Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

May 2012

In this issue

New edit to review Medicare OPPS payments exceeding charges

Provider types affected

This *MLN Matters*® article is intended for hospitals submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for outpatient prospective payment system (OPPS) services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7771 which informs Medicare contractors about changes to FISS edits for outpatient prospective payment system (OPPS) claims. Please make sure your billing staff is aware of these changes and complies with any requests from Medicare contractors for additional information on OPPS claims.

Background

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), recently issued several final audit reports regarding the "Review of Medicare Payments Exceeding Charges for Outpatient Services Processed" to various MACs. Audit findings in these reports include: providers reporting incorrect units of service and/ or incorrect Healthcare Common Procedure Coding System (HCPCS) codes, or use of HCPCS codes that do not reflect the procedures performed.

Based on findings in these reports, the Center for Medicare & Medicaid Services (CMS) is implementing a verification policy where the OPPS payment is greater than the billed charges on bill types 12x, 13x and 14x.

Contractors will suspend those claims receiving the verification edit for development and contact providers to resolve billing errors. If the contractor determines that the reimbursement is excessive and claim corrections are required, the contractor will return the claim to the provider. If the contractor determines that the billing is accurate and the reimbursement is not excessive, the contractor will override the edit and continue to process the claim.

Additional information

The official instruction, CR 7771 issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2463CP.pdf*.

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

(continued on Page 4)

Contents

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

Publication staff:
Cindi Fox
Terri Drury
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

Examining the difference between an NPI and a PTAN

Provider types affected

This *MLN Matters*® special edition article is intended for physicians, providers, and suppliers who are enrolled in Medicare.

What You Need to Know

This article explains the difference between a national provider identifier (NPI) and a provider transaction access number (PTAN). There are no policy changes in this article.

Background

New enrollees

All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare contractor, the provider or supplier will also be issued a provider transaction access number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI.

Revalidation

Section 6401(a) of the Affordable Care Act established a requirement for all enrolled physicians, providers, and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Providers and suppliers receiving requests to revalidate their enrollment information have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the differences between the NPI and the PTAN.

National provider identifier (NPI)

The NPI is a national standard under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions.

- The NPI is a unique identification number for covered health care providers.
- The NPI is issued by the National Plan and Provider Enumeration System (NPPES).
- Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions (for example, insurance claims) adopted under HIPAA.
- The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI does not carry information about healthcare providers, such as the state in which they live or their medical specialty. This reduces the chances of insurance fraud.
- Covered providers and suppliers must share their NPI with other suppliers and providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Since May 23, 2008, Medicare has required that the NPI be used in place of all legacy provider identifiers, including the unique physician identification number (UPIN), as the unique identifier for all providers, and suppliers in HIPAA standard transactions.

You should note that individual health care providers (including physicians who are sole proprietors) may obtain only one NPI for themselves (Entity Type 1 Individual). Incorporated individuals should obtain one NPI for themselves (Entity Type 1 Individual) if they are health care providers and an additional NPI(s) for their corporation(s) (Entity Type 2 Organization). Organizations that render health care or furnish health care supplies may obtain NPIs (Entity Type 2 Organization) for their organizations and their subparts (if applicable).

For more information about the NPI, visit the NPPES website at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.

Provider transaction access number (PTAN)

A PTAN is a Medicare-only number issued to providers by Medicare contractors upon enrollment to Medicare. When a Medicare contractor approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

- The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using Medicare contractor self-help tools such as the interactive voice response (IVR) phone system, Internet portal, online application status, etc.
- The PTAN's use should generally be limited to the provider's contacts with Medicare contractors.

Relationship of the NPI to the PTAN

The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider's enrollment. If the provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANS are generally assigned.

Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the Provider Enrollment Chain & Ownership System (PECOS), the master provider and supplier enrollment system.

Protect your information in PECOS

All providers and suppliers should carefully review their PECOS records in order to protect themselves and their

(continued on next page)

Difference *(continued)*

practices from identity theft. PECOS should only contain active enrollment records that reflect current practice and group affiliations. You can review and update your PECOS records in the following ways:

- Use Internet-based PECOS: Log on to internet-based PECOS at *https://pecos.cms.hhs.gov/pecos/login.do*.
- Use the paper CMS 855 enrollment application (i.e., 855A, 855B, 855I, 855O, 855R, or 855S).
- Note: The Medicare contractor may not release provider specific information to anyone other than the individual provider, authorized/delegated official of the provider organization, or the contact person. The request must be submitted in writing on the provider's letterhead and signed by the individual provider, authorized/delegated official of the organization or the contact person.

The MLN fact sheet titled "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)," provides guidelines and steps you can take to protect your identity while using Internet-based PECOS. This fact sheet is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf*.

