

C Medicare B CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

January 2014



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Registration information for ICD-10 testing week

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. To help you prepare for this transition, the Centers for Medicare & Medicaid Services (CMS) announces a national testing week for current direct submitters (providers and clearinghouses) from March 3 through 7, 2014.

This testing week will give trading partners access to the Medicare administrative contractors' (MAC) and the common electronic data interchange (CEDI) for testing with real-time help desk support. The event will be conducted virtually. Registration is required.

What you can expect during testing

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

More information is available in *MLN Matters®* article *MM8465, ICD-10 Testing with Providers through the Common Edits and Enhancements Module (CEM) and Common Electronic Data Interchange (CEDI)*.



Register now

Registration information is available at <http://medicare.fcso.com/ICD-10/265463.pdf>.

Source: CR 8465



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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.

Ambulance

2014 ambulance fee schedule

The Centers for Medicare & Medicaid Services (CMS) has issued the ambulance fee schedule (AFS) file, effective for services January 1 through December 31, 2014.

Florida

Code	LOC 99 (01/02)	LOC 03	LOC 04
A0425	\$7.16	\$7.16	\$7.16
A0425*	\$7.23	\$7.23	\$7.23
A0426	\$260.53	\$274.93	\$275.49
A0426*	\$263.08	\$277.63	\$278.19
A0427	\$412.50	\$435.31	\$436.20
A0427*	\$416.54	\$439.57	\$440.47
A0428	\$217.10	\$229.11	\$229.58
A0428*	\$219.23	\$231.36	\$231.83
A0429	\$347.37	\$366.57	\$367.32
A0429*	\$350.77	\$370.17	\$370.92
A0430	\$2,909.78	\$3,023.86	\$3,028.31
A0430*	\$4,364.68	\$4,535.80	\$4,542.46
A0431	\$3,383.06	\$3,515.69	\$3,520.86
A0431*	\$5,074.59	\$5,273.54	\$5,074.59
A0432	\$379.93	\$400.94	\$401.76
A0432*	\$383.66	\$404.87	\$405.70
A0433	\$597.04	\$630.05	\$631.34
A0433*	\$602.89	\$636.23	\$637.53
A0434	\$705.59	\$744.60	\$746.12
A0434*	\$712.51	\$751.90	\$753.44
A0435	\$8.40	\$8.40	\$8.40
A0435*	\$12.60	\$12.60	\$12.60
A0436	\$22.43	\$22.43	\$22.43
A0436*	\$33.65	\$33.65	\$33.65

U.S. Virgin Islands

Code	Allowance
A0425	\$7.16
A0425*	\$7.23
A0426	\$268.01
A0426*	\$270.64
A0427	\$424.35
A0427*	\$428.51
A0428	\$223.34
A0428*	\$225.53
A0429	\$282.26
A0429*	\$360.85
A0430	\$2969.05
A0430*	\$4453.57
A0431	\$3451.96
A0431*	\$5177.94
A0432	\$390.85
A0432*	\$394.68
A0433	\$614.19
A0433*	\$620.21
A0434	\$725.86
A0434*	\$732.97
A0435	\$8.40
A0435*	\$12.60
A0436	\$22.43
A0436*	\$33.65

Puerto Rico

Code	Allowance
A0425	\$7.16
A0425*	\$7.23
A0426	\$209.64
A0426*	\$211.69
A0427	\$331.93
A0427*	\$335.18
A0428	\$174.70
A0428*	\$176.41
A0429	\$279.52
A0429*	\$357.34
A0430	\$2506.80
A0430*	\$3760.20

Code	Allowance
A0431	\$2914.53
A0431*	\$4371.79
A0432	\$305.72
A0432*	\$308.72
A0433	\$480.42
A0433*	\$485.13
A0434	\$567.77
A0434*	\$573.34
A0435	\$8.40
A0435*	\$12.60
A0436	\$22.43
A0436*	\$33.65

* Rural rate

Ambulatory Surgical Center

January 2014 update of the ambulatory surgical center payment system

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8575 which describes changes to and billing instructions for various payment policies implemented in the January 2014 ambulatory surgical center (ASC) payment system update. CR 8575 also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure your billing staff is aware of these changes.

Background

This article is based on CR 8575 which describes updates to the HCPCS and changes to and billing instructions for various payment policies implemented in the January 2014 ACS payment system update.

CR 8575 also includes 2014 payment rates for:

- Separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and
- Covered surgical and ancillary services (ASCFS file).



Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare physician fee schedule (MPFS). The payment files associated with CR 8575 reflect the most recent changes to 2014 MPFS payment rates.

New services

Effective January 1, 2014, the Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS surgical procedure code for ASC use, as noted in Table 1:

Table 1 – New procedure payable under the ASC payment system, effective January 1, 2014

Code	Short descriptor	Long descriptor	ASC payment indicator (PI)
C9737	Lap esoph augmentation	Laparoscopy, surgical, esophageal sphincter augmentation with device (eg, magnetic band)	G2

Drugs, biologicals, and radiopharmaceuticals

a) New 2014 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For 2014, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, as shown in Table 2.

Table 2 – New 2014 HCPCS codes, effective for certain drugs, biologicals, and radiopharmaceuticals

2014 code	Long descriptor	ASC PI
A9575	Injection, Gadoterate Meglumine, 0.1 mL	N1
A9586*	Florbetapir f18, diagnostic, per study dose, up to 10 millicuries	N1
A9599	Radiopharmaceutical, Diagnostic, For Beta-amyloid Positron Emission Tomography (PET) Imaging, Per Study Dose	N1

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ASC (continued)

2014 code	Long descriptor	ASC PI
C9133	Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.	K2
C9441	Injection, ferric carboxymaltose, 1 mg	K2
C9497	Lozapine, inhalation powder, 10 mg	K2
J0401	Injection, Aripiprazole, Extended Release, 1 mg	K2
J1446	Injection, TBO-Filgrastim, 5 micrograms	Y5
J1602	Injection, golimumab, 1 mg, for intravenous use	K2
J7508	Tacrolimus, Extended Release, Oral, 0.1 mg	K2
J9371	Injection, Vincristine Sulfate Liposome, 1 mg	K2
Q4137	Amnioexcel or Biodexcel, Per Square Centimeter	N1
Q4138	BioDfence DryFlex, Per Square Centimeter	N1
Q4139	AmnioMatrix or BioDMatrix, injectable, 1 cc	N1
Q4140	Biodfence, Per Square Centimeter	N1
Q4141	Alloskin AC, Per Square Centimeter	N1
Q4142	XCM Biologic Tissue Matrix, Per Square Centimeter	N1
Q4143	Repriza, Per Square Centimeter	N1
Q4145	Epifix, Injectable, 1mg	N1
Q4146	Tensix, Per Square Centimeter	N1
Q4147	Architect Extracellular Matrix, Per Square Centimeter	N1
Q4148	Neox 1k, Per Square Centimeter	N1
Q4149	Excellagen, 0.1 cc	N1

* – A9586 is ASC PI of N1, retroactive to October 1, 2013.

b. Other changes to HCPCS for certain drugs, biologicals, and radiopharmaceuticals

Table 3 notes the drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS codes, their long descriptors, or both. For each product:

- The 2013 HCPCS code and long descriptors are noted in the two left-hand columns; and
- The 2014 HCPCS code and long descriptors are noted in the adjacent right-hand columns.

Table 3 – Other changes to HCPCS for certain drugs, biologicals, and radiopharmaceuticals

2013 code	2013 Long descriptor	2014 code	2014 Long descriptor
C1204	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	A9520	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries
J0152	Injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds)	J0151	Injection, Adenosine For Diagnostic Use, 1 mg (not to be used to report any Adenosine Phosphate Compounds, Instead use A9270)
J0718	Injection, certolizumab pegol, 1 mg	J0717	Injection, certolizumab pegol, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1440	Injection, filgrastim (g-csf), 300 mcg	J1442	Injection, Filgrastim (G-CSF), 1 microgram
J1441	Injection, filgrastim (g-csf), 480 mcg	J1442	Injection, Filgrastim (G-CSF), 1 microgram
C9130	Injection, immune globulin (Bivigam), 500 mg	J1556	Injection, immune globulin (Bivigam), 500 mg
C9294	Injection, taliglucerase alfa, 10 units	J3060	Injection, taliglucerase alfa, 10 units

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ASC (continued)

2013 code	2013 Long descriptor	2014 code	2014 Long descriptor
Q2051*	Injection, Zoledronic Acid, Not Otherwise Specified, 1 mg	J3489	Injection, Zoledronic Acid, 1mg
C9298	Injection, ocriplasmin, 0.125 mg	J7316	Injection, Ocriplasmin, 0.125mg
C9295	Injection, carfilzomib, 1 mg	J9047	Injection, carfilzomib, 1 mg
C9297	Injection, omacetaxine mepesuccinate, 0.1 mg	J9262	Injection, omacetaxine mepesuccinate, 0.01 mg
C9292	Injection, pertuzumab, 10 mg	J9306	Injection, pertuzumab, 1 mg
C9131	Injection, ado-trastuzumab emtansine, 1 mg	J9354	Injection, ado-trastuzumab emtansine, 1 mg
C9296	Injection, ziv-aflibercept, 1 mg	J9400	Injection, Ziv-Aflibercept, 1 mg
Q0171	Chlorpromazine hydrochloride, 10 mg, oral, fda approved prescription	Q0161	Chlorpromazine hydrochloride, 5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen
Q0172	Chlorpromazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotheapy treatment, not to exceed a 48-hour dosage regimen	Q0161	Chlorpromazine hydrochloride, 5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen
Q2027	Injection, Sculptra, 0.1 ml	Q2028	Injection, Sculptra, 0.5 mg
Q3025	Injection, interferon beta-1a, 11 mcg for intramuscular use	Q3027	Injection, Interferon Beta-1a, 1 mcg For Intramuscular Use

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

The payment rate for one HCPCS code was incorrect in the October 2013 ASC drug file, and the corrected payment rate is listed in Table 4. It has been included in the revised October 2013 ASC Drug file, (effective for claims with dates of service October 1, 2013, through December 31, 2013) and processed prior to the implementation of the January 2014 ASC quarterly update.

Suppliers who think they may have received an incorrect payment for dates of service October 1, 2013, through December 31, 2013, may request their MAC to adjust previously processed claims.

Table 4 – Updated payment rates for certain HCPCS codes, effective October 1 through December 31, 2013

Code	Short descriptor	Corrected payment rate
C1204	Tc 99m tilmanocept	\$223.15

Skin substitute procedures

Effective January 1, 2014, the payment for skin substitute products that do not qualify for outpatient payment prospective system (OPPS) pass-through status will be packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also being implemented in the ASC payment system effective January 1, 2014. Skin substitute products are divided into two groups:

- 1) High cost skin substitute products, and
- 2) Low cost skin substitute products for packaging purposes.

Table 5 lists skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. Note that beginning January 1, 2014, ASCs should not separately bill for packaged skin substitutes (ASC PI=N1).

(continued on next page)

ASC (continued)

Table 5 – Skin substitute product assignment to high cost/low cost status for 2014

Code	Short descriptor	ASC PI	Low/high cost skin substitute
C9358	SurgiMend, fetal	N1	Low
C9360	SurgiMend, neonatal	N1	Low
C9363	Integra Meshed Bil Wound Mat	N1	Low
Q4100	Skin substitute, NOS	N1	Low
Q4101	Apligraf	N1	High
Q4102	Oasis wound matrix	N1	Low
Q4103	Oasis burn matrix	N1	Low
Q4104	Integra BMWD	N1	Low
Q4105	Integra DRT	N1	Low
Q4106	Dermagraft	N1	High
Q4107	Graftjacket	N1	High
Q4108	Integra matrix	N1	Low
Q4110	Primatrix	N1	High
Q4111	Gammagraft	N1	Low
Q4115	Alloskin	N1	Low
Q4116	Alloderm	N1	High
Q4117	Hyalomatrix	N1	Low
Q4119	Matristem wound matrix	N1	Low
Q4120	Matristem burn matrix	N1	Low
Q4121	Theraskin	N1	Low
Q4122	Dermacell	K2	n/a
Q4123	Alloskin	N1	Low
Q4124	Oasis tri-layer wound matrix	N1	Low
Q4125	Arthroflex	N1	High
Q4126	Memoderm/derma/tranz/integup	N1	High
Q4127	Talymed	K2	n/a
Q4128	Flexhd/Allopatchhd/matrixhd	N1	Low
Q4129	Unite biomatrix	N1	Low
Q4131	Epifix	K2	n/a
Q4132	Grafix core	K2	n/a
Q4133	Grafix prime	K2	n/a
Q4134	hMatrix	N1	High
Q4135	Mediskin	N1	Low
Q4136	EZderm	N1	Low
Q4137	Amnioexcel or biodexcel, 1cm	N1	Low
Q4138	BioDfence DryFlex, 1cm	N1	Low
Q4140	Biodfence 1cm	N1	Low
Q4141	Alloskin ac, 1 cm	N1	Low
Q4142	Xcm biologic tiss matrix 1cm	N1	Low
Q4143	Repriza, 1cm	N1	Low
Q4146	Tensix, 1cm	N1	Low
Q4147	Architect ecm, 1cm	N1	Low
Q4148	Neox 1k, 1cm	N1	Low

High cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by *Current Procedural Terminology (CPT®)* codes 15271-15278.

