

C Medicare B CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

August 2014



Deadline for ICD-10 allows health care industry ample time to prepare for change

Deadline set for October 1, 2015

On July 31, the Department of Health & Human Services *issued a rule* finalizing October 1, 2015, as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10. This deadline allows providers, insurance companies, and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on October 1, 2015.

The ICD-10 codes on a claim are used to classify diagnoses and procedures on claims submitted to Medicare and private insurance payers. By enabling more detailed patient history coding, ICD-10 can help to better coordinate a patient's care across providers and over time. ICD-10 improves quality measurement and reporting, facilitates the detection and prevention of fraud, waste, and abuse, and leads to greater accuracy of reimbursement for medical services. The code set's granularity will improve data capture and analytics of public health surveillance and reporting, national quality reporting, research and data analysis, and provide detailed data to enhance health care delivery. Health care providers and specialty groups in the United States provided extensive input into the

development of ICD-10, which includes more detailed codes for the conditions they treat and reflects advances in medicine and medical technology.

"ICD-10 codes will provide better support for patient care, and improve disease management, quality measurement, and analytics," said Marilyn Tavenner, Administrator of CMS. "For patients under the care of multiple providers, ICD-10 can help promote care coordination."

Using ICD-10, doctors can capture much more information, meaning they can better understand important details about the patient's health than with ICD-9-CM. Moreover, the level of detail that is provided for by ICD-10 means researchers and public health officials can better track diseases and health outcomes. ICD-10 reflects improved diagnosis of chronic illness and identifies underlying causes, complications of disease, and conditions that contribute to the complexity of a disease. Additionally, ICD-10 captures the severity and stage of diseases such as chronic kidney disease, diabetes, and asthma.

The previous revision, ICD-9-CM, contains outdated, obsolete terms that are inconsistent with current medical

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

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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.

Medicare Part B 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 Address, Phone Numbers, and Websites section of this publication for the address in which to send written appeals requests.

Clarification of the 'confined to the home' definition

Provider types affected

This *MLN Matters*[®] article is intended for physicians, home health agencies, and other providers that submit claims to Medicare administrative contractors (MACs) related to certifying or providing home health services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 8818 which clarifies the definition of the patient as being “confined to the home” to more accurately reflect the definition as articulated in the Social Security Act (Sections 1814(a) and 1835(a)).

Caution – what you need to know

In addition to clarifying the definition of the patient as being “confined to the home,” vague terms, such as “generally speaking”, have been removed from Medicare’s manual instructions to ensure clearer and more specific requirements of the definition. These changes present the requirements first and more closely align the *Medicare Benefit Policy Manual* with the Social Security Act. This will help prevent confusion, promote a clearer enforcement of the statute, and provide more definitive guidance to home health agencies (HHAs) in order to foster compliance.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding these changes, and make sure that your billing staffs are aware of these changes.

Background

In the 2012 home health prospective payment system (HH PPS) proposed rule published on July 12, 2011, the Centers for Medicare & Medicaid Services (CMS) proposed its intent to provide clarification to the *Medicare Benefit Policy Manual* language regarding the definition of “confined to the home”. In the 2012 HH PPS final rule published on November 4, 2011 (FR 76 68599-68600; see <http://www.gpo.gov/fdsys/pkg/FR-2011-11-04/pdf/2011-28416.pdf>), this proposal was finalized. This clarification was recommended by the Office of Inspector General (OIG).

CR 8818 revises the *Medicare Benefit Policy Manual* (Pub 100-02), Chapter 15 (Covered Medical and Other Health Services), Section 60.4.1 (Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit), and it includes revised Section 60.4.1 as an attachment. The revised Section 60.4.1 is summarized as follows:

For a patient to be eligible to receive covered home health services, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:



1. Criteria-one:

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.

If the patient meets one of the criteria-one conditions, then the patient must ALSO meet two additional requirements defined in criteria-two below.

2. Criteria-two:

There must exist a normal inability to leave home; **and**

Leaving home must require a considerable and taxing effort.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in a state, shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively

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DEFINITION

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short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of this reimbursement unless they meet one of the above conditions above.

The complete portion on the revised manual is attached to CR 8818.

Additional information

The official instruction, CR 8818 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R192BP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare->



[Learning-Net work-MLN/MLNMattersArticles/index.html](http://Learning-Net-work-MLN/MLNMattersArticles/index.html) under - How Does It Work.

MLN Matters® Number: MM8818
 Related Change Request (CR) #: CR 8818
 Related CR Release Date: August 1, 2014
 Effective Date: September 2, 2014
 Related CR Transmittal #: R192BP
 Implementation Date: September 2, 2014

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Try our E/M interactive worksheet

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



Ambulatory Surgical Center

October 2014 update of the ASC payment system

Provider types affected

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

Provider action needed

Change request (CR) 8880 describes changes to and billing instructions for various payment policies implemented in the October 2014 ASC payment system update. CR 8880 also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staffs are aware of these changes.

Key points of CR 8880

New services

There are no new services assigned for separate payment under the ambulatory surgical center (ASC) payment system, effective October 1, 2014.

Billing for drugs, biologicals, and radiopharmaceuticals

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

Payments for separately payable drugs and biologicals based on ASPs are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, the Centers for Medicare & Medicaid Services (CMS) will incorporate changes to the payment rates in the October 2014 release of the ASC drug file. The updated payment rates, effective October 1, 2014, will be included in the October 2014 update of the ASC addendum BB, which will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Up_dates.html.

New HCPCS codes for drugs and biologicals separately payable under the ASC payment system, effective October 1, 2014

Four drugs and biologicals have been granted ASC payment status effective October 01, 2014. These items, along with their descriptors and ASC payment indicators (PIs) are as follows:

Code	Short descriptor	Long descriptor	ASC PI
C9023	Inj testosterone undecanoate	Injection, testosterone undecanoate, 1 mg	K2



Code	Short descriptor	Long descriptor	ASC PI
C9025	Injection, ramucirumab	Injection, ramucirumab, 5 mg	K2
C9026	Injection, vedolizumab	Injection, vedolizumab, 1 mg	K2
C9135	Factor ix (Alprolix)	Factor ix (antihemophilic factor, recombinant), Alprolix, per 10 i.u.	K2

Note: These HCPCS codes are new codes effective October 1, 2014.

Revised ASC payment indicator for HCPCS codes J9160 and J9300

Effective October 1, 2014, the payment indicator for HCPCS codes J9160 (Injection, denileukin diftiox, 300 micrograms) and J9300 (Injection, gemtuzumab ozogamicin, 5 mg) will change from K2 to Y5 because the product associated with HCPCS code J9160 is no longer marketed. Effective October 1, 2014, the payment indicator for HCPCS code J9300 (Injection, gemtuzumab ozogamicin, 5 mg) will change from K2 to Y5 because the product associated with HCPCS code J9300 is no longer marketed.

Updated payment rate for HCPCS code J9171, effective January 1 through March 31, 2014

The payment rate for one HCPCS code was incorrect in the January 2014 ASC drug file. The corrected payment rate is listed in the following table, and has been installed in the revised January 2014 ASC drug file, effective for services furnished on January 1 through March 31, 2014. Suppliers who think they may have received an incorrect payment for dates of service January 1 through March 31, 2014, may request their MAC to adjust the previously processed claims.

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ASC

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Code	Short descriptor	Corrected payment rate	ASC PI
J9171	Docetaxel injection	4.63	K2

Updated payment rates for certain HCPCS codes, effective April 1 through June 30, 2014

The payment rate for three HCPCS codes was incorrect in the April 2014 ASC drug file. The corrected payment rate is listed in the following table, and has been installed in the revised April 2014 ASC drug file, effective for services furnished on April 1 through June 30, 2014. Suppliers who think they may have received an incorrect payment for dates of service April 1 through June 30, 2014, may request their MAC to adjust the previously processed claims.

Code	Short descriptor	Corrected payment rate	ASC PI
J7335	Capsaicin 8% patch	25.49	K2
J8700	Temozolomide	6.94	K2
J9171	Docetaxel injection	4.35	K2

Updated payment rates for certain HCPCS codes, effective July 1 through September 30, 2014

The payment rate for two HCPCS codes was incorrect in the July 2014 ASC drug file. The corrected payment rates are listed in the following table, and have been installed in the revised July 2014 ASC drug file, effective for services furnished on July 1 through September 30, 2014. Suppliers who think they may have received an incorrect payment

for dates of service July 1 through September 30, 2014, may request their MAC to adjust the previously processed claims.

Code	Short descriptor	Corrected payment rate	ASC PI
J9047	Injection, carfilzomib, 1 mg	29.67	K2
J9315	Romidepsin injection	270.24	K2

Additional information

The official instruction, CR 8880, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3025CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under – How Does It Work.

MLN Matters® Number: MM8880
 Related Change Request (CR) #: CR 8880
 Related CR Release Date: August 15, 2014
 Effective Date: October 1, 2014
 Related CR Transmittal #: R3025
 Implementation Date: October 6, 2014

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Learn more at <https://medicare.fcso.com/Landing/139820.asp>.

Cardiac Services

Cardiac rehabilitation programs for chronic heart failure

Provider types affected

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

What you need to know

Stop – impact to you

Effective for dates of service on and after February 18, 2014, Medicare covers cardiac rehabilitation services for beneficiaries with stable, chronic heart failure.

Caution – what you need to know

This article, based on change request (CR) 8758, informs you that, effective for dates of service on and after February 18, 2014, Medicare covers cardiac rehabilitation services for beneficiaries with stable, chronic heart failure, defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least six weeks. Stable patients are defined as patients who have not had recent (≤6 weeks) or planned (≤6 months) major cardiovascular hospitalizations or procedures.

Go – what you need to do

Make sure your billing staffs are aware of these changes.

Background

On June 4, 2013, the Centers for Medicare & Medicaid Services (CMS) initiated a national coverage analysis (NCA) to expand Medicare coverage of cardiac rehabilitation for beneficiaries diagnosed with chronic heart failure.

Items and services furnished under a cardiac rehabilitation program may be covered under Medicare Part B per Section 1861(s)(2)(CC) and 1861(eee)(1) of the Social Security Act. Among other things, Medicare regulations define key terms, address the components of a cardiac rehabilitation program, establish the standards for physician supervision, and limit the maximum number of program sessions that may be furnished. These regulations may be viewed at 42 *Code of Federal Regulations* (CFR), Section 410.49, available at <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A2.0.1.2.10>.

CR services mean a physician-supervised program that furnishes physician prescribed exercise, cardiac risk

factor modification, including education, counseling, and behavioral intervention; psychosocial assessment, outcomes assessment, and other items/services as determined by the Secretary under certain conditions.

The regulations describe the cardiac conditions that would enable a beneficiary to obtain cardiac rehabilitation services. Specifically, coverage is permitted for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months
- A coronary artery bypass surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- A heart or heart-lung transplant

Effective for dates of service on or after February 18, 2014,

this change request adds stable, chronic heart failure to the list of cardiac conditions above that would enable a beneficiary to obtain Cardiac Rehabilitation services.

CMS may add “other cardiac conditions as specified through a national coverage determination” (42 CFR Section 410.49(b)(vii)).

Any cardiac indication not specifically identified in 42 CFR 410.49(b)(1)(vii) or identified as covered in any national coverage determination (NCD)

is considered non-covered.

Also, note that MACs will not search for and adjust claims processed prior to the implementation of CR 8758. However, your MAC will adjust such claims that you bring to their attention.

