process
  - Learn how to launch a webcast and get the most out of your interactive learning experience
  - Download recordings of past First Coast webcasts
- Learn about upcoming Medifest events
  - View all the classes offered by session without having to log in
  - Take online training in preparation for Medifest
- Explore our online course catalog and register for informative courses
  - Train when and where it is most convenient for you
  - Access online training resources 24/7
- Access useful links
- Find help when you need it:
  - Call or email First Coast University's dedicated staff
  - Find answers in our FAQs section
  - Share your feedback

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

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