Low cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278.

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ASC (continued)

All OPSS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT® code 15271-15278.

Coverage determinations

Assignment of a HCPCS code and a payment rate under the ASC payment system to a drug, device, procedure, or service does not imply coverage by the Medicare program. The assignment indicates how the product, procedure, or service may be paid if covered by the program. Your MAC will determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat a beneficiary's condition and it is excluded from payment.

Additional information

The official instruction, CR 8575, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2849CP.pdf>.

If you have any questions, please contact your 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>.

MLN Matters® Number: MM8575

Related Change Request (CR) #: CR 8575

Related CR Release Date: January 2, 2014

Effective Date: January 1, 2014

Related CR Transmittal #: R2849CP

Implementation Date: January 6, 2014

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Implementation of ASC quality reporting program payment reduction

Note: This article was revised January 16, 2014, to remove an erroneous reference to remittance advice remarks code N552 that had been in the "Reason and remark codes used to communicate reduced payments" portion of the article. This information was previously published in the September 2013 *Medicare B Connection*, Pages 7-8.

Provider types affected

This MLN Matters® article is intended for physicians and ambulatory surgical centers (ASCs) submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries and paid under the ASC payment system.

What you need to know

This article is based on change request (CR) 8349, which instructs Medicare contractors to implement payment reductions for those ASCs that do not successfully meet ASC quality reporting (ASCQR) program requirements. Please be sure your staffs are aware of the reporting requirements and the application of the ASCQR program penalties.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented a quality reporting program for ASCs in the 2012 outpatient prospective payment system (OPSS)/ASC final rule with comment period

(76 *Federal Register* (FR) 74492 to 74517), finalizing additional program policies in the fiscal year (FY) 2013 inpatient prospective payment system (IPPS)/long term care hospital (LTCH) final rule with comment period (77 FR 53637 to 53644).

Beginning with services January 1, 2014, ASCs that do not successfully meet ASCQR program requirements shall be subject to a payment reduction.

Section 109(b) of the Medicare Improvement and Extension Act of 2006 under Division B, Title I of the Tax Relief and Health Care Act of 2006 (MIEA-TRCHA; Pub. L. 109-432) amended Section 1833(i) of the Social Security Act to state that the Secretary may provide that any ASC that does not submit quality measures to the Secretary in accordance with paragraph (7) shall incur a 2.0 percentage point reduction to any annual increase provided under the revised ASC payment system for such year. Any facility that receives Medicare payment under Part B as an ASC and is subject to this annual payment increase, whether independent or operated by a hospital, is subject to these provisions.

The application of a reduced ASC fee schedule (ASCFS) update results in reduced national unadjusted payment rates that will apply to certain ASC services provided by Medicare certified ASCs that fail to meet the ASCQR program requirements. All other ASCs paid under the 2014 ASC payment system will receive the full ASC payment update without the reduction.

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Quality *(continued)*

For the first affected payment update, that is, for 2014, CMS will analyze fee-for-service claims data from dates of service October 1 to December 31, 2012, paid by the Medicare administrative contractor by April 30, 2013, to determine if an ASC successfully meets ASCQR program requirements. ASCs that are not successful, and are subject to these requirements, will be subject to the payment reduction to the 2014 payment rates. The processing of claims with the reduced ASCFS payment rates for certain ASCs constitutes the application of the ASCQR program penalty.

Participation in the ASCQR program

ASCs will be deemed successful and not penalized, for purposes of the ASCQR program by meeting program requirements during a specified reporting period. For purposes of the 2014 payment determination, ASCs must report quality data codes (QDCs) on Medicare Part B claims submitted for reimbursement using the CMS-1500 or related electronic data set and must meet data completeness requirements. The QDCs for reporting are outlined in CR 7754, transmittal 2425, dated March 16, 2012, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2425CP-.pdf>. The QDCs are also outlined in the *MLN Matters*® article MM7754, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7754.pdf>.

Determination of whether an ASC failed to meet quality reporting requirements will be made by CMS, at the individual supplier level, based on the billing ASC facility's national provider identifier (NPI).

The payment reduction under the ASCQR program applies to certain Medicare Part B covered ASC services subject to the ASC annual payment update. The payment reduction per statute is a 2.0 percentage point reduction to any payment update provided under the revised ASC payment system for the year applied. CMS will supply the reduced payment rates to contractors as part of the ASCFS update.

ASC module programming will be applied to the quality penalty reduced payment rates on the ASCFS in the same manner and order as is applied to the non-reduced ASCFS schedule amount. For example, in 2014, the ASCFS amount for a particular service is \$100. If the ASC is not subject to a payment reduction, the paid amount the ASC will receive is \$80 [$\100 (the allowed ASC fee schedule amount) - $(\$100 \times 20$ percent (beneficiary co-pay) = $\$80$]. However, if the ASC is subject to a 2.0 percentage point payment reduction due to not successfully meeting ASCQR program requirements, the 2.0 percentage point reduction will be applied to the initial allowed ASCFS payment. As such, the reduced ASCFS amount is $\$98$. If the beneficiary co-pay is 20 percent, the beneficiary will pay $\$98 \times 20$ percent = $\$19.60$. The paid amount to the ASC accounting for the payment reduction will, thus, be $\$78.40$ ($\$98 - \19.60) = $\$78.40$.

Process for removing an ASC from the ASCQR program payment reduction

If an ASC believes that a payment reduction was applied in error, the ASC may apply for reconsideration to CMS through a process which was finalized in the FY 2013 IPPS/LTCH final rule with comment period (77 FR 53643). An ASC seeking a reconsideration of a quality reporting payment determination must submit to CMS a completed reconsideration request form by March 17 of the affected payment year. CMS would complete any reconsideration reviews and communicate the results of these determination to the designated ASC staff.

If CMS determines through the reconsideration process that a payment reduction was applied in error, CMS will notify contractors to remove the ASC from the payment reduction via an ASC quality penalty list update file that will be supplied to contractors. This ASC penalty list update file will be sent to contractors up to five times per month at weekly intervals; these will be full replacement files.

Two actions will occur when the contractor receives notice that an ASC is to be removed from the payment reduction. First, the contractor shall no longer process claims submitted by the ASC identified in error using the reduced payment rates. Second, the contractor shall reprocess all claims affected by the reduced payment rates for that supplier for that calendar year no later than 45 days after receipt of the notification to remove the ASC from the payment reduction. The reduced payment rates are only applied as an entire "calendar year" adjustment. ASCs will not be added to the annual ASC quality penalty list during the year; therefore, partial year reduced payment rates will not be assessed.

Note: The 2 percentage point reduction only impacts the ASCFS. It does not apply to or impact codes appearing on the ASCDRUG file, the ASCPI file code assignments, or the ASC code pair file.

Reason and remark codes used to communicate reduced payments

Beginning January 1, 2014, Medicare will use the following messages for the ASCs receiving the reduced payment amount on the ASCFS:

- **Claim adjustment reason code (CARC) 237** – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
- **Remittance advice remark code (RARC): N551** – Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.
- **CARC 237** – Legislated/Regulatory Penalty. At least one Remark Code must be provided; this Remark Code may be comprised of either the

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Quality *(continued)*

NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.

Additional information

The official instruction, CR 8349, issued to your MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1280OTN.pdf>.

MLN Matters® article MM7754 “April 2012 Update of the Ambulatory Surgical Center (ASC) Payment System” is available here <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7754.pdf>.

CR 7754 (Transmittal 2425) outlines the ASC Quality Measures, it is available here <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2425CP-.pdf>.

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

MLN Matters® Number: MM8349 *Revised*
 Related Change Request (CR) #: CR 8349
 Related CR Release Date: August 16, 2014
 Effective Date: January 1, 2014
 Related CR Transmittal #: R1280OTN
 Implementation Date: January 6, 2014

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Drugs and Biologicals

Pegfilgrastim (Neulasta®) HCPCS code J2505 indications and limitations

First Coast Service Options Inc. (First Coast) recently conducted data analysis pertaining to the administration of Neulasta®. Data analysis indicated that Neulasta® is routinely being administered the day after the last dose of the cytotoxic chemotherapy cycle. This raised a question as to whether or not the local coverage determination (LCD) requirements under the indications and limitations and/ or medical necessary pertaining to the 24-hour guidelines are being met.

First Coast revised LCD L29254, Pegfilgrastim (Neulasta®) for Healthcare Common Procedure Coding System (HCPCS) code J2505, effective February 7, 2013. Under the indications and limitation of coverage and/or medical necessity section the conditions for administering Neulasta® are as follows:

- The administration of Neulasta® should not occur 14 days before, and 24 hours after, administration of cytotoxic chemotherapy with the following Medicare exception for off-label use:
- If the patient is on a dose dense 14-day chemotherapy cycle, it would be acceptable to administer Neulasta® outside the 14-day before and 24-hour after rule for chemotherapy. Neulasta® would typically be administered on the second day of the 14-day dose dense chemotherapy cycle. An example of this would be a patient receiving dose dense Cytoxan/Adriamycin and Taxol for breast cancer. The chemotherapy drug record/orders should indicate that the patient is on a 14-day dose dense chemotherapy cycle schedule.

Documentation requirements

Providers must clearly document the time the last dose of the cytotoxic chemotherapy cycle ended and the time Neulasta was administered on the following day to meet the 24-hour guideline for Neulasta® or the documentation drug record/orders should indicate that the patient is on a 14-day dose dense chemotherapy cycle schedule.

Evaluation and Management

CMS to correct overpayments and denials for new patient claims affected by implementation of CR 8165

The Centers for Medicare & Medicaid Services (CMS) has identified issues related to change request (CR) 8165, *Common Working File (CWF) Informational Unsolicited Response (IUR) or Reject for A New Patient Visit Billed by the Same Physician or Physician Group within the Past Three Years* (see the related [MLN Matters® article](#), which was implemented with the October 2013 release.

CMS determined that the recovery process implemented with this CR generated incorrect overpayments and denials of new patient and established patient evaluation and management (E&M) codes, affecting approximately 318,000 claims. CMS is working to correct these claims and zero out the account receivables created. Providers do not need to take action. The correction process will be completed by the end of December. If a provider received an appropriate denial for a new patient E&M code that should have been billed as an established E&M code, the provider should request a clerical reopening via telephone, in writing, or through the MAC portal (where applicable).

Source: CMS PERL 201312-05

Hospital discharge day management service

First Coast Service Options Inc. (First Coast) has identified through data analysis payments of more than one hospital discharge day management service per hospital stay. *Current Procedural Terminology (CPT®)* codes identified in this analysis include 99238 (*Hospital discharge 30 minutes or less*) and 99239 (*Hospital discharge day management; more than 30 minutes*). Per Medicare guidelines, only one CPT® 99238 or 99239 is payable per patient per hospital stay.

As outlined in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, 30.6.9.2, the principal physician of record shall append modifier AI (Principal physician of record) to the claim for the initial hospital care code. Modifier AI identifies the physician who oversees the patient's care from all other physicians who may furnish specialty care. Only the attending physician of record (or the physician or qualified nonphysician practitioner acting on the behalf of the attending physician) reports the discharge day management service. Hospital discharge day management service, CPT® code 99238 or 99239 is described as a face-to-face evaluation and management (E/M) service.

Billing requirements

When billing for a hospital discharge day management service – either CPT® code 99238 or 99239 – the claim must reflect the date the actual face-to-face visit occurred by the physician or the qualified nonphysician practitioner even if the patient is discharged from the facility on a different calendar date.

Expansion of Medicare telehealth services for 2014

Provider types affected

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

What you need to know

Stop – impact to you

This article is based on change request (CR) 8553, which updates Medicare telehealth services in the *Medicare Benefit Policy Manual* and the *Medicare Claims Processing Manual*.

Caution – what you need to know

In the 2014 physician fee schedule final rule with comment period, the Centers for Medicare & Medicaid Services (CMS) added two codes to the list of Medicare telehealth services. Additionally, CMS modified regulations describing eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of metropolitan statistical areas effective January 1, 2014. This definition is consistent with the determinations made by the Office of Rural Health Policy (ORHP) in the Health Resources and Services Administration (HRSA). Finally, CMS modified regulations in order to establish geographic eligibility for Medicare telehealth originating sites for each calendar year based upon the status of the area as of December 31st of the prior calendar year.

Go – what you need to do

Make sure that your billing staffs are aware of these changes.

Background

CMS is adding the following services to the list of Medicare telehealth services for CY 2014:

- *CPT[®] 99495: Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge.*
- *CPT[®] 99496: Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge.*

This policy will allow the required face-to-face visit component of both services to be furnished through telehealth.

CMS is finalizing the regulatory definition of “rural HPSA” for purposes of determining eligibility for Medicare telehealth originating sites to include HPSAs located in rural census tracts, consistent with ORHP’s definition of “rural.” HRSA has developed a tool that will help providers determine geographic eligibility for Medicare telehealth services. This tool, the “Medicare Telehealth Payment Eligibility Analyzer,” is available at <http://datawarehouse.hrsa.gov/telehealthAdvisor/telehealthEligibility.aspx>.

CMS is also finalizing a change in policy so that geographic eligibility for an originating site is established and maintained on an annual basis, consistent with other telehealth payment policies. Absent this proposed change, the status of a geographic area’s eligibility for telehealth originating site payment is effective at the same time as the effective date for changes in designations that are made outside of CMS. Accordingly, CMS is revising regulations at 42 Code of Federal Regulations (CFR) section 410.78(b)(4) to conform to both of these policies.