Additional information

CR 8758 consists of four transmittals, each of which relates to a Medicare manual. The transmittal related to the *National Coverage Determination Manual* is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R171NCD.pdf>. The transmittal related to the *Medicare Claims Processing Manual* is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2989CP.pdf>, the transmittal related to the *Medicare Program Integrity Manual* is at



See **CARDIAC**, next page

Consolidated Billing

October 2014 HCPCS codes used for SNF consolidated billing enforcement

Provider types affected

This *MLN Matters*[®] article is intended for providers and suppliers submitting claims to Medicare contractors (Medicare administrative contractors (MACs), including durable medical equipment MACs, for services provided to Medicare beneficiaries during a skilled nursing facility (SNF) stay.

Provider action needed

Change request (CR) 8829 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF prospective payment system (PPS), effective January 1, 2014. Make sure your billing staffs are aware of these HCPCS code updates.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are excluded from the consolidated billing (CB) provision of the SNF PPS.

You should note that other providers (not just SNFs) may be paid for services that are excluded from SNF PPS and CB, even for those provided to beneficiaries in a SNF stay. However, Medicare will only pay claims from SNFs (no other providers) that are submitted to MACs (including DME MACS) for services that do not

Additionally, SNF CB applies to non-therapy services only when furnished to a SNF resident during a covered Part A stay; however, it applies to physical and occupational therapies, and speech-language pathology services

whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems edit for services provided to SNF beneficiaries, both included and excluded from SNF CB. appear on the exclusion lists.

The updated lists for institutional and professional billing are available at <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Index.htm>. The following table displays the HCPCS code updates that CR 8829 provides that are effective for dates of service on or after January 1, 2014.

Code	Description	Action
Q2050	Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10mg	Add to file 1 coding list and add to major category 3.A.
G0461	Immunohistochemistry or immunocytochemistry, per specimen; first single or multiplex antibody stain	Add to file 2 coding list
G0462	Immunohistochemistry or immunocytochemistry, per specimen; each additional single or multiplex antibody stain (list separately in addition to code for primary procedure)	Add to file 2 coding list

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<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R530PI.pdf>, and the transmittal related to the *Medicare Benefit Policy Manual* is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R191BP.pdf>.

You may also want to review *MLN Matters*[®] article MM6850, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm6850.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNMattersArticles/index.html>.

If you have any questions, please contact your MAC

at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNMattersArticles/index.html>.

MLN Matters[®] Number: MM8758
 Related Change Request (CR) #: CR 8758
 Related CR Release Date: July 18, 2014
 Effective Date: February 18, 2014
 Related CR Transmittal #: R171NCD, R2989CP, R530PI, and R191BP
 Implementation Date: August 18, 2014

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CONSOLIDATED

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Code	Description	Action
G0463	Hospital outpatient clinic visit for assessment and management of a patient	Exclude for outpatient bill types 13x and 85x billed with revenue code 0510
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	Terminate in major category V. A. effective 12/31/13

Note: If you bring claims to your MAC's attention, they will re-open and re-process claims (with dates of service on or after, January 1, 2014) that have previously been denied/rejected prior to the implementation of CR 8829.

Additional information

The official instruction, CR 8829 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2991CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html>.

Correction to SNF consolidated billing code lists

Certain Healthcare Common Procedure Coding System (HCPCS) codes were not included in the 2014 annual update to the skilled nursing facility (SNF) consolidated billing code editing lists. A correction to the coding lists will be implemented in October, 2014. The affected HCPCS codes for practitioner billing are Q2050 and the professional component of G0461 and G0462. The affected code for institutional provider billing is Q2050. If you have claims that have been erroneously denied, you should contact your Medicare administrative contractor to have the claims re-opened and re-processed.

MLN Matters® Number: MM8829
 Related Change Request (CR) #: CR 8829
 Related CR Release Date: July 18, 2014
 Effective Date: January 1, 2014
 Related CR Transmittal #: R2991CP
 Implementation Date: October 6, 2014

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Drugs and Biologicals

October 2014 ASP Medicare Part B drug pricing files and revisions to prior pricing files

Provider types affected

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

Provider action needed

Change request (CR) 8836 instructs MACs to download and implement the October 2014 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the July 2014, April 2014, January 2014, and October 2013, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 6, 2014, with dates of service October 1, 2014, through December 31, 2014. MACs will not search and adjust

claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The average sales price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are in Chapter 4, Section 50, of the *Medicare Claims Processing Manual* which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>. The following table shows how the quarterly payment files will be applied:

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ASP

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Files	Effective dates of service
October 2014 ASP and ASP NOC	October 1 through December 31, 2014
July 2014 ASP and ASP NOC	July 1 through September 30, 2014
April 2014 ASP and ASP NOC	April 1 through June 30, 2014
January 2014 ASP and ASP NOC	January 1 through March 31, 2014
October 2013 ASP and ASP NOC	October 1 through December 31, 2013

Note: CMS requires physicians and other providers to bill using the appropriate HCPCS or *Current Procedural Terminology (CPT®)* code and to accurately report the units of service. Physicians and other providers should ensure the units billed do not exceed the maximum number of units per day based on the code descriptor, reporting instructions associated with the code, and/or other CMS local or national policy, as noted at <http://www.cms.gov/Medi%20care/Medicare-Fee-for-Service-Part-B-Drugs/>

Correct billing of Aprepitant (J8501)

According to the Centers for Medicare & Medicaid Services' (CMS') national coverage determination (NCD) 110.18 (Aprepitant for chemotherapy-induced emesis), Medicare covers the use of the oral three-drug regimen of Aprepitant (Emend®), a 5-HT3 antagonist, and dexamethasone for patients receiving certain highly emetogenic chemotherapy agents in the treatment of reducing chemotherapy-induced emesis. On May 29, 2013, CMS revised the NCD to extend coverage for highly and moderately emetogenic chemotherapy.

Per the CMS, Internet-only manual (IOM), *Medicare National Coverage Determination (NCD) Manual* (Publication 100-03, Chapter 1, 110.18), CMS defines highly emetogenic chemotherapy and moderately emetogenic chemotherapy as those anticancer agents so designated in at least two of three guidelines published by the National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO), and European Society of Medical Oncology (ESMO)/Multinational Association of Supportive Care in Cancer (MASCC).

The defined patient population for which the use of oral anti-emetic three drug combination was determined to be reasonable and necessary is for patients who received one or more of the following anti-cancer chemotherapeutic agents:

- Carmustine (J9050)
- Cisplatin (J9060)
- Cyclophosphamide (J8530, J9070)
- Dacarbazine (J9130)

[McrPartBDrugAvgSalesPrice/index.html](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2990CP.pdf).

Additional information

The official instruction, CR 8836 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2990CP.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: MM8836
 Related Change Request (CR) #: CR 8836
 Related CR Release Date: July 18, 2014
 Effective Date: October 1, 2014
 Related CR Transmittal #: R2990CP
 Implementation Date: October 6, 2014

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- Mechlorethamine (J9230)
- Streptozocin (J9320)
- Doxorubicin (J9000, Q2049)
- Epirubicin (J9178)
- Lomustine (J8999)
- The following drugs are effective for dates of service on or after May 29, 2013:
 - Alemtuzumab (J9010)
 - Azacitidine (J9025)
 - Bendamustine (J9033)
 - Carboplatin (J9045)
 - Clofarabine (J9027)
 - Cytarabine (J9098, J9100)
 - Daunorubicin (J9150, J9151)
 - Idarubicin (J9211)
 - Ifosfamide (J9208)
 - Irinotecan (J9206)
 - Oxaliplatin (J9263)
 - Dactinomycin (J9120) (added; identified by at least two of the three guidelines as a highly emetogenic chemotherapy agent).

Billing requirements

Services must be bill using Healthcare Common

See **J8501**, next page

Intravenous immune globulin demonstration

Provider types affected

This *MLN Matters*[®] article is intended for suppliers submitting claims to durable medical equipment Medicare administrative contractors (DME MACs) for intravenous immune globulin (IVIG) drugs and services to Medicare beneficiaries who are participants in the IVIG demonstration.

Suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

Provider action needed

In this article, the Centers for Medicare & Medicaid Services (CMS) alerts providers to a three year demonstration to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of primary immune deficiency disease (PIDD). CMS has designed the IVIG demonstration to pay a bundled payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of PIDD. The demonstration will begin paying for services as of October 1, 2014, and will continue for three years, as long as funding remains available.

Background

Depending on the circumstances, traditional fee-for-service (FFS) Medicare covers some, or all, components of home infusion services. By special statutory provision, Medicare Part B covers IVIG for persons with PIDD who wish to receive the drug at home. Medicare does not separately pay for any services or supplies to administer the drug if the person is not homebound and is otherwise receiving services under a Medicare home health episode of care. As a result, many beneficiaries have chosen to receive the drug at their doctor's office, in an outpatient hospital setting, or to self-administer the drug subcutaneously. Beneficiaries may also alternate between settings or drug formulations, if necessary, to accommodate travel or other personal situations.



IVIG demonstration

The "Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012" authorized the demonstration under Part B of Title XVIII of the Social Security Act. The demonstration is limited to no more than 4,000 beneficiaries, and the \$45 million budget covers benefit costs, as well as administrative expenses for implementation and evaluation. Participation is voluntary and may be terminated by the beneficiary at any time.

Under this demonstration, Medicare will issue under Part B a bundled payment for all items and services that are necessary to administer IVIG in the home to enrolled beneficiaries who are not otherwise homebound and receiving home health care benefits. In processing all services and supplies needed for the administration of IVIG, CMS is not making any changes to existing coverage determinations to receive the IVIG drug in the home or for services and supplies that are otherwise not covered under the traditional FFS Medicare Part B benefit.

The demonstration only applies to situations where the beneficiary requires IVIG for the treatment of PIDD, or is currently receiving subcutaneous immune globulin to treat PIDD and wishes to switch to IVIG. This demonstration does not apply if the immune globulin is intended to be administered subcutaneously. Only those beneficiaries with PIDD who are eligible to receive IVIG under

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J8501

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Procedure Coding System (HCPCS) code J8501 (Aprepitant, oral, 5 mg) with the appropriate cancer diagnosis. Providers submitting claims to Medicare fiscal intermediaries (FIs) must bill HCPCS J8501 with revenue code 0636 (drugs requiring detailed coding).

Effective for claims with dates of service on or after May 29, 2013, Medicare administrative contractors (MACs) will deny lines for oral Aprepitant if an encounter for antineoplastic chemotherapy (ICD-9 V58.11 or ICD-10 Z51.11) is not present. If Aprepitant denies on a claim,

the 5HT3 and dexamethasone will also deny. Effective July 7, 2014, an audit was implemented to suspend claims for medical review when Aprepitant (J8501) is billed without a 5HT3 antagonist (HCPCS codes Q0162, Q0166, or Q0180); and dexamethasone (HCPCS J8540) on the same claim. In the case where a patient already has the oral agents at home, the provider must include a supporting statement to that fact.

Source: Change request 8418

IVIG

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the current Medicare benefit (have Part B, and have traditional FFS Medicare) will be eligible to enroll in the demonstration and have the services paid under the new demonstration.

This demonstration will not change how subcutaneous administration of immune globulin (SCIG) is covered and paid for under the traditional Medicare FFS program. In addition, nothing in this demonstration will impact how IVIG is paid by Medicare for beneficiaries who are covered under a home health episode of care.