For dates of service on or after January 1, 2014, MACs will accept *CPT[®] 99495* and *99496* submitted on professional claims. In addition, for dates of service on or after January 1, 2014, MACs will accept and pay *CPT[®] 99495* and *99496* when submitted with a GQ or GT modifier. For critical access hospitals (CAHs), MACs will accept and pay according to the appropriate physician or practitioner fee schedule amount when electing method II on type of bill 85x.

Additional information

Further information regarding telehealth services is available at <http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.

The official instruction, CR 8553, issued to your MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2848CP.pdf>.

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

MLN Matters[®] Number: MM8553
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 Related CR Release Date: December 30, 2013
 Effective Date: January 1, 2014
 Related CR Transmittal #: R2848CP
 Implementation Date: January 6, 2014

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Improper payments of hospital observation services

First Coast Service Options Inc. (First Coast) identified through data analysis improper payments for observation evaluation and management services. Evaluation and management services were identified that did not correspond with the amount of time the patient received observation services in an acute care facility.



As outlined in the Centers for Medicare & Medicaid (CMS) *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12 (Sections 30.6.8), and Chapter 4 (Section 290.2.2):

Similar to initial observation codes, payment for a subsequent observation care code is for all the care rendered by the treating physician on the day(s) other than the initial or discharge date. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

When a patient receives observation care for less than eight hours on the same calendar date, the initial observation care, from *Current Procedural Technology (CPT®)* codes 99218-99220, shall be reported by the physician. The observation care discharge service, *CPT®* code 99217, shall not be reported for this scenario.

When a patient is admitted for observation care and then is discharged on a different calendar date, the physician shall report initial observation care, from *CPT®* codes 99218-99220, and *CPT®* observation care discharge *CPT®* code 99217. On the rare occasion when a patient remains in observation care for three days, the physician shall report an initial observation care code (*CPT®* codes 99218-99220) for the first day of observation care, a subsequent observation care code (*CPT®* codes 99224-99226) for the second day of observation care, and an observation care discharge *CPT®* code 99217 for the observation care on the discharge date. When observation care continues beyond three days, the physician shall report a subsequent observation care code (*CPT®* codes 99224-99226) for each day between the first day of observation care and the discharge date.

When a patient receives observation care for a minimum of 8 hours, but less than 24 hours, and is discharged on the same calendar date, observation or inpatient care services (including admission and discharge services) from *CPT®* codes 99234-99236 shall be reported. The observation discharge, *CPT®* code 99217, cannot also be reported for this scenario.

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's orders. Observation time ends when all medically necessary services related to observation care are completed.

Documentation requirements

The physician shall satisfy the E/M documentation guidelines for furnishing observation care or inpatient hospital care. In addition to meeting the documentation requirements for history, examination, and medical decision making, documentation in the medical record shall include:

- Documentation stating the stay for observation care or inpatient hospital care involves eight hours, but less than 24 hours;
- Documentation identifying the billing physician was present and personally performed the services; and
- Documentation identifying the order for observation services, progress notes, and discharge notes were written by the billing physician.

Puzzled about your enrollment status?

Put the pieces together using the enrollment status lookup. View all active applications, specific applications, and confirm if you have been sent a revalidation request at <http://medicare.fcso.com/Enrollment/PEStatus.asp>.

Laboratory/Pathology

April 2014 changes to the laboratory national coverage determination edit software

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8585, which announces the changes that will be included in the April 2014 quarterly release of the edit module for clinical diagnostic laboratory services inclusive of ICD-10 translations. Please make sure that your billing staffs are aware of these changes for 2014.



Background

CR 8585 announces the changes that will be included in the April 2014 quarterly release of the edit module for clinical diagnostic laboratory services. The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation, effective April 1, 2003.

In accordance with the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 16, Section 120.2),

the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-9-CM codes.

CR 8585 communicates requirements to shared system maintainers (SSMs) and contractors notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for April 2014. These changes are effective for services furnished on or after April 1, 2014, for ICD-9, and on or after October 1, 2014, for ICD-10.

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

Additional information

The official instruction, CR 8585, issued to your A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2852CP.pdf>.

If you have any questions, please contact your 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: MM8585
 Related Change Request (CR) #: CR 8585
 Related CR Release Date: January 10, 2014
 Effective Date: April 1, 2014 – ICD-9 only; October 1, 2014 – ICD-10 only
 Related CR Transmittal #: R2852
 Implementation Date: April 7, 2014

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New waived tests

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 8560, which informs MACs of new Clinical Laboratory Improvement Act (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so that they can accurately process claims. There are six newly added waived complexity tests.

Caution – what you need to know

(CLIA regulations require that, for each test it performs, a laboratory facility must be appropriately certified. The *Current Procedural Terminology (CPT)*® codes that CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 8560, from which this article is taken, informs 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 2014 and that you remain current with certification requirements.

Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Medicare and Medicaid programs only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the 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 8560 (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.

The *CPT*® code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

CPT® code	Effective date	Description
G0434QW	May 29, 2013	“SCI International Inc. New Choice At Home Drug Test: Marijuana (Strip Format)”
82465QW 83718QW 84478QW 82962	July 1, 2013	Infopia USA, LipidPro® Professional Lipid Profile and Glucose Measuring System
G0434QW	July 29, 2013	Alere iCup DX 14 (Cassette Dip Card format)
G0434QW	September 25, 2013	American Screening Corporation, Inc. Discover Drug Test Cards
G0434QW	September 25, 2013	American Screening Corporation, Inc. Discover Multi-Panel Drug Test Cups
82465QW 83718QW 84478QW 82962	November 12, 2013	Jant Pharmacal Corp, LipidPlus Professional Lipid Profile and Glucose Measuring System

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Waived (*continued*)

Additional information

The official instruction, CR 8560, issued to your MAC, regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2854CP.pdf>.

For further information, you may view the CLIA Web page available at <http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html>.

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

MLN Matters® Number: MM8560

Related Change Request (CR) #: CR 8560

Related CR Release Date: January 10, 2014

Effective Date: April 1, 2014

Related CR Transmittal #: R2854CP

Implementation Date: April 7, 2014

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Medicare Physician Fee Schedule Database

Emergency update to the 2014 Medicare physician fee schedule database

Provider types affected

This MLN Matters® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries and which are paid under the 2014 Medicare physician fee schedule database (MPFSDB).

What you need to know

This article is based on change request (CR) 8534 which informs MACs that the payment files released for the MPFS based upon the MPFS final rule published in the *Federal Register* December 10, 2013, are updated by CR 8534. CR 8534 amends those payment files and accounts for the year-end Congressional legislation for a 0.5 percent update to the 2014 conversion factor and extends the non-budget neutral geographic practice cost index (GPCI) work floors, all effective for January 1, 2014, through March 31, 2014. This is the result of the passage of the Pathway for SGR Reform Act of 2013.

MACs will begin to pay claims using these new files no later than January 16, 2014, effective for dates of service as of January 1, 2014. In addition, MACs will post the new MPFS fees to their websites no later than January 3, 2014.

Additional information

The official instruction, CR 8534, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2847CP.pdf>.

If you have any questions, please contact your 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>.

MLN Matters® Number: MM8534

Related Change Request (CR) #: CR 8534

Related CR Release Date: December 27, 2013

Effective Date: January 1, 2014

Related CR Transmittal #: R2847CP

Implementation Date: January 6, 2014

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Summary of policies in the 2014 Medicare physician fee schedule final rule and telehealth originating site facility fee payment

Provider types affected

This *MLN Matters*[®] article is intended for physicians and non-physician practitioners (NPPs) submitting claims to Medicare administrative contractors (MAC) for services to Medicare beneficiaries.

Provider action needed

This article, based on change request (CR) 8533, provides a summary of the policies in the 2014 Medicare physician fee schedule (MPFS) final rule and announces the telehealth originating site facility fee payment. Please see the *Background* and *Policy* section of this article for details of the changes. Make sure that your billing staffs are aware of these updates for 2014.

Background

CR 8533 provides a summary of the policies in the 2014 MPFS. Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period November 27, 2013, that updates payment policies and Medicare payment rates for services furnished by physicians and nonphysician practitioners (NPPs) that are paid under the MPFS in 2014.

The final rule addresses Medicare public comments on payment policies that were described in the proposed rule earlier this year, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014," (displayed July 8, 2013 and published in the *Federal Register* July 19, 2013).

The final rule also addresses interim final values established in the 2013 MPFS final rule with comment period, which was displayed November 1, 2012, and published in the *Federal Register* November 16, 2012. The final rule assigns interim final values for new and revised codes for 2014 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until January 27, 2014.

Key provisions of the MPFS final rule

Sustainable growth rate (SGR) and MPFS conversion factor for 2014

Without a change in the law, the conversion factor will be reduced by 20.1 percent for services in 2014. The President's budget calls for averting these cuts and finding a permanent solution to this problem. The 2014 conversion factor is \$27.2006, which reflects a smaller reduction in the conversion factor than the 24.4 percent reduction that CMS projected

in March 2013. The smaller reduction is due in part to a 4.72 percent adjustment to the conversion factor to offset the decrease in Medicare physician payments that would otherwise have occurred due to the 2014 rescaling of the relative value units (RVUs) so that the proportions of total payments for the work, practice expense (PE), and malpractice RVUs match the proportions in the final revised Medicare economic index (MEI) for 2014. This issue is discussed further below. The overall 2014 reduction in physician fee schedule payments required under the SGR methodology is unchanged by this rescaling.

On December 20, 2013, after the MPFS final rule was issued, Congress passed the "Pathway for SGR Reform Act of 2013." This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect January 1, 2014. The new law provides a 0.5 percent update through March 31, 2014. The 2014 conversion factor under this new law is \$35.8228.

Medicare economic index

CMS finalized the proposed revisions to the calculation of the MEI, which is the price index used to update physician payments for inflation. The changes are in response to recommendations by a technical advisory panel that met during 2012. The MEI is one of the factors used in determining the MPFS conversion factor. The final rule includes changes in the MPFS RVUs assigned to the work and practice expense categories so that the weights used in the MPFS payment calculation will continue to mirror those in the MEI. As a result, some payment is being redistributed to work from PE.

Telehealth services

CMS modified the regulations establishing the geographic criteria for eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of urban areas as determined by the Office of Rural Health Policy. This change will more appropriately allow sites located within HPSAs in metropolitan statistical areas (MSAs) that have rural characteristics to qualify as originating sites and improve access to telehealth services in shortage areas. In this rule, CMS also finalizes a policy that determines an originating site's geographic eligibility based on the areas as of December 31 of the preceding year for the entire calendar year. This change will avoid mid-year changes to geographic designations (sometimes without advance notice to Medicare beneficiaries and providers) that could result in unexpected disruptions to established telehealth originating sites and avoid the need to make mid-year Medicare telehealth payment policy changes. In addition, we are adding transitional care management services (CPT[®] codes 99495-99496) to the list of

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Summary *(continued)*

eligible Medicare telehealth services).

Telehealth originating site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in Section 1842(i)(3) of the Act. The MEI increase for 2014 is 0.8 percent. Therefore, for 2014, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or \$24.63. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

**Revisions to the practice expense geographic adjustment**

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect the local cost of operating a medical practice as compared to the national average. CMS calculates separate GPCIs to adjust the work, PE, and malpractice cost components of each payment. The law requires that we review the GPCIs every three years and adjust them as appropriate with a two-year phase-in of the new GPCIs. We are finalizing new GPCIs using updated data. The updated GPCIs will be phased in over 2014 and 2015. Additionally, we will apply the statutorily mandated 1.5 work GPCI floor in Alaska and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming).

Misvalued codes

Consistent with amendments made by the Affordable Care Act, CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes and make adjustments, where appropriate. We finalized the values for around 200 codes in the 2014 final rule. In addition, we assigned interim final values for approximately 200 services, including hip and knee replacements, mental health services, and GI endoscopy services. These interim final rates are open for public comment until January 27, 2014.

CMS is not finalizing its proposal to adjust relative values under the MPFS to effectively cap the physician PE payment for procedures furnished in a non-facility setting at the total payment rate for the service when furnished in an ambulatory surgical center or hospital outpatient setting. Instead, CMS will take additional time to consider issues raised by the public commenters and plans to address this issue in future rulemaking. In addition, for 2014, we are finalizing 18 codes that we identified and proposed as potentially misvalued services in consultation with MAC medical directors.

Application of therapy caps to critical access hospitals (CAHs)

The law applies annual limitations or “therapy caps” one per beneficiary incurred expenses for outpatient therapy services – one for physical therapy and speech-language pathology services combined and another for occupational therapy services. CMS finalized its proposal to apply the therapy caps and related policies to outpatient therapy services furnished by a CAH beginning January 1, 2014, in order to properly apply the law that established the therapy caps.

Compliance with state law for incident-to services

CMS is requiring as a condition of Medicare payment that “incident to” services be furnished in compliance with applicable state law. This policy strengthens program integrity by allowing Medicare to deny or recoup payments when services are furnished not in compliance with state law. We also eliminated redundant regulations for each type of practitioner by consolidating the “incident to” requirements for all practitioners that are permitted to bill Medicare directly for their services, reducing the regulatory burden and making it less difficult for practitioners to determine what is required in order to bill Medicare for “incident to” services. This portion of the final rule with comment period is effective on January 27, 2014.

The outpatient mental health treatment limitation

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends Section 1833(c) of the Social Security Act to phase out the outpatient mental health treatment limitation over a 5-year period, from 2010-2014. The limitation had resulted in Medicare paying approved lower percentage of the allowed amount under the MPFS for outpatient mental health treatment rather than the 80 percent that is paid for most other services. This limitation expires on January 1, 2014. In 2014, Medicare will pay the same percentage of the MPFS amount for outpatient mental health services as other Part B services (i.e. 80 percent of the MPFS amount).

Primary care and chronic care management

As part of its ongoing efforts to appropriately value primary care services, Medicare will begin making a separate payment for chronic care management

(continued on next page)

Summary *(continued)*

services beginning in 2015. Chronic care management services include the development, revision, and implementation of a plan of care; communication with the patient, caregivers, and other treating health professionals; and medication management. Medicare beneficiaries with multiple chronic conditions who wish to receive these services can choose a physician or other eligible practitioner from a qualified practice to furnish these necessary to support payment for furnishing care management services through the 2015 MPFS.

Additional information

The final rule will appear in the December 10, 2013, *Federal Register*. For more information, see <https://www.federalregister.gov/articles/2013/12/10/2013-28696/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory>.

The official instruction, CR 8533, issued to your MAC regarding this change, may be viewed at <http://>

www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2840CP.pdf.

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

MLN Matters® Number: MM8533
Related Change Request (CR) #: CR 8533
Related CR Release Date: December 20, 2013
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Related CR Transmittal #: R2840CP
Implementation Date: January 6, 2014

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Therapy Services

Therapy cap values for 2014

Provider types affected

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

What you need to know

This article is based on change request (CR) 8407, which informs Medicare contractors about changes to the policy for outpatient therapy caps for 2014. For physical therapy and speech-language pathology combined, the therapy cap for 2014 will be \$1,920. For occupational therapy, the cap for 2014 will be \$1,920. Make sure that your billing staffs are aware of these changes.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B. These limitations are commonly referred to as "therapy caps." The therapy caps are updated each year based on the Medicare economic index. The Deficit Reduction Act of 2005 directed the Secretary to implement a process for exceptions to therapy caps for medically necessary services. The exceptions process for the therapy caps has been continuously extended

several times through subsequent legislation. Most recently, Section 603(a) of the American Taxpayer Relief Act of 2012 extended the therapy caps exception process through December 31, 2013.

Additional information

The official instruction, CR 8407 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2807CP.pdf>.

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

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Related CR Release Date: November 6, 2013
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Related CR Transmittal #: R2807CP
Implementation Date: January 6, 2014

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2014 annual update to the therapy code lists

Provider types affected

This *MLN Matters*® article is intended for physicians, therapists, and other providers who submit claims to Medicare administrative contractors (MACs), including home health & hospice MACs for outpatient rehabilitation therapy services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8482 which updates the therapy code list for 2014 by adding four “always therapy” codes, one “sometimes therapy” code, and deletes two current codes. The update to the therapy code list reflects those made in the 2014 Healthcare Common Procedure Coding System and *Current Procedural Terminology*, Fourth Edition (HCPCS/CPT®-4). Please make sure your billing and coding staff are aware of these changes.

Background

The Social Security Act (Section 1834(k)(5)); (see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The HCPCS/CPT®-4 is the coding system used for the reporting of these services.

CR 8482, from which this article is taken, updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2014 HCPCS/CPT®-4. The therapy code listing can be found at <http://www.cms.gov/Medicare/Billing/TherapyServices/index.html>.

CR 8482 updates the therapy code list with four “always therapy” codes, one “sometimes therapy” code, and deletes two current codes for 2014 as shown in the following tables.

Always therapy codes added for 2014

Code	Descriptor
92521	<i>Evaluation of speech fluency (eg, stuttering, cluttering)</i>
92522	<i>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)</i>
92523	<i>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (eg, receptive and expressive language)</i>

Code	Descriptor
92524	<i>Behavioral and qualitative analysis of voice and resonance</i>

Always therapy coded deleted for 2014

Code	Descriptor
92506	<i>Evaluation of speech, language, voice, communication, and/or auditory processing disorder, and/or aural rehabilitation status.</i>

Sometimes therapy code added for 2014

Code	Descriptor
97610*	<i>Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day</i>

Sometimes therapy code deleted for 2014

Code	Descriptor
0183T*	<i>Low frequency, non-contact, non-thermal ultrasound, including topical applications(s), when performed, wound assessment, and instruction(s) for ongoing care, per day</i>

*97610 replaces current code 0183T effective January 1, 2014

Additional information

The official instruction, CR 8482, issued to MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2844CP.pdf>.

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

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Widespread probe results: Therapy services billed by physical medicine and rehabilitation physicians

First Coast Service Options Inc. (First Coast) conducted a widespread probe (WSP) review in response to an aberrant billing pattern for CPT® codes 97032 (*Application of a modality to one or more areas; electrical stimulation [manual], each 15 minutes*); 97035 (*Application of a modality to one or more areas; ultrasound, each 15 minutes*) and 97124 (*Therapeutic procedure, one or more areas, each 15 minutes; massage including effleurage, petrissage and/or tapotement [stroking, compression, percussion]*) billed by specialty 25 (physical medicine and rehabilitation) in Puerto Rico. The results of the widespread probe yielded a 62 percent claim error rate. The most common reason for an error to be assigned was insufficient documentation including failure to meet Medicare's documentation requirements specific to therapy services. As a result of the widespread probe findings, First Coast has implemented a prepayment medical review edit for therapy services billed by physical medicine and rehabilitation physicians in Puerto Rico.



The following is a brief summary of Medicare requirements for therapy services. Therapy services shall be payable when the medical record and the information on the claim form consistently and accurately report covered therapy services. Documentation must be legible, relevant, and sufficient to justify the services billed.

The patient receiving outpatient therapy services must be under the care of a physician/nonphysician practitioner (NPP). NPP signifies a physician assistant, clinical nurse specialist or nurse practitioner, who may, if state and local law permit it, and when appropriate rules are followed, provide, certify, or supervise therapy services.

Therapy services **must** relate directly and specifically to a written treatment plan. The plan (also known as a plan of care or plan of treatment) **must** be established before treatment is started. The plan is established when it is developed (e.g., written or dictated). The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established **must** be recorded within the plan. See Pub. 100-02, Chapter 15, Section 220.3 for further documentation requirements)

“The plan of care shall contain, at minimum, the following information as required by regulation

(42CFR424.24, 410.61, and 410.105(c) (for CORFs)). (See §220.3 for further documentation requirements):

- Diagnosis
- Long Term treatment goals; and
- Type, amount, duration and frequency of therapy services

The plan of care shall be consistent with the related evaluation, which may be attached and is considered incorporated into the plan. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources. Long Term treatment goals should be developed for the entire episode of care and not only for the services provided under a plan for one interval of care in the current setting. When the episode of care is anticipated to be long enough to require more than one certification, the long term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. When episodes in the setting are short, measurable goals may not be achievable; documentation should

state the clinical reasons progress cannot be shown. The type of treatment may be PT, OT, or SLP, or, where appropriate, the type may be a description of a specific treatment or intervention. Where a physician/NPP establishes a plan, the plan must specify the type (PT, OT, SLP) of therapy planned.”

Various entities may request documentation to support services billed to the Medicare program (e.g., Medicare administrative contractor [MAC], comprehensive error rate testing [CERT], recovery auditor [RA], zone program integrity contractors [ZPIC], or the office of inspector general [OIG]).

The following documentation **must** be submitted in response to a request for documentation, unless the requesting contractor specifies otherwise.

- Evaluation and plan of care (POC) (may be one or two documents). Include the initial evaluation and any reevaluations relevant to the episode being reviewed; Certification (physician/NPP approval of the plan) and recertification when records are requested after the certification/recertification is due;
 - Progress reports (including discharge notes, if
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Widespread (*continued*)

applicable) when records are requested after the reports are due;

- Treatment notes for each treatment day (may also serve as progress reports when required information is included in the notes). Daily treatment notes must indicate the individual modalities performed that day. Minutes must be documented for each modality that represents a time-based code and the total time in treatment must be documented; and
- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands the reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation. If the patient is expected to exceed the therapy cap, the record must clearly indicate the medical necessity for the patient to receive covered services above the cap.

Note: The excessive use of modifier KX (Requirements specified in the medical policy have been met) may indicate abusive billing.

Therapy services have their own benefit under Section 1861 of the Social Security Act (“the Act”) and shall be covered when provided according to the standards and conditions of the benefit described in Medicare manuals. Statute 1862 (a) (20) of the Act requires that payment be made for a therapy service billed by a physician/NPP only if the service meets the standards and conditions – other than licensing – that would apply to a therapist.

Medicare is authorized to pay **only** for services provided by those trained specifically in physical therapy, occupational therapy or speech-language pathology. That means that the services of athletic trainers, massage therapists, recreational therapists, kinesiotherapists, low vision specialists or any other profession may not be billed as covered therapy services.

In addition, there is no coverage for services provided “incident to” the service of a therapist. Although physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the benefit for therapy services and not by the benefit for services “incident to” a physician/NPP. The services furnished by PTAs and OTAs are not incident to the therapist’s services. A physical therapist must supervise PTAs and an occupational therapist must supervise OTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for PTAs in all settings except private practice (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed.

The service of a PTA and OTA shall not be billed as services “incident to” a physician/NPP’s service, because they do not meet the qualifications of a therapist. Only services provided by a licensed therapist or an individual who has completed an accredited PT or OT curriculum and are qualified for licensure may provide services “incident to” the physician/NPP.

Providers are encouraged to review the complete requirements for billing rehabilitation services found on First Coast’s Therapy and Rehabilitation Services local coverage determination [L29399](#) (Puerto Rico and the U.S. Virgin Islands) as well as the requirements found in the [Internet-only manual \(IOM\), Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 220-230](#).

Additional information

Visit First Coast’s Medicare provider website [rehabilitation services](#) page for the latest news on therapy services. To learn about upcoming educational events related to therapy services visit the events calendar for more information.

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.



General Coverage

President Obama signs the ‘Pathway for SGR Reform Act of 2013’

New law includes physician update fix through March 2014

On December 26, 2013, President Obama signed into law the “Pathway for SGR Reform Act of 2013.” This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect January 1, 2014. The new law provides for a 0.5 percent update for such services through March 31, 2014. President Obama remains committed to a permanent solution to eliminating the sustainable growth rate (SGR) reductions that result from the existing statutory methodology. The administration will continue to work with Congress to achieve this goal.

The new law extends several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act) as well as provisions of the Affordable Care Act. Specifically, the following Medicare fee-for-service policies have been extended. The Centers for Medicare & Medicaid Services (CMS) also has included Medicare billing and claim processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, and more information about other provisions will be forthcoming.

Section 1101: Medicare Physician Payment Update

– as indicated above, the new law provides for a 0.5 percent update for claims with dates of service on or after January 1, 2014, through March 31, 2014. CMS is currently revising the 2014 Medicare physician fee schedule (MPFS) to reflect the new law’s requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2014 conversion factor is \$35.8228.

Section 1102: Extension of Medicare Physician Work Geographic Adjustment Floor – the existing 1.0 floor on the physician work geographic practice cost index is extended through March 31, 2014. As with the physician payment update, this extension will be reflected in the revised 2014 MPFS.

Section 1103: Extension Related to Payments for Medicare Outpatient Therapy Services

– Section 1103 extends the exceptions process for outpatient therapy caps through March 31, 2014. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through March 31, 2014. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD). Additional information about the exception process for therapy services may be found in the “*Medicare Claims Processing Manual*,” Pub. 100-04, Chapter 5, Section 10.3.

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received January 1, 2014. For physical therapy and speech language pathology services combined, the 2014 limit for a beneficiary on incurred expenses is \$1,920. There is a separate cap for occupational therapy services which is \$1,920

for 2014. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 1103 also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2014, through March 31, 2014, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of \$3,700 for therapy services, including OPD therapy services, for a year. There are two separate \$3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

Section 1104: Extension of Ambulance Add-On Payments

– Section 1104 extends the following two Job Creation Act ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that



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originate in urban areas is extended through March 31, 2014; and (2) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the “super rural” bonus) is extended through March 31, 2014. The provision relating to air ambulance services that continued to treat as rural any area that was designated as rural on December 31, 2006, for purposes of payment under the ambulance fee schedule, expired June 30, 2013.

Section 1105: Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals – the Affordable Care Act allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges from the hospital. To qualify, the hospital must have less

than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment through March 31, 2014, retroactive to October 1, 2013. Be on the alert for further information about implementation of this provision.

Section 1106: Extension of the Medicare-Dependent Hospital (MDH) Program – the MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until March 31, 2014, and is retroactive to October 1, 2013. Be on the alert for further information about implementation of this provision.

Source: CMS PERL 201312-06

Further information on mandatory reporting of an eight-digit clinical trial number

Provider types affected

This *MLN Matters*[®] article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including durable medical equipment MACs (DME MACs) for items and services provided in clinical trials to Medicare beneficiaries.

Provider action needed

This article is related to CR 8401, which requires, effective January 1, 2014, the mandatory reporting of a clinical trial identifier number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the *Medicare National Coverage Determination (NCD) Manual*, Section 310.1.