Beneficiaries participating in the demonstration shall not be restricted in any way from receiving Medicare covered IVIG, and non-demonstration Medicare covered related services from different providers at different times, should they so choose. For example, a beneficiary receiving services under the demonstration at home may choose to switch and receive them at a doctor's office or outpatient department at any time. The beneficiary may switch back to receiving services under the demonstration as long as they are otherwise still eligible, and funding remains available.

Beneficiaries under hospice shall not be excluded from this demonstration, and their demonstration claims shall be processed in the same manner as other Medicare (non-demonstration) claims for hospice patients.

Beneficiaries covered under a home health episode of care may apply to participate in the demonstration but will not be eligible to have services paid for under the demonstration until after the home health episode of care has ended. Similarly, beneficiaries who are participating in the demonstration and subsequently become eligible to receive services under a home health episode of care will not be eligible to have services paid for under the demonstration for the period of time they are covered under such episodes.

Providers/suppliers billing for the services and supplies covered under the demonstration must meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of services related to home infusion of IVIG.

Beneficiary eligibility

In order to pay for the new demonstration covered services, the following requirements must be met:

1. The beneficiary must be enrolled in the demonstration (on the eligibility file provided by NHIC, Corp., the implementation support contractor);
2. The beneficiary must be eligible to have the IVIG drug paid for at home (have a diagnosis of PIDD) under the traditional FFS Medicare benefit;
3. The beneficiary must be enrolled in Medicare Part B and not be enrolled in a Medicare Advantage plan (i.e. have traditional FFS Medicare coverage);
4. The beneficiary must not be covered on the date



of service in a home health episode (In such circumstances, the services are covered under the home health episode payment.);

5. The place of service must be the beneficiary's home or a setting that is "home-like".

Billing details

A new "Q" code has been established for services, supplies, and accessories used in the home under the Medicare IVIG demonstration:

Q2052 (long description): Services, supplies, and accessories used in the home under Medicare Intravenous immune globulin (IVIG) demonstration.

Q2052 (short description): IVIG demo, services/supplies.

The code is for use with the IVIG demo only and the jurisdiction for this code is DME MAC.

The new demonstration service code (Q2052) must be billed as a separate claim line on the same claim and for the same date of service as the IVIG drug itself.

Specialty pharmacies will bill for the IVIG drug itself when intended for home administration by beneficiaries who are not homebound and not covered under a home health benefit episode. For those beneficiaries participating in the demonstration, specialty pharmacies shall bill for the demonstration covered services on the same claim as the drug itself. Claims for the demonstration bundled service (Q2052) billed in the absence of the "J" code for the IVIG drug will not be payable. The new demonstration covered services will be paid as a bundle and will be subject to coinsurance and deductible in the same manner as other Part B services.

For 2014, the nationwide Medicare allowable for Q2052 will be \$300 each time the IVIG is administered. While this is expected to be approximately monthly, it can be more or less frequent depending upon a patient's medical need.

As with all DMEPOS claims, specialty pharmacies will bill these claims to the appropriate DME MAC jurisdiction based on the beneficiary's state.

The following "J" codes represent immune globulin drugs

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that are administered intravenously and payable in 2014 under Medicare Part B for services rendered in the home (or home-like setting) for beneficiaries with PIDD: Privigen, (J1459), Bivigam (J1556), Gammaplex (J1557), Gamunex (J1561), Immune Globulin Not Otherwise Specified (J1566 and J1599), Octagam (J1568), Gammagard liquid (J1569), and Flebogamma (J1572). Immune globulin drugs covered under Medicare Part B for administration in the home for patients with PIDD are subject to change; coverage of any drugs under the demonstration shall not differ from drugs that are eligible for payment under Part B for beneficiaries not enrolled in the demonstration.

If the claim for IVIG is not otherwise payable under Medicare Part B, the Q2052 claim line is not payable under the demonstration. The claim for Q2052 must have the same date of service and place of service code on the claim line as the IVIG (J code) for which it is applicable. If multiple administrations of IVIG are submitted on a single claim, each date of service must be on a separate claim line. If these requirements are not met, the claim will not be processed and Medicare will return a group code of CO (contractual obligation), a remittance advice remarks code (RARC) of M51 (Missing/incomplete/invalid procedure code(s)) and a claim adjustment remarks code (CARC) of B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated).

If a claim is submitted with the HCPCS Q2052 code and the beneficiary is not enrolled in the demonstration on the date of service, the claim will be denied with a RARC of M138 (Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.), a CARC of 96 (Non-covered charge(s)), and a group code of CO.

Coverage of demonstration services shall be subject to the usual coordination of benefit process and the usual Medicare secondary payer process as well.

How beneficiaries can apply for the IVIG demonstration

To participate in this demonstration the beneficiary must complete and submit an application form. All applications must be signed by the beneficiary as well as his or her physician. Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration

CMS has contracted with NHIC, Corp., DME MAC jurisdiction A, to help administer the demonstration. NHIC will review all applications for eligibility and will create and upload an enrollment file to be used by CMS' claim processing systems.

CMS will conduct an initial enrollment period from

August 8-September 12, 2014. Completed applications must be received by NHIC, Corp. no later than 5:00 pm ET September 12, 2014, to be considered. Incomplete applications will be returned to the beneficiary and will not be reviewed. Beneficiaries will be notified by September 30, 2014, whether or not they have been accepted. Since the number of beneficiaries and funds available to implement this demonstration are limited, not all beneficiaries who are eligible may be accepted if more eligible beneficiaries apply than can be served with the funds available. If the number of eligible beneficiaries that apply during the initial enrollment period is below the statutory limits, then additional applications will continue to be accepted after the September 12, 2014, deadline on a rolling basis until enrollment and/or funding limits are reached.

The enrollment application and the application completion guide are available at <http://www.medicarenhic.com> or through the IVIG Demo hotline at: (844)-625-6284.

Completed applications may be submitted by fax or mail to NHIC, Corp. at the following address:

Applications may be mailed to:

NHIC, Corp.
IVIG Demo
P.O. Box 9140
Hingham, MA. 02043-9140

For overnight mailings:

NHIC, Corp
IVIG Demo
75 William Terry Dr.
Hingham, MA. 02043

Applications may be faxed to:

Fax 781-741-3533

Additional information

If you have any questions, please contact your DME MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

MLN Matters® Number: SE1424
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation: N/A

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Durable Medical Equipment

October 2014 update for DMEPOS fee schedule

Provider types affected

This *MLN Matters*[®] article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including hospice & home health MACs, and durable medical equipment MACs for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8865 to alert providers and suppliers that CMS issued instructions updating the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule payment amounts, effective October 1, 2014. Make sure your billing staffs are aware of these changes.

Background

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

Key points of CR 8865

Splints, casts, and certain intraocular lenses (IOLs)

As part of this update, the splint and cast (SC) payment category indicator will be added to the file for the following SC Healthcare Common Procedure Coding System (HCPCS) codes reflecting payment calculated in accordance with the regulations at 42 CFR, Section 414.106 for splints and casts:

A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010, Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021, Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032, Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041,

Q4042, Q4043, Q4044, Q4045, Q4046, Q4047, Q4048, Q4049

The 'IL' payment category indicator will be added to the file for V2630, V2631, and V2632 HCPCS codes for IOLs inserted in a physician's office reflecting payment calculated in accordance with the IOL payment regulations at 42 CFR, Section 414.108.

You may want to review *MLN Matters*[®] article MM8645, "April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule" at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8645.pdf>, which includes additional discussion on the establishment of national fee schedule amounts for codes for splints, casts, and IOLs.



<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8645.pdf>, which includes additional discussion on the establishment of national fee schedule amounts for codes for splints, casts, and IOLs.

Off-the-shelf (OTS) orthotics

Effective October 1, 2014, the following two new codes are added to the HCPCS file to describe prefabricated knee orthoses that are furnished off-the-shelf (OTS):

K0901: Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf; and

K0902: Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without

varus/valgus adjustment, prefabricated, off-the-shelf.

Since these two orthotic OTS codes represent a coding explosion of the prefabricated knee orthosis codes L1843 and L1845, the fees for the above codes will be added to the DMEPOS fee schedule file and established by applying the fees for codes L1843 and L1845 to the new OTS codes K0901 and K0902, respectively. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the "Medicare Claims Processing Manual," Chapter 23, Section 60.3.1. at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>.

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

Specific coding and pricing issues

1. This update also notifies that HCPCS codes K0734, K0735, K0736, and K0737 found in Attachment B of CR 6270, were discontinued; and
2. Cross walked to HCPCS codes E2622, E2623, E2624, and E2625, respectively, effective January 1, 2011.

Billing instructions for these wheelchair seat cushion items may refer to any of these codes.

Additional information

The official instruction, CR 8865, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3011CP.pdf>.

You may review Attachment B (Page 19) of CR 6270 at

Medicare demonstration allows for prior authorization for certain PMDs

Note: This article was revised August 7, 2014, to add information regarding the addition of 12 states (Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington) to the demonstration. This information was previously published in the [September 2012 Medicare B Connection, Pages 7-9](#).

Provider types affected

This *MLN Matters*[®] special edition article is intended for Medicare fee-for-service (FFS) suppliers who submit claims to the durable medical equipment Medicare administrative contractors (DME MACs) for power mobility devices (PMDs) in the demonstration states (Arizona, California, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Washington). Physicians and other practitioners who prescribe these devices for Medicare beneficiaries who reside in the demonstration states may also benefit from this article.

What you need to know

PMDs includes power wheelchairs and power-operated vehicles (POVs) that a beneficiary uses in their home (42 CFR 410.38(c)). Power wheelchairs are four-wheeled motorized vehicles that are steered by operating an electronic device or joystick to control direction and turning. POVs are three- or four-wheeled motorized scooters that are operated by a tiller. PMDs are classified as items of durable medical equipment (DME) for Medicare coverage purposes.

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1630CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

MLN Matters[®] Number: MM8865
Related Change Request (CR) #: CR 8865
Related CR Release Date: August 1, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3011CP
Implementation Date: October 6, 2014

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Power-operated vehicles (POVs or scooters): Under the mobility-assistive equipment (MAE) national coverage determination (NCD), POVs may be medically necessary for beneficiaries who cannot effectively perform mobility-related activities of daily living (MRADLs) in the home using a cane, walker, or manually operated wheelchair.

In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment. These vehicles are appropriately used in the home environment to improve the ability of chronically-disabled persons to cope with normal domestic, vocational, and social activities.

Power (motorized) wheelchairs: Under the MAE NCD, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, manually-operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair. Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurological or muscular condition.

This article provides guidance on upcoming changes to billing requirements for PMDs. Please make sure your medical and billing staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing waste, fraud, and abuse in the Medicare fee-for-service program. CMS is conducting

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a 3-year demonstration to ensure that Medicare only pays for PMDs that are medically necessary under existing coverage guidelines for orders written on or after September 1, 2012. The demonstration was initially implemented in seven states with high rates of Medicare fraud: California, Texas, Florida, Michigan, Illinois, North Carolina, and New York. Due to the demonstration's early success, the demonstration will be expanded to 12 additional states: Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington. These 19 states accounted for 71 percent of the total Medicare PMD expenditures in 2011. The expanded demonstration will be effective for orders written on or after October 1, 2014. This demonstration targets a claim type known to be susceptible to fraud and that has had high rates of improper payments.

The demonstration implements a prior authorization request process for PMDs for Medicare beneficiaries residing in the demonstration states. The prior authorization request can be completed by the ordering physician/ practitioner or the DME supplier. The physician/ practitioner or supplier who submits the request is referred to as the "submitter." The DME MAC will review the prior authorization request.