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

Since the release of CR 8401, the Centers for Medicare & Medicaid Services (CMS) has learned that some physicians, providers, and suppliers do not have the capability at this time to submit the clinical trial identifier number associated with trial-related claims. This article presents those physicians, providers, and

suppliers with an alternative means of satisfying the CR 8401 requirements until January 1, 2015. At that time, such providers must fully comply with CR 8401. Make sure that your billing staffs are aware of the requirement and the implementation changes and dates.

Background

CMS understands that implementing CR 8401 by January 1, 2014, would create an undue hardship on a number of its stakeholders. As a result, for physicians, providers, and suppliers who do not have the capacity at this time to report the clinical trials identifier number associated with trial-related claims, CMS is providing an option to submit a generic number in place of the actual national clinical trials (NCT) number.

Beginning January 1, 2014, and continuing no later than through December 31, 2014, those above-mentioned physicians, providers, and suppliers may instead report an 8-digit, generic number of 99999999 using the instructions in CR 8401.

This will allow trial-related claims to process

appropriately if they are prepared according to instructions in CR 8401. Keep in mind that trial-related claims will be returned if they do not contain either the actual clinical trial identifier number or the 8-digit generic number 99999999 – you may not leave those indicated fields blank. That said, CMS encourages those affected by CR 8401 to update their internal claim processing procedures as expeditiously as

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Clinical *(continued)*

possible so they can begin reporting the actual clinical trial identifier number as CR 8401 instructs.

Note: This in no way precludes those already reporting and/or able to report the actual clinical trial number on clinical trial-related claims from doing so. Beginning January 1, 2015, without further notice, CR 8401 shall be fully implemented.

Note: For clarification, the clinical trial identifier number is required for all items/services provided in relation to participation in a clinical trial, clinical study, or registry that may result from coverage with evidence development (CED), the Medicare clinical trial policy, or a CMS-approved investigational device exemption (IDE) study. For IDE trials, both the IDE and the clinical trial identifier number are required. Specifically, include the clinical trial identifier number if: the beneficiary is enrolled in an approved clinical trial; and, the claim is for the investigational item or service, and/or, the costs are related to the investigational item or service, and/or, the costs are related to routine care for the condition in the clinical trial.

Beginning January 1, 2015, without further notice, CR 8401 will be fully implemented.

Additional information

The official instruction, CR 8401, issued to your MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2805CP.pdf>. The *MLN Matters*[®] article related to CR 8401 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf>.

Section 3100.1 of the *Medicare National Coverage Determinations (NCD) Manual* is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf#page=150.

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

MLN Matters[®] Number: SE1344

Related Change Request (CR) #: CR 8401

Related CR Release Date: October 30, 2013

Effective Date: January 1, 2014

Related CR Transmittal #: 2805

Implementation Date: January 6, 2014

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**Calculate the possibilities ...**

Whether you're estimating the amount of a Medicare payment, the length of an ESRD coordinating period, or the deadlines for sending an appeals request or responding to an additional development request, try the easy way to calculate the possibilities. Find everything you need to "do it yourself" in our new Tool center.

Documentation requirements for home health prospective payment system face-to-face encounter

Provider types affected

This *MLN Matters*[®] special edition article is intended for physicians who refer patients to home health (HH), order HH services, and/or certify patients' eligibility for the Medicare HH benefit, home health agencies, and non-physician practitioners (NPPs).

What providers need to know

Effective January 1, 2011, the Affordable Care Act mandates that prior to certifying a beneficiary's eligibility for the HH benefit, the certifying physician must document that he or she or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the beneficiary.

Background

The regulation governing the face-to-face encounter requires that as a condition for payment, the encounter occur within 90 days prior to the start of care or up to 30 days after the start of care and the documentation of the encounter includes "...an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services...."

Improper payments by type of error

The majority of HH PPS improper payments are due to "insufficient documentation" errors. "Insufficient documentation" errors occur when the medical documentation submitted is inadequate to support payment for the services billed or when a specific documentation element that is required is missing.

Most "insufficient documentation" errors for HH PPS result from claims where the narrative portion of the face-to-face encounter document does not sufficiently describe how the clinical findings from the encounter support the beneficiary's homebound status and the need for skilled services.

Note: The homebound status of the patient and his/her need for skilled services must be written in a brief narrative, signed by the physician, titled "Home Health Face to Face Encounter", and dated.

Some of the records reviewed contained very little clinical information beyond simple lists of diagnoses, recent injuries, or procedures. For example, "insufficient documentation" includes instances where the need for skilled nursing is justified with only a listed diagnosis, such as chronic obstructive pulmonary disease (COPD), osteoarthritis, or fracture of the humerus; and the beneficiary's homebound status is documented only by a notation such as "gait abnormality" or "taxing effort."

As described in the regulation (42 CFR 424.22(a)(1)(v)), such information is not sufficient. The face-to-face

encounter documentation must explain why the findings from the encounter support the medical necessity of the services ordered and the beneficiary's homebound status. Also, the *Medicare Benefit Policy Manual* states that the documentation must include a brief narrative that "describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services."

Required narrative requirements

The two elements of the **required brief narrative** for documenting the HH face-to-face encounter are:

1. **Confined to the home:** Describe why the patient is homebound. An individual shall be considered "confined to the home" (homebound) if **both** of the following **two criteria** are met:
 - A. The patient must either:
 - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence, OR
 - Have a condition such that leaving his or her home is medically contraindicated.

Examples:

- a. Ambulates limited distance of 125' with assistance of a walker due to acute stroke;
- b. Poor endurance, shortness of breath with minimal ambulation due to congestive heart failure (CHF) and needs assistance to leave the home.

B. There must exist:

- A normal inability to leave home; AND
- Leaving home must require a considerable and taxing effort.

Examples:

- a. Deteriorating mental status, unable to leave home unsupervised;
- b. b. Frequent seizure activity, requires supervision/assistance of another person

2. **Need for skilled services:** *To qualify for home health services, the beneficiary must need intermittent skilled nursing services, physical therapy (PT), or speech language pathology (SLP) services.* Describe what the RN, PT, or SLP and other services will be doing in the home. For example, "skilled nursing required to assess and manage new COPD regimen."

(continued on next page)

Documentation *(continued)*

- Skilled nursing services must be reasonable and necessary for the treatment of the patient's illness or injury. Skilled nursing services can be, but are not limited to:
 - Teaching/training
 - Observe/assess
 - Complex care plan management
 - Administration of certain medications
 - Tube feedings
 - Wound care, catheters and ostomy care
 - NG and Tracheostomy aspiration/care
 - Psychiatric evaluation and therapy
 - Rehabilitation nursing
- PT, OT, SLP services must be reasonable and necessary for the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of his or her unique medical condition. Assuming all other eligibility and coverage requirements have been met, one of the following three conditions must be met for therapy services to be covered :
 - a. The skills of a qualified therapist are needed to restore patient function.
 - Therapy services must be provided with the expectation that, based on the assessment made by the physician of the patient's restorative potential, the condition of the patient will improve materially in a reasonable and generally predictable period of time.
 - b. The skills of a qualified therapist are needed to design or establish a maintenance program.
 - The clinical condition of the patient requires the specialized skill, knowledge and judgment of a qualified therapist to design or establish a maintenance program, related to the patient's illness or injury, in order to ensure the safety of the patient and the effectiveness of the program.
 - c. The skills of a qualified therapist (not an assistant) are needed to perform maintenance therapy.
 - The clinical condition of the patient is such that the complexity of the therapy services required to maintain function involves the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant) or the clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist himself/herself (and not an assistant)

in order to ensure the patient's safety and to provide an effective maintenance program.

Example: Ms. Jane Doe is a 99-year-old female hospitalized with congestive heart failure (CHF) exacerbation (she has co-morbid asthma and low vision). She is going home and needs skilled nursing due to a new medication regimen and high potential for hospital readmission. She also needs in-home PT for strength training due to deconditioning during CHF exacerbation and safety assessment because she is at risk for falls. She is unable to leave the house without a walker.

Element 1: "Confined to the Home" Status due to deconditioning, CHF, and low vision.

Element 2: Skilled Nursing is required due to medication changes. PT is required for strength training and home assessment due to fall risk.

Additional information

Attached to this article are documents that you may want to review showing correct and incorrect examples of documentation.

A list of frequently asked questions is available at <http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html>.

MLN Matters® article SE1038 provides guidance for the original face-to-face implementation, is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1308.pdf>.

You may also review MLN Matters® article MM8444 which provides clarification of the definition of "confined to the home" as stated in the revised Section 30.1.1 of Chapter 7 of the *Medicare Benefit Policy Manual*. The article may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8444.pdf>.

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

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 Related CR Transmittal #: N/A
 Implementation Date: N/A

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.

RARC and CARC and MREP and PC Print update

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare claims administration contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8561 which updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists that are effective on April 1, 2014. CR 8561 also instructs fiscal intermediary standard system (FISS) and VIPs Medicare system (VMS) maintainers to update PC Print and Medicare Remit Easy Print (MREP) software by April 7, 2014. Make sure that your billing staffs are aware of these updates and that they obtain the updated MREP or PC Print software.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Accordingly, Medicare policy states that CARCs and appropriate RARCs must be used for:

- Transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, along with group code to report payment adjustments and informational RARCs to report appeal rights, and other adjudication related information; and
- Transaction 837 (coordination of benefits (COBs)).

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or use another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

CARC and RARC code sets are updated three times a year on a regular basis. CR 8561 lists only the changes that have been approved since the last code update issued August 30, 2013, in CR 8422, Transmittal R2776CP and does not provide a complete list of codes for these two code sets. The *MLN Matters*® article corresponding to CR 8422, MM8422, can be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8422.pdf>.

Note: If there is any discrepancy in the code text as posted on Washington Publishing Company (WPC) website and as reported in any CR, the WPC version should be implemented.

Changes in CARC list since CR 8422

The following tables list the changes in the CARC database since the last code update CR 8422. The full CARC list may be downloaded from the WPC website, available at <http://wpc-edi.com/Reference>.

New codes – CARC

Code	Narrative	Effective date
257	The disposition of the claim/service is pending during the premium payment grace period, per Health Insurance Exchange requirements. (Use only with Group Code OA)	11/01/2013
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	11/01/2013
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.	11/01/2013

(continued on next page)



RARC (continued)

Code	Narrative	Effective date
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	11/01/2013
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)	11/01/2013
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	11/01/2013
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	11/01/2013
P6	Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	11/01/2013
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	11/01/2013
P8	Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	11/01/2013
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.	11/01/2013
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.	11/01/2013
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)	11/01/2013
P12	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	11/01/2013

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RARC (continued)

Code	Narrative	Effective date
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	11/01/2013
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	11/01/2013
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.	11/01/2013
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)	11/01/2013
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only	11/01/2013
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.	11/01/2013
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.	11/01/2013
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	11/01/2013
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/01/2013
P22	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/01/2013
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/01/2013

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RARC (continued)

Modified codes – CARC

Code	Modified narrative	Effective date
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	11/01/2013
253	Sequestration - reduction in federal payment	11/01/2013

Deactivated codes – CARC

Code	Current narrative	Effective date
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	07/01/2014
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF)	07/01/2014
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	07/01/2014
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	07/01/2014
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)	07/01/2014
218	Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	07/01/2014
220	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)	07/01/2014
221	Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)	07/01/2014
230	No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty.	07/01/2014
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.	07/01/2014

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RARC (continued)

Code	Current narrative	Effective date
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)	07/01/2014
W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply.	07/01/2014
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	07/01/2014
W3	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.	07/01/2014
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	07/01/2014
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)	07/01/2014
W6	Referral not authorized by attending physician per regulatory requirement.	07/01/2014
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	07/01/2014
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	07/01/2014
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	07/01/2014
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	07/01/2014
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	07/01/2014

(continued on next page)

RARC (continued)

Code	Current narrative	Effective date
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	07/01/2014

Changes in RARC list since CR 8422

The following are changes in the RARC database since the last code update CR 8422. The full RARC list can be downloaded from the WPC website available at <http://wpc-edi.com/Reference>.

New codes – RARC

Code	Narrative	Effective date
N677	Alert: Films/Images will not be returned.	11/1/2013
N678	Missing post-operative images/visual field results.	11/1/2013
N679	Incomplete/Invalid post-operative images/visual field results.	11/1/2013
N680	Missing/Incomplete/Invalid date of previous dental extractions.	11/1/2013
N681	Missing/Incomplete/Invalid full arch series.	11/1/2013
N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	11/1/2013
N683	Missing/Incomplete/Invalid prior treatment documentation.	11/1/2013
N684	Payment denied as this is a specialty claim submitted as a general claim.	11/1/2013
N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.	11/1/2013
N686	Missing/incomplete/invalid questionnaire needed to complete payment determination.	11/1/2013
N687	Alert - This reversal is due to a retroactive disenrollment. (Note: To be used with claim/service reversal)	11/1/2013
N688	Alert – This reversal is due to a medical or utilization review decision. (Note: To be used with claim/service reversal)	11/1/2013
N689	Alert –This reversal is due to a retroactive rate change. (Note: To be used with claim/service reversal)	11/1/2013
N690	Alert – This reversal is due to a provider submitted appeal. (Note: To be used with claim/service reversal)	11/1/2013
N691	Alert – This reversal is due to a patient submitted appeal. (Note: To be used with claim/service reversal)	11/1/2013
N692	Alert – This reversal is due to an incorrect rate on the initial adjudication (Note: To be used with claim/service reversal)	11/1/2013
N693	Alert – This reversal is due to a cancelation of the claim by the provider.	11/1/2013
N694	Alert – This reversal is due to a resubmission/change to the claim by the provider.	11/1/2013
N695	Alert – This reversal is due to incorrect patient financial responsibility information on the initial adjudication.	11/1/2013
N696	Alert – This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment. (Note: To be used with claim/service reversal)	11/1/2013
N697	Alert – This reversal is due to a payer’s retroactive contract incentive program adjustment. (Note: To be used with claim/service reversal)	11/1/2013
N698	Alert – This reversal is due to non-payment of the Health Insurance Exchange premiums by the end of the premium payment grace period, resulting in loss of coverage. (Note: To be used with claim/service reversal)	11/1/2013

Modified codes – RARC

(continued on next page)

RARC (continued)

Code	Modified narrative	Effective date
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	11/01/2013
N103	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate.	11/01/2013
N178	Missing pre-operative images/visual field results	11/01/2013
N244	Incomplete/Invalid pre-operative images/visual field results.	11/01/2013
N597	Adjusted based on a medical/dental provider's apportionment of care between related injuries and other unrelated medical/dental conditions/injuries.	11/01/2013

Deactivated codes – RARC

Code	Current narrative	Effective date
N365	This procedure code is not payable. It is for reporting/information purposes only.	07/01/2014
N627	Service not payable per managed care contract.	07/01/2014
N632	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.	07/01/2014

Additional information

The official instruction, CR 8561, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2855CP.pdf>.

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

MLN Matters® Number: MM8561
 Related Change Request (CR) #: CR 8561
 Related CR Release Date: January 10, 2014
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 Related CR Transmittal #: R2855CP
 Implementation Date: April 7, 2014

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Revised CMS-1500 claim form instructions for version 02/12

Provider types affected

This *MLN Matters*[®] article is intended for physicians and other providers submitting claims to Medicare contractors (carriers, A/B Medicare administrative contractors (A/B MACs), and durable medical equipment Medicare administrative contractors (DME/MACs)) for services provided to Medicare beneficiaries.

- DN – Referring provider
- DK – Ordering provider
- DQ – Supervising provider

Providers should enter the qualifier to the left of the dotted vertical line on item 17.

Provider action needed

Stop – impact to you

This change request (CR) 8509 revises the current CMS-1500 claim form instructions to reflect the revised CMS-1500 claim form, version 02/12.

Caution – what you need to know

Form version 02/12 will replace the current CMS-1500 claim form, 08/05, effective with claims received on and after April 1, 2014:

- Medicare will begin accepting claims on the revised form, 02/12, on January 6, 2014;
- Medicare will continue to accept claims on the old form, 08/05, through March 31, 2014;
- On April 1, 2014, Medicare will accept paper claims on only the revised CMS-1500 claim form, 02/12; and
- On and after April 1, 2014, Medicare will no longer accept claims on the old CMS-1500 claim form, 08/05.

Go – what you need to do

Make sure that your billing staff are aware of these instructions for the revised form version 02/12.

Background

The National Uniform Claim Committee (NUCC) recently revised the CMS-1500 claim form. On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised form, 02/12. The revised form has a number of changes. Those most notable for Medicare are new indicators to differentiate between ICD-9 and ICD-10 codes on a claim, and qualifiers to identify whether certain providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. In addition, the revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

The qualifiers that are appropriate for identifying an ordering, referring, or supervising role are as follows:

The Administrative Simplification Compliance Act (ASCA) requires Medicare claims to be sent electronically unless certain exceptions are met. Those providers meeting these exceptions are permitted to submit their claims to Medicare on paper. Medicare requires that the paper format for professional and supplier paper claims be the CMS-1500 claim form. Medicare therefore supports the implementation of the CMS-1500 claim form and its revisions for use by its professional providers and suppliers meeting an ASCA

exception. More information about ASCA exceptions can be found in Chapter 24 of the *Medicare Claims Processing Manual* which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf>.

Additional information

The official instruction, CR 8509 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2842CP.pdf>. CR 8509 contains the instructions for completing the revised CMS-1500 claim form (02/12), which will become part of Chapter 26 in the *Medicare Claims Processing Manual* (Pub. 100-04).

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

MLN Matters[®] Number: MM8509
 Related Change Request (CR) #: CR 8509
 Related CR Release Date: December 27, 2013
 Effective Date: January 6, 2014
 Related CR Transmittal #: R2842CP
 Implementation Date: January 6, 2014

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Medicare system project for electronic submission of medical documentation

Provider types affected

This special edition (SE) *MLN Matters*[®] article is intended for all Medicare fee-for-service (FFS) providers and suppliers who submit medical documentation to Medicare review contractors.

Provider action needed

This article is based on the utilization of the electronic submission of medical documentation (esMD) via Medicare's esMD gateway to respond to review contractor's requests for medical documentation.

Background

The Centers for Medicare & Medicaid Services (CMS) uses several types of review contractors to measure, prevent, identify, and correct improper payments or identify potential fraud.

Review contractors find improper payments and potential fraud by reviewing a sample of claims. They request medical documentation from the provider or supplier and manually review the claims against the medical documentation to verify the providers' compliance with Medicare's rules.

As of September 2011, providers are able to respond to these requests for medical documentation electronically using the esMD via Medicare's esMD gateway. Since September 2011, CMS enhanced the esMD gateway to support several new use cases, for example:

- In September 2012, CMS implemented a prior authorization (PA) process via the esMD gateway for power mobility devices (PMD) for FFS Medicare beneficiaries who reside in seven states with high populations of error prone providers (CA, IL, MI, NY, NC, FL and TX).
- In January 2013, CMS expanded the CMS esMD gateway to allow durable medical equipment (DME) suppliers and providers to send electronic PA requests to Medicare review contractors.
- In June 2013, CMS enabled automated prior authorization review results responses from Medicare review contractors to health information handlers (HIHs) via the esMD gateway.

Medicare's esMD system provides an alternative mechanism for submitting medical documentation, PMD PA requests, and PMD result code responses to review contractors. A list of review contractors that will accept esMD transactions, as well as receive PMD PA requests and send PMD PA review results can be found at <http://go.cms.gov/RevCon>.

The primary intent of esMD is to reduce provider costs and cycle time by minimizing paper processing and mailing of medical documentation to review contractors.

The number of participants in the CMS esMD program has grown steadily since its inception.

As of September 30, 2013:

- 449,460 unique medical record transactions have been submitted;
- 30,199 Medicare providers are using esMD to respond to medical record requests;
- 55 Medicare providers use esMD to submit prior authorization requests;
- 24 HIHs are certified by CMS to offer esMD services;
- 27 Review contractors are approved by CMS to accept medical records via esMD



Medicare providers, including physicians, hospitals, and suppliers must obtain access to a CONNECT-compatible gateway in order to send medical documentation electronically to review contractors.

For example:

- Larger providers, such as hospital chains, may choose to build their own gateway;
- Many providers may choose to obtain gateway services by entering into a contract or other arrangement with a HIH that offers esMD gateway services.

HIHs contract with providers to supply them with esMD services much the same way that providers contract with claims clearinghouses to supply them with claims submission services.

A listing of the HIHs that have been approved by CMS to offer esMD services can be found at <http://go.cms.gov/esmd-HIH>.

HIH's set the price of their esMD provider services. Providers are encouraged to contact one or more of the HIHs to determine what esMD services are available.

(continued on next page)

esMD *(continued)*

While esMD is not mandatory, many healthcare providers find that it reduces costs, increases efficiency, and shortens processing times for certain transactions. CMS has instructed review contractors to not target providers for medical review based on their use of esMD.

The esMD system accepts portable document format (PDF) files, which enables providers to use esMD services as long as they have the proper scanning mechanism. Some HIHs may offer scanning services in addition to their esMD services.

Additional information

If you have any questions, please contact the review contractor to whom you wish to send esMD transactions. The review contractor toll-free numbers can be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.

For more information, visit the esMD Web page at <http://www.cms.gov/esmd> or follow esMD on Twitter@CMSSGov (#CMS_esMD).

For more information on the Medicare recovery audit program, see the *MLN Matters*[®] article SE1024 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1024.pdf>.

Contact information for your Recovery Auditor is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/RAC-Contact-Information-AbbrState-Apr2013.pdf>.

MLN Matters[®] Number: SE1343
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Reassigning benefits to a Part A provider

Any individual who wants to reassign his/her benefits to an eligible entity, or terminates an existing reassignment, must complete the form CMS-855R. If the individual is not enrolled in Medicare, they will also need to enroll via the form CMS-855I.

If the individual wants to reassign benefits to a Part A provider, the entity receiving the reassigned benefits must enroll with the contractor utilizing the form CMS-855B, and the physician reassigning benefits must complete and submit form CMS-855R and form CMS-855I if not previously enrolled.

For additional information, refer the change request *(CR)* 7864 or the related *MLN Matters*[®] article *MM7864*.

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.

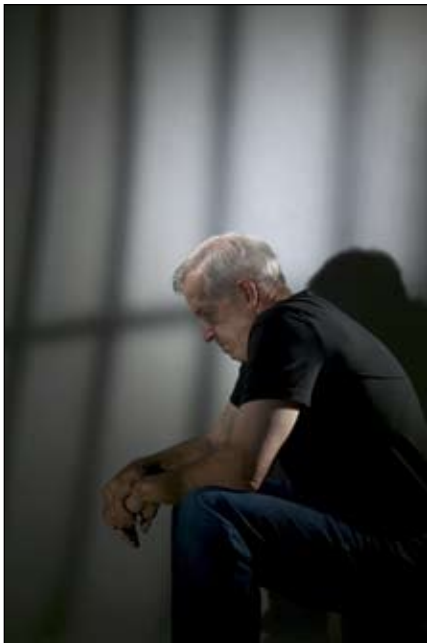
CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at <http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html>.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

Revised liability and denial messages for services furnished to incarcerated beneficiaries

Note: This article was revised January 15, 2014, to reflect the revised change request (CR) 8488 issued December 27, 2013. In the article, the effective and implementation dates are changed and the CARC and RARC descriptions are changed to reflect the revised CR 8488 descriptions. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. This information was previously published in the December 2013 *Medicare B Connection*, Pages 25-26.

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administration contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs) for services provided to Medicare beneficiaries while they are in federal, state, or local custody.



Provider action needed

This article is based on CR 8488 which instructs Medicare claims administration contractors to use an updated claim adjustment reason code (CARC), remittance advice remark code (RARC), and group code when denying claims for services furnished to incarcerated Medicare beneficiaries. See the *Background* and *Additional information* sections of this article for further details regarding these changes. Make sure that your billing staffs are aware of these changes.

Background

According to Federal regulations at 42 CFR 411.4, Medicare does not pay for services furnished to a

beneficiary who has no legal obligation to pay for the service, and no other person or organization has a legal obligation to provide or pay for the service. Refer to the *Electronic Code of Federal Regulations (e-CFR)* at <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=1270613eb7cae1ed8c62899034b0eca2&rgn=div8&view=text&node=42:2.0.1.2.11.1.35.3&idno=42>. This exclusion presumptively applies to individuals who are incarcerated.

Under 42 CFR 411.6, Medicare does not pay for services furnished by a federal provider of services or by a federal agency. Also, under 42 CFR 411.8, Medicare does not pay for services that are paid for directly or indirectly by a governmental entity.

As such, when claims for services furnished to beneficiaries who are incarcerated are submitted to Medicare, the claims are rejected by the common working file (CWF) and denied by the claims processing contractors. Per previously issued instructions (most recently, CR 7678, Transmittal 1054, issued March 7, 2012; see related *MLN Matters*® article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7678.pdf>), MACs use the following remittance advice messages and group code when denying such claims:

- **CARC: 96** – “Non-covered charges.”
- **RARC: N103** – “Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.”
- **Group code: PR** – patient responsibility

CR 8488 revises the remittance advice messages and group code used for denials of claims for services furnished to incarcerated beneficiaries.

MACs will begin using the following new CARC code when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody:

- **CARC: 258** – Claim/service is not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover this claim/service.

In addition, MACs will begin using the following revised RARC N103 language when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody:

(continued on next page)

Incarcerated *(continued)*

- **RARC: N103** – “Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/Local authority as appropriate.”

MACs will begin using the following group code to assign proper liability when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody so that the provider or supplier should seek repayment for the cost of its services provided from the authority that was in custody of the beneficiary on the date of service:

- **Group code:** OA – other adjustment

Other than the above, MACs will continue to use existing remittance advice codes and messages and MSN language already in place when denying claims for services furnished to beneficiaries while they are in

federal, state, or local custody.

Additional information

The official instruction, CR 8488 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1330OTN.pdf>.

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

MLN Matters® Number: MM8488 *Revised*
Related Change Request (CR) #: CR 8488
Related CR Release Date: December 27, 2013
Effective Date: April 1, 2014
Related CR Transmittal #: R1330OTN
Implementation Date: April 7, 2014

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Changes to payment dispute process between non-contracted providers, MAOs, and other payers after January 31, 2014

Currently, the Centers for Medicare & Medicaid Services (CMS) provides the services of an independent contractor, C2C Solutions, Inc., to adjudicate payment disputes between non-contracted providers, Medicare Advantage organizations (MAOs), and other payers. After January 31, 2014, CMS will no longer be able to offer these services due to budgetary constraints. However, C2C will continue to adjudicate all payment disputes received by January 31, 2014, which meet the filing requirements. After January 31, 2014, C2C will return any payment disputes to providers with instructions to contact the MAO or other payer directly to dispute the payment.