The following HCPCS codes are subject to prior authorization process in the demonstration states:

- Group 1 power-operated vehicles (K0800-K0802 and K0812);
- All standard power wheelchairs (K0813 through K0829);
- All group two complex rehabilitative power wheelchairs (K0835 through K0843);
- All group three complex rehabilitative power wheelchairs without power options (K0848 through K0855);
- Pediatric power wheelchairs (K0890-K0891); and
- Miscellaneous power wheelchairs (K0898).

Note: Group 3 complex rehabilitative power wheelchairs with power options (K0856 through 0864) are excluded.

The prior authorization process allows submitters to send a prior authorization request for a PMD before the supplier delivers the device to the beneficiary's home. All relevant documentation to support Medicare coverage of the PMD should be submitted to the appropriate DME MAC for an initial decision. The request package should include the face-to-face encounter documentation, the seven element order, the detailed product description, and whatever additional documentation is necessary to show that coverage requirements have been met.

Physicians/practitioners can bill G9156 after he/she submits an initial prior authorization request to partially compensate physicians for the additional time spent in submitting the prior authorization request.

Please note, that the prior authorization demonstration does not create new documentation requirements for physician/practitioners or suppliers. It simply allows them to provide the information earlier in the claims process.

After receiving the prior authorization request, the DME MAC will conduct a medical review and communicate the coverage decision to the beneficiary, physician/practitioner and supplier within 10 business days of receiving the request. Under rare, emergency circumstances, Medicare will complete this process within two business days. Claims with affirmative prior authorization requests will be paid so long as all other Medicare coverage and documentation requirements are met. Claims with a non-affirmative prior authorization decision will not be paid by Medicare.

If a second prior authorization request is resubmitted after a non-affirmative decision on an initial prior authorization request, the DME MAC will conduct a medical review within 20 business days and communicate a coverage decision to the beneficiary, physician/ practitioner, and supplier. Tricare programs and private insurance use similar time frames for prior authorization of non-emergent services.

Suppliers may choose to submit claims without a prior authorization decision. However, the claim will be subject to prepayment review. CMS currently assesses a payment reduction for orders written on or after December 1, 2012, in the initial demonstration states. CMS will begin to assess a payment reduction for noncompliance with the prior authorization process for any orders written on or after January 1, 2015, in the 12 additional states. If the claim satisfies Medicare's coverage and documentation requirements, it will be paid with a 25 percent reduction in Medicare reimbursement. The 25 percent reduction will not be applied if the claim is submitted by a contract supplier under the Medicare DMEPOS competitive bidding program and the claim is for a PMD provided to a Medicare beneficiary residing in a competitive bidding area.

Extensive education and outreach to physicians, treating practitioners, suppliers, and Medicare beneficiaries on the requirements of the prior authorization process has been initiated by CMS and will continue after the implementation of the demonstration. Additional information and updates on the demonstration will be posted at <http://go.cms.gov/PADemo>.

Utilizing the prior authorization request process will help CMS improve methods for identifying and prosecuting fraud and prevent improper payments. This will help ensure that Medicare only pays for PMD claims that are medically necessary under existing coverage guidelines. It will also provide valuable data for tackling the continued challenges the Medicare program faces.

Key points

CMS initially conducted this three year demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on the beneficiary's address as reported to the Social Security Administration and recorded in Medicare's common working file (CWF). This demonstration will expand to Arizona, Maryland, Georgia,

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Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington for orders written on or after October 1, 2014. This demonstration involves all four DME MACs.

Competitive bidding would not affect participation in this demonstration. However, if a contract supplier submits a payable claim for a beneficiary with a permanent residence, according to the CWF, in a competitive bidding area, that supplier would receive the single payment amount under the competitive bid contract. In other words, the single payment amount rules for contract suppliers outlined in 42 CFR 414.408 are not affected by this demonstration.

This demonstration will help ensure that no Medicare payments are made for PMDs unless a beneficiary's medical condition warrants the equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers. It will also help protect beneficiaries from unexpected financial liability.

Additional information

The prior authorization of power-mobility device section of the CMS Web page is at <http://go.cms.gov/PADemo>.

MLN Matters[®] special edition article SE1112, "Power Mobility Device Face-to-Face Examination Checklist," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf>.

The Medicare Learning Network[®] (MLN[®]) fact sheet,

"Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf.

Please visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> for the latest MLN[®] educational products designed to help Medicare FFS Providers understand – and avoid – common billing errors and other improper activities.

You may want to review *MLN Matters*[®] article MM8056, which is available at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8056.pdf>. The article clarifies that only one G9156 code (for preauthorization incentive payment) may be billed, per beneficiary, per PMD even if the physician or treating practitioner must resubmit the prior authorization request.

MLN Matters[®] Number: SE1231 *Revised*

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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Laboratory/Pathology

Clinical laboratory new waived tests

Provider types affected

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

Provider action needed

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid 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.

The *Current Procedural Terminology* (CPT[®]) codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and thus requiring certification) change each year. Change request (CR) 8805 informs the MACs about the latest new CPT[®] codes that are subject to CLIA edits. Make sure your billing staffs

are aware of these latest CLIA-related changes, and that you remain current with certification requirements.

Background

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The CPT[®] codes for the following new tests must have the modifier QW (CLIA-waived test) to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR 8805 (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:

- G0434QW, September 6, 2013, BTNX Inc. Rapid Response Multi-Drug Urine Test Cup;
- G0434QW, September 6, 2013, BTNX Inc. Rapid Response Multi-Drug Urine Test Panel;

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- G0434QW, October 4, 2013, uVera Diagnostics, Inc. CR2 Multi-Drug Urine Test Cup;
- G0434QW, October 4, 2013, uVera Diagnostics, Inc. CR3 Multi-Drug Urine Test Cup;
- G0434QW, October 4, 2013, uVera Diagnostics, Inc. SMARTOX U3 Multi-Drug Urine Test Cup;
- G0434QW, October 24, 2013, American Institute of Toxicology, Inc., AIT Laboratories Drug of Abuse Cup;
- 80061QW, 82962, 82465QW, 83718QW, 84478QW, November 12, 2013, Jant Pharmacal LipidPlus Lipid Profile and Glucose Measuring System (LipidPlus Lipid Profile test strips);
- G0434QW, December 4, 2013, Nobel Medical Inc. INSTA-SCREEN Multi-Drug Urine Test Cup;
- G0434QW, December 5, 2013, Micro Distributing II, LTD One Step Multi-Drug Urine Test Panel;
- G0434QW, February 11, 2014, Alfa Scientific Designs, Inc. Confidential Drug Test – Multi Drugs of Abuse Urine Test (OTC);
- 87880QW, February 18, 2014, BD Veritor System for Rapid Detection of Group A Strep (direct from throat swab);
- 85018QW, February 18, 2014, Clarity HbCheck Hemoglobin Testing System;
- 87077QW, February 18, 2014, Jant Accutest Rapid Urease test (H. pylori detection);
- G0434QW, March 13, 2014, UCP Biosciences, Inc. UCP Multi-Drug Test Key Cups;
- 83986QW, March 18, 2014, RightBio Metrics, RightSpot Infant pH Indicator;
- 83986QW, March 18, 2014, RightBio Metrics, RightSpot pH Detector;
- 83986QW, March 18, 2014, RightBio Metrics, RightSpot pH Indicator;
- 85018QW, March 21, 2014, AimStrip Hb Hemoglobin (Hb) Testing System;
- G0434QW, April 11, 2014, PTox Drug Screen Cup {Cassette Dip Card format};
- 86308QW, April 22, 2014, Polymedco Polystat Mono {whole blood};
- 82274QW, G0328QW, April 22, 2014, Rapid Response(TM) FIT-Fecal Immunochemical Test;
- 84443QW, May 16, 2014, Germaine Laboratories, Inc. AimStep Thyroid Screen {whole blood};
- 82055QW, May 21, 2014, Express Diagnostics International, Incorporated Saliva Alcohol Test;
- 83037QW, May 22, 2014, BIO-RAD in2it (II) System Analyzer Prescription Home Use; and
- 87880QW, May 23, 2014, Accustrip Strep A {Specimen type (Throat Swab)}.

You should be aware that your MAC will not search their files, to either retract payment or retroactively pay claims; however, they should adjust such claims that you bring to their attention.

Additional Information

The official instruction, CR 8805, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2988CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

MLN Matters® Number: MM8805
 Related Change Request (CR) #: CR 8805
 Related CR Release Date: July 18, 2014
 Effective Date: : October 1, 2014
 Related CR Transmittal #: R2988CP
 Implementation Date: October 6, 2014

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DEADLINE

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practice, new technology, and preventive services.

ICD-10 represents a significant change that impacts the entire health care community. As such, much of the industry has already invested resources toward the implementation of ICD-10. CMS has implemented a comprehensive testing approach, including end-to-end testing in 2015, to help ensure providers are ready. While many providers, including physicians, hospitals, and health plans, have completed the necessary system changes to transition to ICD-10, the time offered by Congress and this rule ensure all providers are ready.

For additional information about ICD-10, please visit the [ICD-10](#) website.

Changes to the laboratory national coverage determination software for ICD-10 codes

Note: This article was revised August 1, 2014, to show the new International Classification of Diseases, Tenth Revision (ICD-10) implementation date of October 1, 2015. While the change request (CR) may not reflect the new date, CMS has made the date change. All other information is unchanged. This information was previously published in the *February 2014 Medicare B Connection*, Page 29.

Provider types affected

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

Provider action needed

CR 8494, from which this article is taken, provides that the laboratory national coverage determination (NCD) edit software will be updated to accommodate the processing of the ICD-10 diagnosis codes. This is a follow-up to CR 8202 (changes to the laboratory NCD software for ICD-10 (dated February 1, 2013), that extended the ICD-9 to ICD-10 implementation date to October 1, 2015. (You can find this CR at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1174OTN.pdf>.)

Background

In accordance with the *Medicare Claims Processing Manual*, Chapter 16 (Laboratory Services), Section 120.2 (Implementation and Updates of Negotiated National Coverage Determinations (NCDs) for Clinical Diagnostic Laboratory Services), 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 maintaining codes in the negotiated NCDs and for biannual updates of the ICD-9-CM codes.

CR 8494, from which this article is taken, instructs the Medicare shared systems maintainers to update the laboratory NCD edit software to accommodate the processing of the ICD-10 diagnosis codes. There are no updates to the laboratory NCD code lists for this quarter.

Additional information

The official instruction, CR 8494, issued to your A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2865CP.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: MM8494 *Revised*
 Related Change Request (CR) #: CR 8494
 Related CR Release Date: January 31, 2014
 Effective Date: October 1, 2014
 Related CR Transmittal #: R2865CP
 Implementation Date: January 6, 2014

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General Coverage

Partial code freeze prior to ICD-10 implementation

Note: This article was revised August 1, 2014, to make changes as a result of the delay of ICD-10 implementation until October 1, 2015. This information was previously published in the *October 2012 Medicare B Connection*, Pages 17-18.

Provider types affected

This *MLN Matters*® special edition article affects all Medicare fee-for-service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What you need to know

At a meeting September 14, 2011, the ICD-9-CM Coordination & Maintenance (C&M) Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 which would end one year after

the implementation of ICD-10. The implementation of ICD-10 was delayed from October 1, 2014, to October 1, 2015 by final rule CMS-0043-F issued on July 31, 2014. This final rule is available at <https://www.federalregister.gov/articles/2014/08/04/2014-18347/change-to-the-compliance-date-for-the-international-classification-of-diseases-10th-revision>.

There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made October 1, 2011.
- On October 1, 2012, October 1, 2013, and October 1, 2014, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by Section 503(a) of Pub. L. 108-173.
- On October 1, 2015, there will be only limited

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code updates to ICD-10 code sets to capture new technologies and diagnoses as required by Section 503(a) of Pub. L. 108-173. No further updates will be made to ICD-9-CM on or after October 1, 2015, as it will no longer be used for reporting; and

- On October 1, 2016, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2016, once the partial freeze has ended.

The code freeze was initially discussed at the September 15, 2010, meeting of the committee. To view the transcript of that meeting, go to: <http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html>.

From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the '091510_Morning_Transcript' file. This section appears on Page 4 of the 78-page document.

To view the summary report of the meeting, go to: <http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html>. From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the "091510_ICD9_Meeting_Summary_report.pdf" file. Information on the code freeze begins on Page 5.

Additional information

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at <http://www.cms.gov/Medicare/Coding/ICD10/index.html>.

In addition, the following CMS resources are available to assist in your transition to ICD-10:

- **Medicare fee-for-service provider resources Web page:** This site links Medicare fee-for-service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this Web page. Bookmark <http://www.cms.gov/Medicare/Coding/ICD10/index.html> and check back regularly for access to ICD-10

implementation information of importance to you.

Note: Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.

- **CMS sponsored national provider conference calls:** During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit <http://www.cms.gov/Medicare/Coding/ICD10/index.html>.
- **See MLN Matters® special edition article, SE1239,** at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf> for an overview of what is needed to implement ICD-10.
- **Frequently asked questions (FAQs):** To access FAQs related to ICD-10, please visit the CMS ICD-10 Web page at <http://www.cms.gov/Medicare/Coding/ICD10/index.html>, select the "Medicare Fee-for-Service Provider Resources" link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- **Workgroup for Electronic Data Interchange (WEDI):** <http://www.wedi.org>; and
- **Health Information and Management Systems Society (HIMSS):** <http://www.himss.org/icd10>.

MLN Matters® Number: SE1240 *Revised*

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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ICD-10 testing opportunities for Medicare FFS providers

On July 31, HHS issued a rule ([CMS-0043-F](#)) finalizing October 1, 2015, as the new compliance date for health care providers and health plans to transition to ICD-10. ICD-10 represents a significant code set change that impacts the entire health care community.

CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS, as well as the Medicare fee-for-service (FFS) provider community, is ready:

- CMS internal testing of its claim processing systems
- CMS beta testing tools available for download
- Acknowledgement testing
- End-to-end testing

For more information, see [MLN Matters® special edition article #SE1409](#), “Medicare FFS ICD-10 Testing Approach.”

Acknowledgement testing

This past March, CMS conducted a [successful ICD-10 acknowledgement testing week](#). Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, special acknowledgement testing weeks in November, March, and June of 2015 will give submitters access to real-time

help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events. Contact your [Medicare administrative contractor \(MAC\)](#) for more information about acknowledgment testing.

End-to-end testing

CMS plans to offer providers and other Medicare submitters the opportunity to participate in end-to-end testing with MACs and the common electronic data interchange (CEDI) contractor in January, April, and July of 2015. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of three testing periods. The goals of this testing are to demonstrate that:

- Providers and submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claim systems
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims
- Accurate remittance advices are produced

Additional details about end-to-end testing will be available soon.

Check the [ICD-10 Medicare FFS Provider Resources](#) Web page for the latest information and educational resources to implement and transition to ICD-10 medical coding.

Medicare fee-for-service ICD-10 testing approach

Note: *This article was revised July 31, 2014, to show the new International Classification of Diseases, 10th Edition (ICD-10) implementation date of October 1, 2015. In addition, the portions of the article that discuss ICD-10 acknowledgement testing and end-to-end testing are updated as a result of the new implementation date. This information was previously published in the [March 2014 Medicare B Connection, Pages 34-36](#).*

Provider types affected

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

Provider action needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready. This [MLN Matters® special edition article](#) is intended to convey the testing approach that the Centers

for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2015, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS as well as the FFS provider community is ready.

When “you” is used in this publication, we are referring to the FFS provider community.

The four-pronged approach includes:

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

Each approach is discussed in more detail below.

CMS internal testing of its claim processing systems

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

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- Alpha testing is performed by each FFS claims processing system maintainer for four weeks;
- Beta testing is performed by a separate integration contractor for eight weeks; and
- Acceptance testing is performed by each MAC for four weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claim processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-initiated beta testing tools

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

- NCDs and LCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at <http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html>.
- The ICD-10 Medicare severity-diagnosis related groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the general equivalence mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at <http://cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html>. On this Web page, you can also find current versions of the ICD-10-CM MS-DRG grouper, Medicare code editor (available from national technical information service), and MS-DRG definitions manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- A pilot version of the October 2013 integrated outpatient code editor (IOCE) that utilizes ICD-10-CM located at <http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf>. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in the near future.

Acknowledgement testing

Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, CMS will be highlighting this testing by offering three separate weeks of ICD-10 acknowledgement testing. These special acknowledgement testing weeks give

submitters access to real-time help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events.

All MACs and the DME MAC common electronic data interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected.

MACs and CEDI will be appropriately staffed to handle increased call volume on their electronic data interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during these testing weeks. The testing weeks will occur in November 2014, March 2015, and June 2015. For more information about acknowledgement testing, refer to the information on your MAC's website.

End-to-end testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods. End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider's receipt of a remittance advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

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

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available shortly. Volunteer submitters will be selected nationwide to participate in the end-to-end testing. The sample group of participants will be selected to represent a broad cross-section of provider types, claims types, and submitter types.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate *MLN Matters*® article.

Claim submission alternatives

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2015, you should investigate downloading the free billing software that CMS offers via their MAC websites. The

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Medicare FFS claim processing guidance for implementing ICD-10 – a re-issue of MM7492

Provider types affected

Note: This article was revised August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the change request may not reflect the new date, CMS has made the date change. All other information is unchanged. This information was previously published in the [June 2014 Medicare B Connection, Pages 11-14](#).

Provider types affected

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

Provider action needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of change request (CR) 7492 (and related *MLN Matters*[®] article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. This article updates MM7492 to reflect the October 1, 2015, implementation date. Make sure your billing and coding staffs are aware of these changes.

Key points of SE1408

[General reporting of ICD-10](#)

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software has been updated to support ICD-10 codes and requires an internet connection. This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance. Alternatively, all MACs offer provider Internet portals, and a subset of these MAC portals offer claims submission; providers submitting to this subset of MACs may choose to use the portal for submission of ICD-10 compliant claims. Register in the portals that offer claims submission to ensure that you have the flexibility to submit professional claims this way as a contingency. More information may be found on your MAC's website.

Additional information

If you have any questions, please contact your MAC at their toll-free number. That number is available at

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to <http://www.cms.gov/Medicare/Coding/ICD10/index.html> for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General claim submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be returned to provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the

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<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work. In addition to showing the toll-free numbers, you will find your MAC's website address at this site in the event you want more information on the free billing software or the MAC's provider Internet portals mentioned above.

MLN Matters[®] Number: SE1409 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: October 1, 2015
Related CR Transmittal #: N/A
Implementation Date: N/A

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appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Claims that span the ICD-10 implementation date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2015. Tables A-D at the end of this article, provide further guidance to providers for claims

that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Additional information

You may also want to review SE1239 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/Downloads/SE1239.pdf>. SE1239 announces the revised ICD-10 implementation date of October 1, 2015.

You may also want to review SE1410 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/Downloads/SE1410.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

MLN Matters® Number: SE1408 *Revised*
 Related Change Request (CR) #: 7492
 Related CR Release Date: N/A
 Effective Date: October 1, 2015
 Related CR Transmittal #: N/A
 Implementation Date: N/A

Table A: Institutional providers

Bill type(s)	Facility type/services	Claim processing requirement	Use FROM or THROUGH date
11x	Inpatient hospitals (incl. TERFHA hospitals, prospective payment system (PPS) hospitals, long term care hospitals (LTCHs), critical access hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
12x	Inpatient Part B hospital services	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
13x	Outpatient hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
14x	Non-patient laboratory services	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
18x	Swing beds	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
21x	Skilled nursing (inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH

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Bill type(s)	Facility type/services	Claim processing requirement	Use FROM or THROUGH date
22x	Skilled nursing facilities (inpatient Part B)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
23x	Skilled nursing facilities (outpatient)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
32x	Home health (inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	THROUGH
3x2	Home health – request for anticipated payment (RAPs)*	* Note - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See Note
34x	Home health – (outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
71x	Rural health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
72x	End-stage renal disease (ESRD)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
73x	Federally qualified health clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74x	Outpatient therapy	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
75x	Comprehensive outpatient rehab facilities	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
76x	Community mental health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
77x	Federally qualified health clinics (effective 4/4/10)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
81x	Hospice- hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

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Bill type(s)	Facility type/services	Claim processing requirement	Use FROM or THROUGH date
82x	Hospice – non hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
83x	Hospice – hospital based	N/A	N/A
85x	Critical access hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

Table B: Special outpatient claim processing circumstances

Scenario	Claim processing requirement	Use FROM or THROUGH date
3-day /1-day payment window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C: Professional claims

Type of claim	Claim processing requirement	Use FROM or THROUGH date
All anesthesia claims	Anesthesia procedures that begin 9/30/2015, but end 10/1/2015, are to be billed with ICD-9 diagnosis codes and use 9/30/2015, as both the FROM and THROUGH date.	FROM

Table D: Supplier claims

Supplier type	Claim processing requirement	Use FROM or THROUGH/TO date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of service occurs after 10/1/2015).	FROM

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Get ready for ICD-10

On October 1, 2015, the health care industry will transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures.

This transition is going to change how you do business—from registration and referrals to superbills and software upgrades. But that change doesn't have to be overwhelming.

The Centers for Medicare & Medicaid Services has the following resources to help your practice prepare for the transition.

[Online ICD-10 guide](#)

[ICD-10 basics for large medical practices](#)



RARC and CARC with 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 administrative contractors (MACs), including durable medical equipment (DME) MACs and home health & hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8855 instructs the MACs to make programming changes to incorporate updates to the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use that 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. Medicare policy states that claim adjustment reason codes (CARCs) and appropriate remittance advice remark codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions.

For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets, CARC and RARC, that must be used along with a group code to report payment adjustments and Informational RARCs to report appeal rights, and other adjudication related information. If there is any adjustment, the appropriate group code must be reported. Additionally, for transaction 837 Coordination of Benefits (COB), CARC and RARC must be used. CARC and RARC code sets are updated three times a year on a regular basis. Medicare contractors must report only currently valid codes in both the remittance advice and COB claim transaction, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met.

MACs must make the necessary CARC/RARC code list updates on a regular basis. Any modification and/or deactivation, even if not initiated by Medicare, will be implemented.

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. MACs are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. 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 another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare has the responsibility to implement code deactivation (making sure that any deactivated code is not used in original business messages), but the deactivated code in derivative messages is allowed. Medicare must be sure to not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 8855, MACs must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times a year and may not match the CMS release schedule. CR 8855 lists only the changes that have been approved since the last code update CR (CR 8703, Transmittal 2920, issued on April 4, 2014; see <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8703.pdf>), and does not provide a complete list of codes for these two code sets. The MACs must get the complete list for both CARC and RARC from the WPC website that is updated three times a year (around March 1, July 1, and November 1) to get the comprehensive lists for both code sets. The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three times a year according to the Medicare release schedule and/or specific CR from a CMS component implementing a policy change that impacts remittance advice code use.