Provider types affected

This information applies to all non-contracted provider types that perform services for beneficiaries enrolled in MAOs, including private fee-for-service plans, program of all-inclusive care for the elderly (PACE) organizations, Section 1876 cost-based contractors, and health care prepayment plans.

Provider action needed

Providers and billing staff should not send any requests for a payment dispute to C2C after January 31, 2014. C2C will return all payment disputes requests received after that date to the provider with instructions to contact the plan to resolve the dispute or take other action the provider deems appropriate. Providers that have exhausted the plan's internal dispute process and who still maintain they have not been reimbursed fairly may file a complaint through 1-800-Medicare in addition to taking other action the provider deems appropriate. CMS does not offer advice to providers on their potential rights in a payment dispute. CMS is committed to ensuring that MAOs and other payers follow regulations at 42 CFR §§422.214, 417.559 and 422.520 when reimbursing non-contracted providers for services provided to Medicare beneficiaries. Non-contracted providers are required to accept as payment, in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

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

Source: CMS PERL 201312-05

Prompt payment interest rate revision

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

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

The new rate of 2.125 percent is in effect through June 30, 2014.

Interest is not paid on:

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

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

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

Additional reporting requirements concerning physician ownership and investment in hospitals

Note: This article was updated January 16, 2014, to reflect current requirements and dates. This information was previously published in the September 2013 *Medicare B Connection*, Pages 35-36.

Provider types affected

This *MLN Matters*[®] special edition article is an update of *MLN Matters*[®] number SE1332, originally published September 13, 2013. It is intended for hospitals that have physician ownership or investment interests, and seek to avail themselves of the whole hospital or rural provider exceptions to the physician self-referral law. In this article, we refer to hospitals with physician owners or investors as “physician-owned hospitals.”

What you need to know

Under Section 1877 of the Social Security Act (the Act), also known as the physician self-referral law, unless an exception applies and is satisfied, 1) a physician may not refer a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, and (2) the entity may not present or cause to be presented a claim to Medicare (or bill another individual, entity, or third party payor) for those referred services.

The Centers for Medicare & Medicaid Services (CMS) issues this article to address the additional reporting requirements imposed by Section 6001 of the Affordable Care Act on physician-owned hospitals seeking to avail themselves of the whole hospital or rural provider exceptions to the physician self-referral law. The instructions in this article related to the reporting by the March 1, 2014 deadline supersede those set forth in the “Supporting Statement for Paperwork Reduction Act Submissions: Annual Report of Physician-Owned Hospital Ownership and/or Investment Interest.” This *MLN*[®] article does not address other additional requirements imposed by Section 6001 of the Affordable Care Act.



(continued on next page)

Hospitals *(continued)*

Background

Two exceptions to the physician self-referral law for ownership or investment interests are the whole hospital and rural provider exceptions. Section 1877(i)(1)(C)(i) of the Act requires physician-owned hospitals to submit to CMS an annual report containing ownership and investment information to qualify for either exception. This reporting requirement is implemented in the physician self-referral regulations at 42 CFR 411.362(b)(3)(i). (This regulation is available at <http://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=CFR-2011-title42-vol2-sec411-362&packageId=CFR-2011-title42-vol2>.)

Physician-owned hospitals that report ownership and investment information by following the instructions set forth in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) or the Medicare Enrollment Application Form CMS-855A (CMS-855A), Attachment 1, for reporting physician-owned hospital ownership and investment information satisfy the above reporting requirement. As further detailed in the instructions, physician-owned hospitals must complete and submit the required information via PECOS at <https://pecos.cms.hhs.gov/pecos/login.do>, or the manual paper process, CMS-855A, Attachment 1. Manual submissions should be forwarded to the hospital's designated Medicare fee for service contractor. Please note that this reporting requirement is not mandatory for Medicare enrollment and does not ensure Medicare enrollment.

Physician-owned hospitals seeking to avail themselves of the whole hospital or rural provider exceptions must report ownership and investment information following the above process by March 1, 2014. Physician-owned hospitals that submitted this information on or after December 1, 2012, consistent with the above process will be considered to have met the March 1, 2014, deadline. Hospitals must submit this information on an annual basis to continue to meet the reporting requirement.

We remind hospitals that information submitted under this process may be published on the CMS website pursuant to Section 1877(i)(2) of the Act. If a hospital reports ownership or investment information under this process but is not seeking to use the whole hospital or rural provider exceptions, the hospital may request that CMS either not publish or remove its information from the website by emailing POHExceptions@cms.hhs.gov.

Additional information

For more information about provisions affecting physician-owned hospitals under the physician self-referral law, visit the Physician Self-Referral Physician-Owned Hospitals Web page at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals.html.

For more information about Medicare enrollment, visit the Medicare Provider-Supplier Enrollment Web page at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>.

MLN Matters® Number: SE1332 *Revised*

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

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CMS updates EFT authorization agreement: CMS 588

The Office of Management and Budget recently approved changes to the [CMS 588](#), Electronic Funds Transfer (EFT) Authorization Agreement. The revised CMS 588 is available on the [CMS Forms List](#).

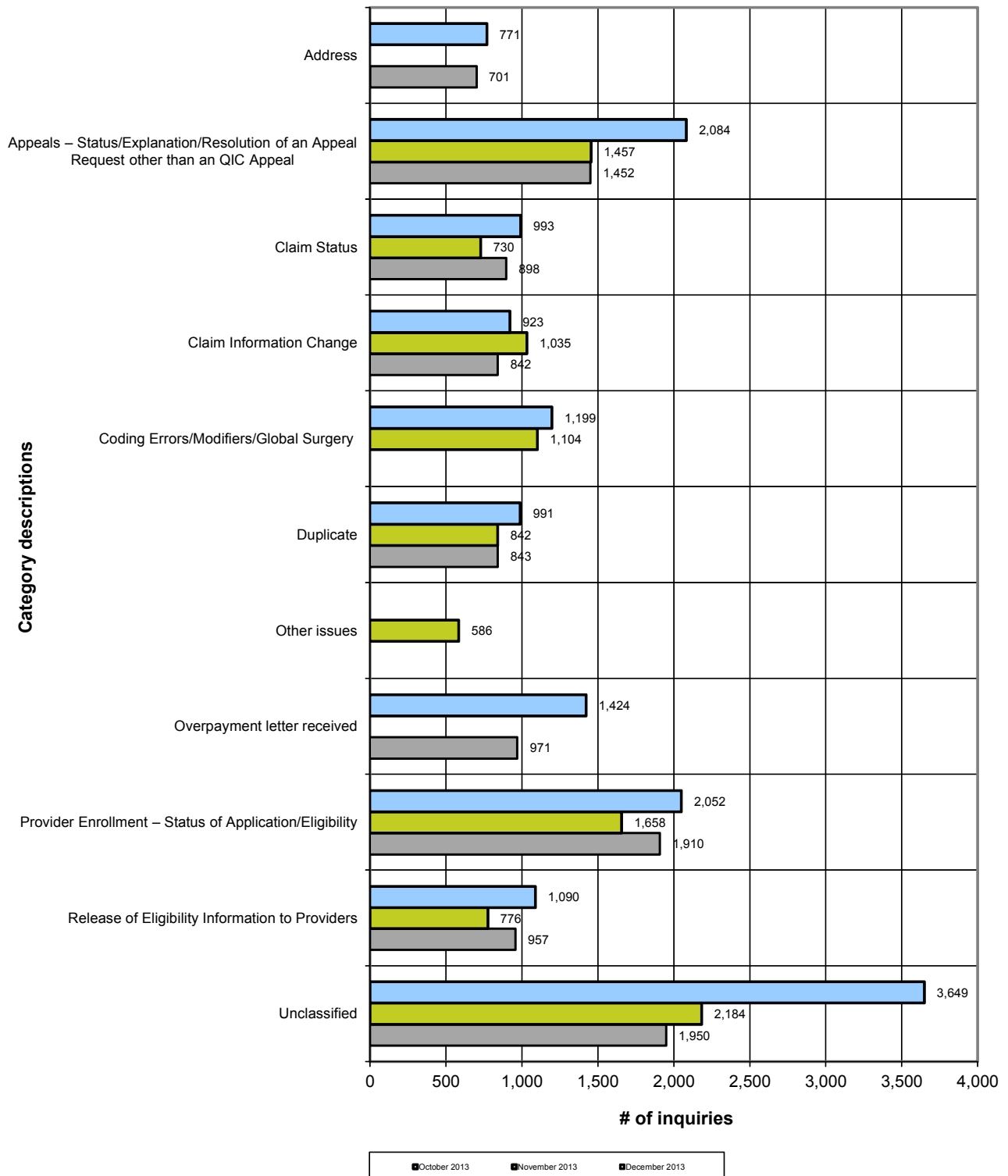
Medicare administrative contractors (MACs) will continue to accept the 05/10 version of the CMS 588 through October 31, 2014. After October 31, 2014, the MACs will return any newly submitted 05/10 versions of the CMS 588 applications with a letter explaining the CMS 588 application has been updated and the provider/supplier must submit a current version (09/13) of the CMS 588 application.

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 October-December 2013.

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

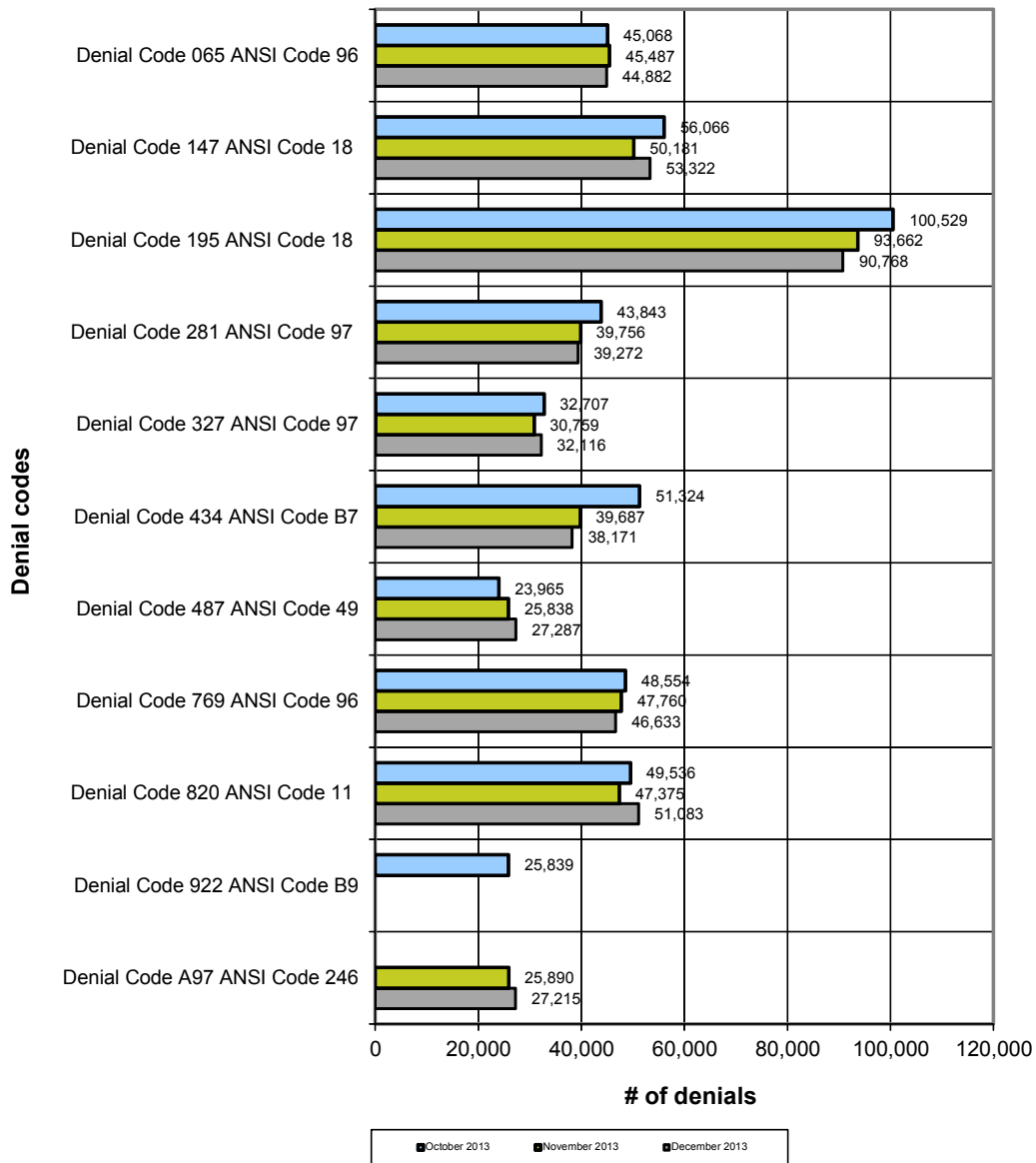
Part B top inquiries for October-December 2013



(continued on next page)

Top (continued)