You can find the WPC website, which has four listings available for both CARC and RARC, at <http://www.wpc-edi.com/Reference>.

Changes in CARC List since CR 8703

The following tables list the changes in the CARC database since the last code update in CR 8703. The full CARC list is available from the WPC website at <http://wpc-edi.com/Reference>.

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New codes – CARC

Code	Modified narrative	Effective date
261	The procedure or service is inconsistent with the patient's history.	6/01/14

Modified codes – CARC

Code	Modified narrative	Effective date
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) Notes: Not for use by Workers' Compensation payers; use code P3 instead. CMS Note : This code was previously deactivated, however it is being reactivated.	6/01/14
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the National Council of Prescription Drugs Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	6/01/14
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	6/01/14
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA) Notes: To be used after the first month of the grace period.	6/01/14

Deactivated codes – CARC: None

Changes in RARC list since CR 8703

The following tables list the changes in the RARC database since the last code update in CR 8703. The full RARC list is available from the WPC website at <http://wpc-edi.com/Reference>.

New codes – RARC: None

Modified codes – RARC

Code	Modified narrative	Effective date
N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.	7/01/14
M77	Missing/incomplete/invalid/inappropriate place of service.	3/14/14
M84	Medical code sets used must be the codes in effect at the time of service.	3/14/14
MA100	Missing/incomplete/invalid date of current illness or symptoms.	3/14/14
N202	Additional information/explanation will be sent separately.	3/14/14
N203	Missing/incomplete/invalid anesthesia time/units.	3/14/14
N205	Information provided was illegible.	3/14/14
N208	Missing/incomplete/invalid DRG code.	3/14/14
N210	Alert: You may appeal this decision.	3/14/14
N211	Alert: You may not appeal this decision.	3/14/14
N212	Charges processed under a Point of Service benefit.	3/14/14
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	3/14/14
N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).	3/14/14
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	3/14/14
N217	We pay only one site of service per provider per claim.	3/14/14
N238	Incomplete/invalid physician certified plan of care.	3/14/14
N245	Incomplete/invalid plan information for other insurance.	3/14/14
N354	Incomplete/invalid invoice.	3/14/14

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Code	Modified narrative	Effective date
N388	Missing/incomplete/invalid prescription number.	3/14/14
N433	Resubmit this claim using only your National Provider Identifier (NPI).	3/14/14
N438	This jurisdiction only accepts paper claims.	3/14/14
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	3/14/14
N467	Missing Tests and Analysis Report.	3/14/14
N474	Incomplete/invalid certification.	3/14/14
N476	Incomplete/invalid completed referral form.	3/14/14
N478	Incomplete/invalid Dental Models.	3/14/14
N482	Incomplete/invalid Models.	3/14/14
N484	Incomplete/invalid Periodontal Charts.	3/14/14
N488	Incomplete/invalid Prosthetics or Orthotics Certification.	3/14/14
N490	Incomplete/invalid referral form.	3/14/14
N543	Incomplete/invalid income verification.	3/14/14
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected this will not be paid in the future.	3/14/14
N554	Missing/Incomplete/Invalid Family Planning Indicator.	3/14/14
N570	Missing/incomplete/invalid credentialing data.	3/14/14
N609	80% of the provider's billed amount is being recommended for payment according to Act 6.	3/14/14
N645	Mark-up allowance.	3/14/14
N667	Missing prescription.	3/14/14
N668	Incomplete/invalid prescription.	3/14/14
N687	Alert: This reversal is due to a retroactive disenrollment.	3/14/14
N688	Alert: This reversal is due to a medical or utilization review decision.	3/14/14
N689	Alert: This reversal is due to a retroactive rate change.	3/14/14

Code	Modified narrative	Effective date
N690	Alert: This reversal is due to a provider submitted appeal.	3/14/14
N691	Alert: This reversal is due to a patient submitted appeal.	3/14/14
N692	Alert: This reversal is due to an incorrect rate on the initial adjudication.	3/14/14
N693	Alert: This reversal is due to a cancellation of the claim by the provider.	3/14/14
N696	Alert: This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment.	3/14/14
N697	Alert: This reversal is due to a payer's retroactive contract incentive program adjustment.	3/14/14
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.	3/14/14
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.	3/14/14

Deactivated codes – RARC: None

Additional information

The official instruction, CR 8855, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2996CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

MLN Matters® Number: MM8855
 Related Change Request (CR) #: CR 8855
 Related CR Release Date: July 24, 2014
 Effective Date: October 1, 2014
 Related CR Transmittal #: R2996CP
 Implementation Date: October 6, 2014

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Medicare Remit Easy Print enhancement

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.

Provider action needed

This article is based on change request (CR) 8856. Medicare Remit Easy Print (MREP) software was developed by the Centers for Medicare & Medicaid Services (CMS) to help providers to transition to electronic remittance advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CR 8856 instructs the developer of the MREP software to update it based on enhancement requests received through the MACs and the CMS website. This software is available free of charge from the CMS website and now offers a number of special reports that users can view and download in addition to the remittance advice. Make sure that your billing staffs are aware of these changes.

Background

CMS offers free software – MREP – to view and print HIPAA compliant ERA, transaction 835 - Health Care Claim Payment/Advice. The software gets enhanced on a regular basis to meet the changing needs of providers

Implementation of phase III CORE 360 CARCs and RARCs rule – version 3.1.1

Note: This article was revised August 12, 2014, to reflect the revised change request (CR) 8711 issued August 8, 2014. The CR revised the CAQH CORE version number and the publication date. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are changed. All other information remains the same. This information was previously published in the *July 2014 Medicare B Connection*, Page 14.

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

This article is based on CR 8711, which instructs the MACs to update the committee on operating rules for information exchange (CORE) 360 uniform use of claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) rule. If you use Medicare's PC Print or Medicare Remit Easy Print (MREP) software, you will need to obtain the new version after it is updated on

and suppliers to help them transition to ERA. The MACs will notify MREP users of the MREP enhancements once implementation is complete. A key change in this latest version of the software is an enhancement to correct paging issues when a long claim runs to another page and that subsequent page was missing headers.

Additional information

The official instruction, CR 8856, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1413OTN.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

MLN Matters[®] Number: MM8856
Related Change Request (CR) #: CR 8856
Related CR Release Date: August 1, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R1413OTN
Implementation Date: January 5, 2015

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October 6, 2014. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the phase III council for affordable quality healthcare (CAQH) CORE electronic funds transfer (EFT) and electronic remittance advice (ERA) operating rule set that must be implemented by January 1, 2014, under the Affordable Care Act.

Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C – Administrative Simplification – to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of

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a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE will publish the next version of the Code Combination List on or about July 1, 2014. This update is based on March 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. (Visit <http://www.wpc-edi.com/> reference for CARC and RARC updates and <http://www.caqh.org/CORECodeCombinations.php> for CAQH CORE defined code combination updates.)

Note: Per the Affordable Care Act mandate, all health plans including Medicare must comply with CORE 360 uniform use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/group code for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Electronic data interchange enrollment tips

The following are tips to keep in mind when completing an electronic data interchange (EDI) enrollment form:

- Effective September 1, 2014, Medicare EDI will return all EDI enrollment forms received containing a form revision date older than July 21, 2014.
- A link to the completion instructions is at the bottom of page 1 of the EDI enrollment form.
- The EDI enrollment form is interactive allowing you to complete the form online, print, sign and date it.
- All fields with an asterisk (*) are required.
- A required fax coversheet precedes the EDI enrollment form.
- The EDI enrollment form is a legal document and all pages must be returned with the request, otherwise, the entire application will be returned.
- Electronic billers will automatically be enrolled for electronic remittance advice (ERA) with the submitter on the request unless otherwise indicated in the ERA section.
- If requesting SPR (standard paper remittance) an exception form is also required. This can be obtained by contacting Medicare EDI and must be sent in with the EDI enrollment form. **Note:** An exception form requires a business justification for requesting remittance on paper.
- If you are enrolling in PC-ACE Pro32™, you must specify the manner in which you select to receive the software. Once the form is completed and printed, you must sign the authorized official original signature

Additional information

The official instruction, CR 8711, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1418OTN.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work?

MLN Matters® Number: MM8711 *Revised*
Related Change Request (CR) #: CR 8711
Related CR Release Date: August 8, 2014
Effective Date: September 2, 2014
Related CR Transmittal #: R1418OTN
Implementation Date: September 2, 2014

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.



field in the PC-ACE Pro32™ section and the signature requirements section.

- Signature requirements: The authorized official original signature and title must be completed on all applications, signing this section confirms you have read and agree with the Agreement, Centers for Medicare & Medicaid Services (CMS) obligations, and Attestation sections on Page 3 and 4.
- It is highly recommended that you keep a copy of your completed enrollment form(s) for your records.
- A link has been provided on the EDI fax coversheet to the Medicare A data direct entry (DDE) page for obtaining the DDE user ID request form.
- EDI forms are processed in the order in which they are received. Notification will be sent to the contact listed on the form advising status of the form.
- Once the form has been completed, print, sign, date and return all pages including the EDI fax cover sheet.
- All forms received after 2:00 p.m. ET will have the date of the receipt of the next business day.

Extension of provider enrollment moratoria for home health agencies and Part B ambulance suppliers

Provider types affected

This *MLN Matters*[®] article is intended for home health agencies (HHAs), HHA sub-units, and Part B ambulance suppliers in parts of Florida, Illinois, Michigan, Texas, and New Jersey that provide services to Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries.

Provider action needed

Stop – impact to you

Effective July 30, 2014, the temporary moratoria on new HHA, HHA sub-units, and Part B ambulance suppliers are being extended for an additional six months in certain geographic locations.

Caution – what you need to know

During the six-month temporary moratorium, initial provider enrollment applications and change of information applications to add additional practice locations, received from HHA, HHA sub-units and Part B ambulance suppliers in the listed counties will be denied. Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

Go – what you need to do

Effective July 30, 2014, HHAs, HHA sub-units, and Part B ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the six-month moratoria has expired. CMS will announce in the *Federal Register* when the moratorium has been lifted or if it will be extended.

Background

In accordance with 42 CFR §424.570(c), the Centers for Medicare & Medicaid Services (CMS) may impose a moratorium on the enrollment of new Medicare providers and suppliers of a specific type or the establishment of new practice locations in a particular geographic area.

On July 29, 2014, CMS announced, in a *Federal Register* notice (<https://www.federalregister.gov/articles/2014/08/01/2014-18174/extended-temporary-moratoria-on-enrollment-of-ambulance-suppliers-and-home-health-agencies-in>), the extension of temporary moratoria on the enrollment of new HHAs, HHA sub-units and Part B ambulance suppliers in designated geographic locations.

The moratoria initially became effective on July 30, 2013, and its implementation was announced in the *Federal Register*, which may be accessed at <https://www.federalregister.gov/articles/2014/02/04/2014-02166/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-new-and-extended-temporary#page-6475>.

Moratoria extension

Effective July 30, 2014, the temporary moratoria on new HHAs and HHA sub-units is being extended for an additional six months in the areas stated in Table 1.

Table 1: Home health agencies and home health agency sub-units under temporary moratorium

City and state	Counties
Fort Lauderdale, FL	Broward
Miami, FL	Miami-Dade Monroe
Detroit, MI	Macomb Monroe Oakland Washtenaw Wayne
Dallas, TX	Collin Dallas Denton Ellis Kaufman Rockwall Tarrant
Houston, TX	Brazoria Chambers Fort Bend Galveston Harris Liberty Montgomery Waller
Chicago, IL	Cook DuPage Kane Lake McHenry Will

In addition, the temporary moratorium on new Part B ambulance suppliers is being extended for an additional six months in the areas stated in Table 2.

Table 2: Part B ambulance suppliers under six-month temporary moratoria

City and state	Counties
Houston, TX	Harris Brazoria Chambers Fort Bend Galveston Liberty Montgomery Waller

See **MORATORIA**, next page

MORATORIA

From previous page

City and state	Counties
Philadelphia, PA	Bucks (PA) Delaware (PA) Montgomery (PA) Philadelphia (PA) Burlington (NJ) Camden (NJ) Gloucester (NJ)

Initial provider enrollment applications and change of information applications to add additional practice locations received from HHAs, HHA sub-units and Part B ambulance suppliers in the above listed counties will be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

Note: HHAs, HHA sub-units and Part B ambulance suppliers are afforded appeal rights. However, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. CMS' basis for imposing a temporary moratorium is not subject to review.

Additional information

For more information regarding CMS' use of temporary moratoriums, please review *MLN Matters*[®] article MM7350 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.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: SE1425
 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

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.



Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Tools to improve your billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

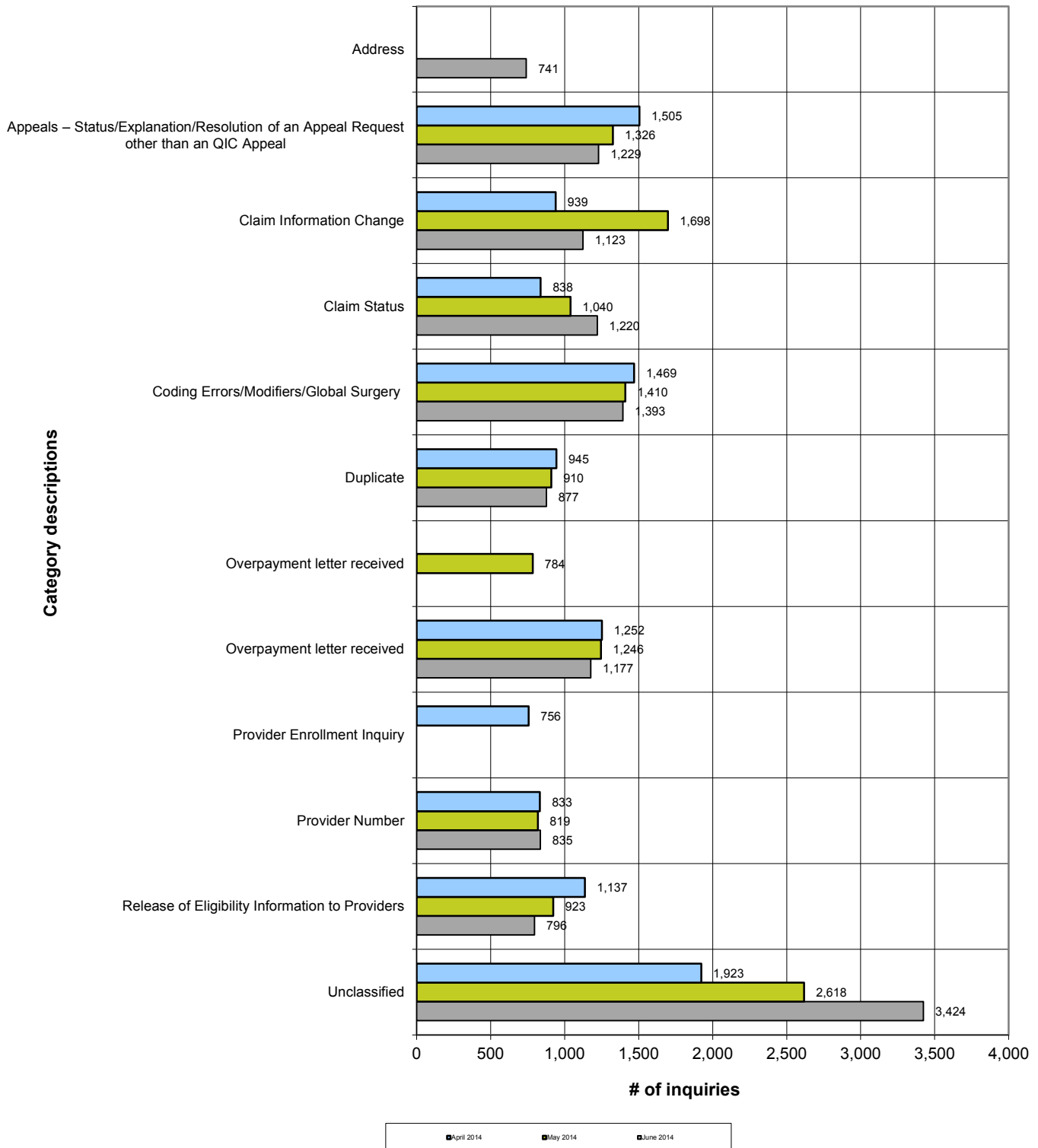
Claims and Inquiry Summary Data

Top inquiries, rejects, and return unprocessable claims

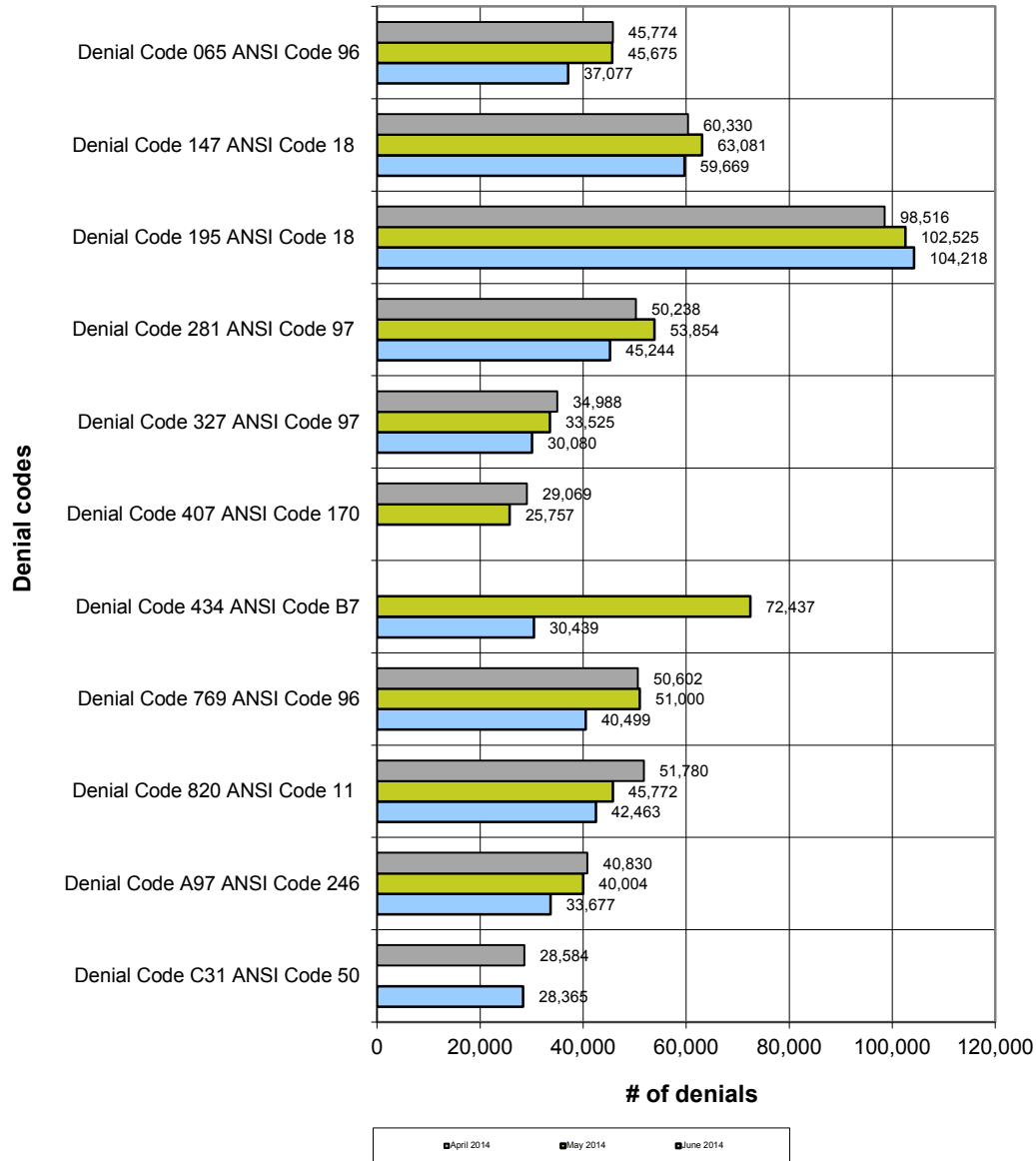
The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands May-July 2014.

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 May-July 2014



Part B top denials for May-July 2014



Use self-service resources to assist with and avoid claim denials

Before contacting customer service, check claim status through the SPOT (Secure Provider Online Tool) or the Part B interactive voice response (IVR) system. The SPOT and 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.