Part B top denials for October-December 2013



What to do when your claim is denied

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

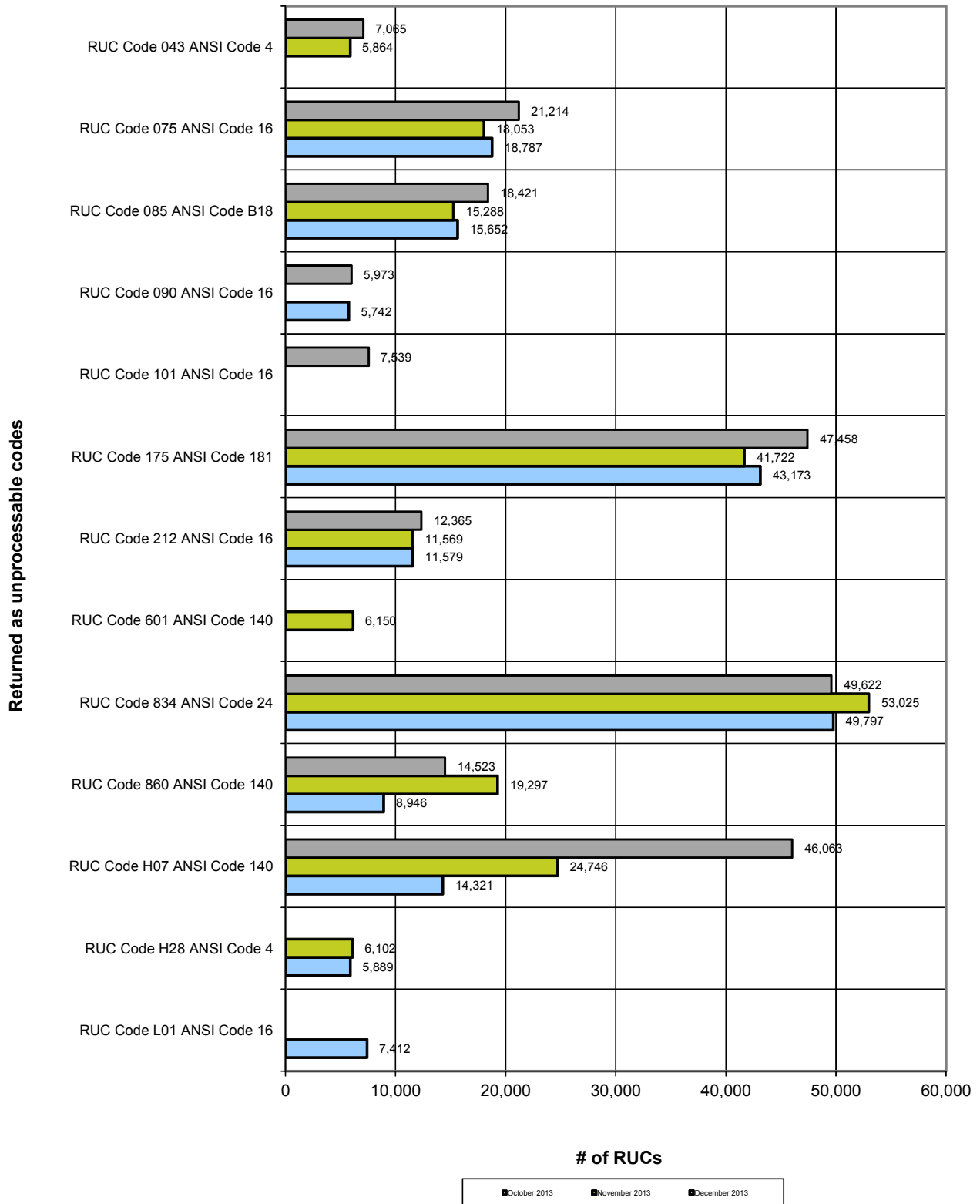
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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

You may also refer to the [Top Part B claim denials](#) and [RUCs](#) tip sheets for tips and resources on correcting and avoiding certain claim denials.

Top (continued)

Part B top return as unprocessable claims for October-December 2013



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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

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Advance beneficiary notice

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

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

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

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

Looking for LCDs?

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

Find out first: Subscribe to First Coast eNews

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. 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.*

Additional Information

2014 HCPCS local coverage determination changes

LCD Title	Changes
Allergy Testing	<p>Deleted <i>Current Procedural Terminology (CPT®)</i> code 88342</p> <p>Added HCPCS codes G0461 and G0462</p> <p>Removed asterisk (*) from <i>CPT®</i> code 86628 that indicated this services is also listed in the Noncovered Services LCD (Not related to 2014 HCPCS update)</p>
Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications	<p>Deleted HCPCS code Q2051</p> <p>Added HCPCS code J3489</p>
Botulinum Toxins (Coding Guidelines only)	<p>Deleted <i>CPT®</i> codes 64613 and 64614</p> <p>Added <i>CPT®</i> codes 64616, 64617, 64642, 64643, 64644, 64645, 64646, and 64647</p> <p>Descriptor change for <i>CPT®</i> codes 43201 and 43236</p>
Cardiovascular Nuclear Imaging Studies	<p>Deleted HCPCS code J0152</p> <p>Added HCPCS code J0151</p>
Diagnostic and Therapeutic Esophagogastroduodenoscopy	<p>Deleted <i>CPT®</i> code 43258</p> <p>Added <i>CPT®</i> codes 43233, 43253, 43254, 43266, and 43270</p> <p>Descriptor change for <i>CPT®</i> codes 43235-43239, 43241, 43243-43251, and 43255</p>
Dialysis (AV fistula and graft) Vascular Access Maintenance	<p>Deleted <i>CPT®</i> codes 37205, 37206, 37207, and 75960</p> <p>Added <i>CPT®</i> codes 37236, 37237, 37238, and 37239</p>
G-CSF (Filgrastim, Neupogen®)	<p>Deleted HCPCS codes J1440 and J1441</p> <p>Added HCPCS codes J1442 and J1446</p> <p>Changed "LCD Title" from "G-CSF (Filgrastim, Neupogen®)" to "G-CSF (Neupogen®, Granix™)"</p>
Hemophilia Clotting Factors	Added HCPCS code C9133
Independent Diagnostic Testing Facility (IDTF) (Coding Guidelines only)	Deleted <i>CPT®</i> codes 77031 and 77032
Interferon	<p>Deleted HCPCS code Q3025</p> <p>Added HCPCS code Q3027</p>
Intensity Modulated Radiation Therapy (IMRT)	<p>Added <i>CPT®</i> code 77293</p> <p>Descriptor change for <i>CPT®</i> code 77295</p>
Intravenous Immune Globulin	<p>Deleted HCPCS code C9130</p> <p>Added HCPCS code J1556</p>
Mohs Micrographic Surgery (MMS) (Coding Guidelines only)	<p>Deleted <i>CPT®</i> code 88342</p> <p>Added HCPCS codes G0461 and G0462</p>
Molecular Pathology Procedures	Added <i>CPT®</i> code 81287
Molecular Pathology Procedures for Human Leukocyte Antigen (HLA) Typing	Descriptor change for <i>CPT®</i> codes 81371, 81376, and 81382

(continued on next page)

LCD Title	Changes
Noncovered Procedures – Endoscopic Treatment of Gastroesophageal Reflux Disease (GERD)	Descriptor change for CPT® codes 43201, 43236, 43241, and 43257
Noncovered Services	Deleted CPT® codes 0124T (changed to CPT® code 68399), 0183T (replaced with CPT® code 97610), 0185T (changed to CPT® code 99199), and 0186T (changed to CPT® code 67299) Descriptor change for CPT® codes 43206 and 43252
Plerixafor (Mozobil®)	Deleted HCPCS codes J1440 and J1441 Added HCPCS codes J1442 and J1446
Renal Angiography	Deleted HCPCS code G0275
Sacral Neuromodulation (Coding Guidelines only)	Added HCPCS code L8679
Skin Substitutes	Added HCPCS codes Q4137, Q4138, Q4139, Q4140, Q4141, Q4142, Q4143, Q4145, Q4146, Q4147, Q4148, and Q4149 to “The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products” section of the LCD Added HCPCS codes C5271, C5272, C5273, C5274, C5275, C5276, C5277, and C5278 to the LCD “Coding Guidelines” attachment. The following change is not related to the 2014 HCPCS update. Based on CR 8575 the following verbiage was added to the LCD “Coding Guidelines” attachment <i>“Beginning January 1, 2014 ASCs should not separately bill for packaged skin substitutes.”</i>
Therapy and Rehabilitation Services	Deleted CPT® code 92506 Added CPT® codes 92521, 92522, 92523, and 92524

Medicare Learning Network®

The Medicare Learning Network® (MLN) is the home for education, information, and resources for the health care professional community. The MLN provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the MLN has to offer you and your staff at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>.



Educational Events

Upcoming provider outreach and educational events February 2014

EDI presents an overview of PC-ACE Pro32™, Medicare’s free billing software

When: Monday, February 17 **Type of event:** Face-to-face
Time: 9:00 a.m.-11:00 a.m.

Medicare Speaks 2014 Orlando

When: Tuesday-Wednesday, February 18-19 **Type of event:** Face-to-face
Time: 7:30 a.m.-4:15 p.m.

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

Two easy ways to register

Online – Visit our provider training website at www.fcsouniversity.com, log on to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event.

First-time User? Set up an account by completing [Request User Account Form](#) online. Providers who do not have yet a national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant’s Name: _____

Registrant’s Title: _____

Provider’s Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, medicare.fcsou.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.



CMS MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) MLN Connects™ Provider eNews is an official Medicare Learning Network® (MLN) – branded product that contains a week’s worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the 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”: January 9, 2014 – <https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-09enews.pdf>

“MLN Connects™ Provider eNews”: January 16, 2014 – <https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-16-enews.pdf>

Source: PERL 201401-01, 201401-02

MLN Connects™ Provider e-News special edition – Monday, December 30

This special edition of the MLN Connects™ Provider e-News includes the following information:

Announcements

- Verifying patient coverage in a health insurance marketplace plan

MLN Connects™ national provider calls

- National Partnership to Improve Dementia Care in Nursing Homes – register now
- Two-midnight benchmark for inpatient hospital admissions – recording available
- End-stage renal disease quality incentive program payment year 2016 final rule – recording available
- 2012 quality and resource use reports overview and December addendum – CE credit available – recording available

Announcements

Verifying patient coverage in a health insurance marketplace plan

It is the beginning of the New Year and you’ll be verifying your patient’s insurance status when they show up in your office. With the beginning of the health insurance marketplace, also known as Health Insurance Exchange, over a million people will have a new insurance plan. In many cases, this will be the first time they have had insurance in years. Many of these people will have signed up for their plan within the past few days. They may not have received their card yet or they may be unaware of the need to carry their insurance information. You may find your office needing to verify their coverage.

How do you verify their coverage?

If the marketplace in your state is run by the federal government, it is best to call their plan’s customer service line, a list of all plans and their customer service numbers can be found in this [data base](#). Here’s a [fact sheet](#) for using the data base. If you can’t find the number, call the Marketplace call center (1-800-318-2596).

If your state has its own health insurance exchange, contact your state. To find the website for your state exchange, select the name of your state in the box at the left hand side of the [healthcare.gov website](#).

How else can you help your patient?

Remind your patients to keep all of their paperwork and receipts from all of their doctor’s appointments and from the pharmacy as well. They may need them for their insurer. Remind them they should carry their card at all

(continued on next page)

Special *(continued)*

times. If they don't have a card, they can contact their plan to get a card.

If the patient is uninsured, they have until March 31 to sign up for non-employer based coverage. They can go to HealthCare.gov to sign up for a plan and apply for financial assistance. The vast majority of uninsured will qualify for financial assistance to reduce their costs. You can also download copies of [fact sheets](#) or educational material for your patients.

MLN Connects™ national provider calls**National Partnership to Improve Dementia Care in Nursing Homes – register now**

Wednesday, February 26; 2-3:30 pm ET

To register: Visit [MLN Connects™ Upcoming Calls](#) . Space may be limited, register early.

The CMS National Partnership to Improve Dementia Care in Nursing homes was developed to improve dementia care through the use of individualized, comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications in nursing homes and eventually other care settings as well.

During this *MLN Connects™* call, a CMS subject matter expert will discuss the critical role of both state and federal surveyors in the implementation of the partnership. Additional speakers will be presenting on the importance of leadership, as well as the strong correlation that exists between proper pain assessment and antipsychotic medication use. A question and answer session will follow the presentation.

Agenda

- Role of surveyors
- Importance of leadership
- Proper pain assessment

The following national provider calls, which have already occurred, were referenced in the special edition:

January 14, 2014 – Two-midnight benchmark for inpatient hospital admissions

January 15, 2014 – End-stage renal disease quality incentive program payment year 2016 final rule

January 16, 2014 – 2012 quality and resource use reports overview and December addendum

Recordings of these calls may be reviewed at <http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html>.

Source: CMS PERL 201312-07

Online Medicare refreshers

The *Medicare Learning Network®* (MLN) Products Web-Based Training (WBT) courses are designed for self-paced training via the Internet.

These WBT courses provide information on a broad range of Medicare topics for health care professionals and their staff. Many of these courses offer continuing education credits.

Click here to explore the wide array of training opportunities.

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/prevaling 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/prevaling 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 Government Benefit
Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare

Palmetto Government 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 2013 through September 2014.	40300260	\$33		
2014 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2014, 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: Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. 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 []				
<i>Please write legibly</i>			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)