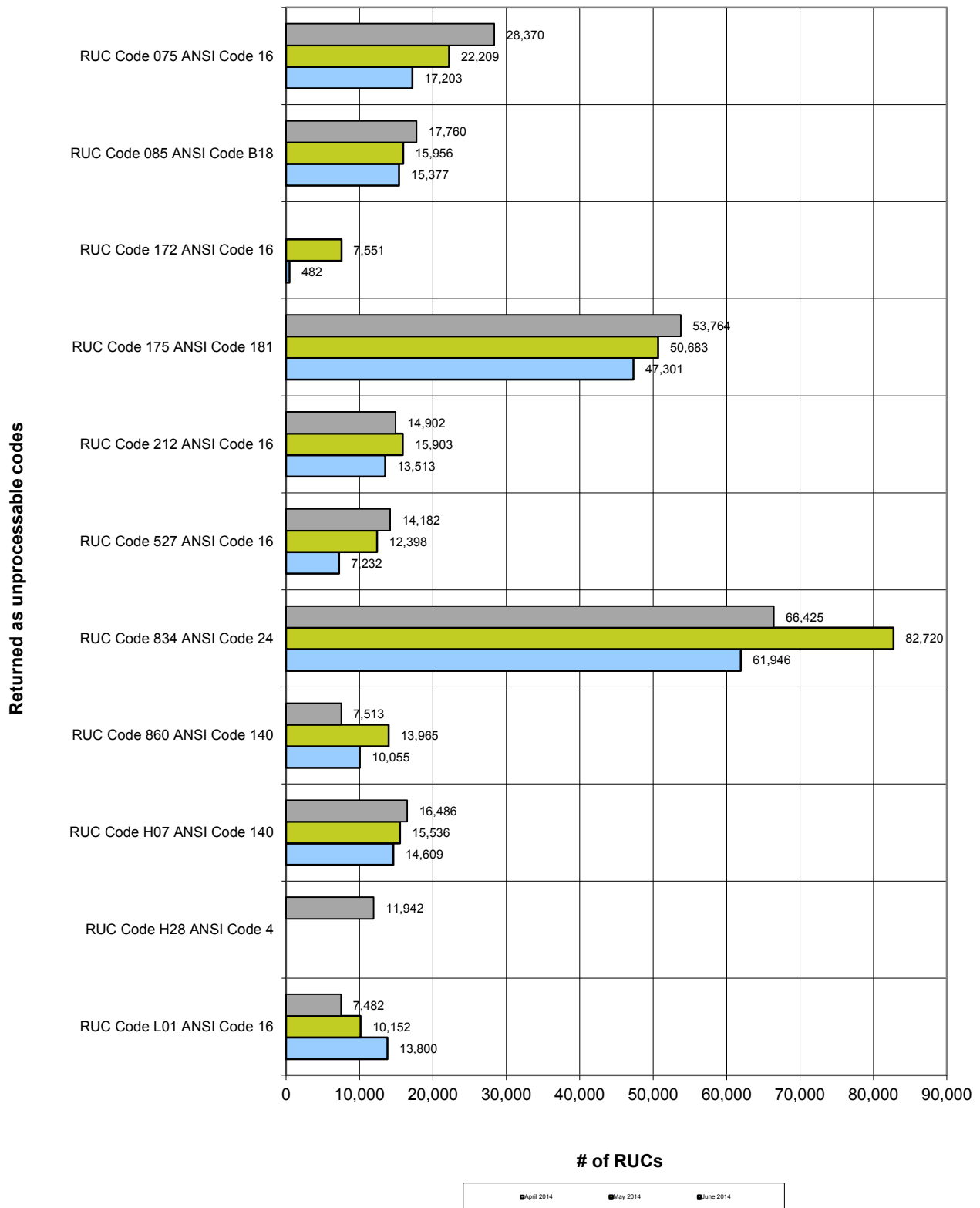
For assistance with denied claims and how to correct them, the following frequently asked questions are

available the First Coast Medicare provider website:

- [Claims completion](#)
- [Denials](#)
- [Billing issues](#)
- [Unprocessable claims](#)

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

Part B top return as unprocessable claims for May-July 2014



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 N (JN) 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



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.

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.

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.*

Retired LCDs

Multiple local coverage determinations retired

LCD ID number: L29053, L29058, L29062, L29129, L29226, L29233, L29262, L29269 (Florida)

LCD ID number: L29071, L29076, L29080, L29147, L29364, L29368, L29469, L29386 (Puerto Rico/U.S. Virgin Islands)

LCD ID number: L31475, L30353 (Florida/ Puerto Rico/U.S. Virgin Islands)

Based on data analysis the following local coverage determinations (LCDs) were retired.

1. Aldesleukin (Proleukin[®], Interleukin-2, Recombinant, and RIL-2)
2. Aluminum
3. ATGAM (Lymphocyte Immune Globulin, Antithymocyte Globulin (Equine))
4. Denileukin Diftitox (Ontak[®])
5. Metastron C Strontium-89 Chloride

6. Nesiritide (Natrecor[®]) Intravenous Infusion Therapy
7. Prostatic Acid Phosphatase
8. Retisert (fluocinolone acetonide intravitreal implant)
9. Selective Treatment of HAE with Cinryze[™], Berinert[®] and Ecallantide
10. Ultrasound of the Spine

Effective date

The retirement of these LCDs is effective for services rendered **on or after August 7, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section..." drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please [click here](#).

Revisions to LCDs

Health and behavior assessment/intervention – revision to the Part B LCD

LCD ID number: L29186 (Florida)

LCD ID number: L29344 (Puerto Rico/U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, this LCD has been revised to add clarifying language, regarding the health and behavior initial assessment and reassessment, under number two in the "Documentation Requirements" section of the LCD. The updated language reads as follows: "Evidence of a referral to the clinical psychologist by the medical provider responsible for the medical management of the patient's physical illness or verification of a recommendation from the medical provider to the Clinical Psychologist, obtained by request and review of the permanent medical record,

must be documented in the medical record for the initial assessment and for reassessment".

Effective date

This LCD revision is effective for services rendered **on or after August 5, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section..." drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please [click here](#).

What is Medicare Fraud?

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



Mohs micrographic surgery – revision to the Part B LCD

LCD ID number: L29230 (Florida)

LCD ID number: L29366 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Mohs micrographic surgery (MMS) was revised and presented during the October 2011 Contractor Advisory Committee (CAC) cycle. An extensive number of comments were received related to defect closure and repair, as well as, which physician specialties are considered qualified to perform Mohs procedures. The revised LCD draft was not finalized at that time, but pended, awaiting the publication of *Appropriate Use Criteria by the American Academy of Dermatology*. A new draft was released again in October 2013, based on ongoing issues identified through medical review and data analysis. Of note, the 2013 data for Mohs services billed in Florida indicated that over 92 million dollars were allowed (not adding the reconstruction of the surgical defect that add considerable cost when utilized) for approximately 67,000 Medicare beneficiaries. Also, the 2012 Medicare provider utilization and payment data for all services is available on the public domain.

Since the October 2013 policy cycle, the medical policy staff and medical directors have collaborated with practicing physicians representing the specialties of dermatology and plastic surgery and further revised the draft to incorporate the appropriate use criteria by the American Academy of Dermatology. Due to the inclusion

of more restrictive language, the draft was re-released in February 2014 for an additional 45-day comment period and presented for discussion at both the Florida and Puerto Rico CAC meetings.

In summary, major revisions to the current LCD are being implemented to address the various issues that were presented during the comment periods for October 2011, October 2013, and February 2014. This LCD has been revised to update the following sections: “Indications and Limitations of Coverage and/or Medical Necessity,” “ICD-9 Codes that Support Medical Necessity,” and “Documentation Guidelines” for the performance of Mohs Micrographic Surgery. In addition, the “Sources of Information and Basis for Decision” section of this LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after October 6, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please [click here](#).

Myocardial imaging, positron emission tomography scan – revision to the Part B LCD

LCD ID number: L29231 (Florida)

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

The local coverage determination (LCD) for myocardial imaging, positron emission tomography (PET) scan has been revised based on issues identified during medical review of documentation. Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, language was added to specify certain indications when a PET scan is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT). Language throughout the LCD was updated and consolidated based on current CMS manual language for PET scans. Also, cardiac sarcoidosis was added to the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD. Dual diagnoses are required for cardiac sarcoidosis, and therefore, ICD-

9-CM codes 135 and 425.8 were added to the “ICD-9 Codes that Support Medical Necessity” section of the LCD for CPT® code 78459. Additionally, ICD-9-CM code for chest pain (786.50) was added. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after September 22, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please [click here](#).

Additional Information**Self-administered drug (SAD) list – Part B: Myalept™
(metreleptin for injection) J3490/J3590/C9399**

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered on or after October 13, 2014, the following drug has been added to the MAC JN Part B SAD list.

- J3490/J3590/C9399 Metreleptin for injection (Myalept™ for subcutaneous use) 11.3mg

The evaluation of drugs for addition to the self-administered drug (SAD) list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.



The SAD lists are available through the First Coast Service Options, Inc. (First Coast) website at: http://medicare.fcso.com/Self-administered_drugs/.

Take the time to 'chat' with the website team

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast's new Live Chat service.



Upcoming provider outreach and educational events

Medicare Part B changes and regulations

When: Wednesday, September 17

Time: 1:00-5:00 p.m. **Type of event:** Webcast

<http://medicare.fcso.com/Events/266999.asp>

Outpatient therapy functional reporting (A/B)

When: Tuesday, October 7

Time: 1:00 -3:00 p.m. **Type of event:** Webcast

<http://medicare.fcso.com/Events/272485.asp>

How to register for SPOT (Secure Provider Online Tool)

When: Tuesday, October 14

Time: 1:00 -2:00 p.m. **Type of event:** Webcast

<http://medicare.fcso.com/Events/273099.asp>

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.fcouniversity.com, log on to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event.

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

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

Please Note:

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

Registrant’s Name: _____

Registrant’s Title: _____

Provider’s Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, medicare.fcso.com, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.



CMS MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects™* Provider eNews is an official *Medicare Learning Network®* (MLN®) – branded product that contains a week’s worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate.

To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to

the latest e-News:

“MLN Connects™ Provider eNews’: August 7, 2014 – <http://go.usa.gov/NmS9>

“MLN Connects™ Provider eNews’: August 14, 2014 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-08-14-eNews.pdf>

“MLN Connects™ Provider eNews’: August 21, 2014 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-08-21-eNews.pdf>



Find out first: Subscribe to First Coast eNews

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

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>.



Phone numbers

Customer service

866-454-9007
877-660-1759 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

866-454-9007
877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

866-454-9007
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 2537
Jacksonville, FL 32231-2537

Redeterminations

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

Redetermination of overpayments

Overpayment Redetermination, Review Request
P.O. Box 45248
Jacksonville, FL 32232-5248

Reconsiderations

Q2 Administrators, LLC
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

General inquiry request
P.O. Box 2360
Jacksonville, FL 32231-2537

Email: FloridaB@fcsso.com
Online form: <http://medicare.fcsso.com/Feedback/161670.asp>

Provider enrollment

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

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 44141
Jacksonville, FL 32231-4141

Medicare Education and Outreach

Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Florida
P.O. Box 2078
Jacksonville, FL 32231-2078

Overnight mail and/or special courier service

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

Websites

Provider

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

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services
<http://www.cms.gov>

First Coast University
<http://www.fcsouniversity.com/>

Beneficiaries

Centers for Medicare & Medicaid Services
<http://www.medicare.gov>

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Customer service

866-454-9007
877-660-1759 (speech and hearing impaired)

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Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 2525
Jacksonville, FL 32231-0019

Redeterminations

Medicare Part B Redetermination
P.O. Box 45013
Jacksonville, FL 32232-5024

Redetermination of overpayments

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

Reconsiderations

Q2 Administrators, LLC
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

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

Email: FloridaB@fcsso.com

Online form: <http://medicare.fcsso.com/Feedback/161670.asp>

Provider enrollment

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

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 44141
Jacksonville, FL 32231-4141

Medicare Education and Outreach

Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

Special courier service

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

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor

<http://medicare.fcsso.com>

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services

<http://www.cms.gov>

First Coast University

<http://www.fcsouniversity.com/>

Beneficiaries

Centers for Medicare & Medicaid Services

<http://www.medicare.gov>

Phone numbers

Customer service

1-877-715-1921
1-888-216-8261 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)
904-361-0407 (FAX)

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

877-715-1921
877-660-1759 (TTY)

General inquiries

877-715-1921
888-216-8261 (TTY)

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

877-715-1921
877-660-1759 (TTY)

The SPOT help desk

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email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 2525
Jacksonville, FL 32231-0019

Redeterminations

Medicare Part B Redetermination
P.O. Box 45056
Jacksonville, FL 32232-5056

Redetermination of overpayments

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

Reconsiderations

Q2 Administrators, LLC
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

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

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Online form: <http://medicare.fcsso.com/Feedback/161670.asp>

Provider enrollment

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

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 45040
Jacksonville, FL 32231-5040

Medicare Education and Outreach

Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Puerto Rico
P.O. Box 45092
Jacksonville, FL 32231-5092

Special courier service

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

Websites

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First Coast University
<http://www.fcsouniversity.com/>

Beneficiaries

Centers for Medicare & Medicaid Services
<http://www.medicare.gov>

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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.

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