Additional information

MLN Matters® special edition article SE1126 titled "Further Details on the Revalidation of Provider Enrollment Information," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf*.

"Medicare Provider–Supplier Enrollment National Educational Products," contains a list of products designed to educate Medicare fee-for-service (FFS) providers about important Medicare enrollment information, including how to use Internet-based PECOS to enroll in the Medicare program and maintain their enrollment information. This resource is available at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf*.

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

MLN Matters® Number: SE1216 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

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.

Healthcare provider taxonomy code updates effective July 1, 2012

Effective July 1, 2012, the health care provider taxonomy code (HPTC) set, which allows providers to indicate their specialty, will be updated. The National Uniform Claim Committee (NUCC) updates the code set twice a year with changes effective April 1 and October 1. The latest version of the HPTC set is available from the Washington Publishing Company's website at *www.wpc-edi.com/codes/taxonomy*. If an invalid HPTC is reported to Medicare, a batch and/or claim-level deletion (rejection) may occur. To ensure you do not receive a claim or file-level rejection, it is recommended that you verify the HPTC is valid (i.e., included in the most recent HPTC set) before submitting. If you require assistance with updating the taxonomy code set in your practice management system, please contact your software support vendor.

Source: Change request (CR) 7742

Edit (*continued*)

MLN Matters® Number: MM7771
Related Change Request (CR) #: CR 7771
Related CR Release Date: May 4, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2463CP
Implementation Date: October 1, 2012

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.

Additional instructions related to CR 7633 – screening and behavioral counseling interventions in primary care to reduce alcohol misuse

Provider types affected

This *MLN Matters*® article is intended for physicians, providers and suppliers submitting claims to fiscal intermediaries (FI), carriers and A/B Medicare administrative contractors (A/B MAC) for screening and behavioral counseling services provided to Medicare beneficiaries.

What you need to know

If a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in Medicare's claims history within a prior 12-month period, change request (CR) 7791 requires contractors to deny these claims. Be sure to inform your staff of these changes.

Background

Pursuant to section 1861(ddd) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) may add coverage of "additional preventive services" through the national coverage determination (NCD) process if all of the following criteria are met. They must be: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare Program. CMS reviewed the USPSTF's "B" recommendation and supporting evidence for "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse" preventive services and determined that all three criteria were met.

According to the USPSTF (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems; and in the general adult population, risky or hazardous drinking is defined as >7 drinks per week or >3 drinks per occasion for women, and >14 drinks per week or >4 drinks per occasion for men. Harmful drinking describes those persons currently experiencing physical, social or psychological harm from alcohol use, but who do not meet criteria for dependence.

In the Medicare population, Saitz (2005) defined risky use as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age, and >14 standard drinks per week or >4 drinks per occasion for men ≤65 years of age. Importantly, Saitz included the caveat that such thresholds do not apply to pregnant women for whom the healthiest choice is generally abstinence. The 2005 *Clinician's Guide* from the National Institutes of Health National Institute on Alcohol Abuse and Alcoholism also stated that clinicians recommend lower limits or abstinence for patients taking medication that interacts with alcohol, or who engage in activities that require attention, skill, or coordination (e.g., driving), or who have a medical condition exacerbated by alcohol (e.g., gastritis).

In the Medicare population, "risky" alchohol use is defined as > 7 drinks per week or > 3 drinks per occasion for women and persons > 65 years of age.

CR 7791 adds further instructions for contractors if a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in claims history within a prior 12-month period. It requires contractors to deny such claims with the following specific messages:

- Claim adjustment reason code (CARC) B15 – this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) M16 – Alert: Please see our website, mailings, or bulletins for more details concerning this policy/ procedure/decision.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary, if a claim is received with a modifier indicating a signed advanced beneficiary notice (ABN) is on file.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received without a modifier indicating no signed ABN is on file.

Also, remember that Medicare will only pay for up to four G0443 services within a 12-month period. Claims for G0443 that exceed that four session limit in a 12 month period will be rejected.

(continued on next page)

Alcohol *(continued)*

Additional information

The official instruction, CR 7791, issued to your FI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2454CP.pdf*.

The *MLN Matters*® article MM7663, entitled, "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse," may be viewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7633.pdf*.

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

MLN Matters® Number: MM7791
Related Change Request (CR) #: 7791
Related CR Release Date: April 26, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2454CP
Implementation Date: October 1, 2012

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.

Negative pressure wound therapy interpretive guidelines

Provider types affected

This *MLN Matters*® special edition article is intended for suppliers who submit claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for negative pressure wound therapy services provided to Medicare beneficiaries.

What you need to know

This article is intended to provide interpretive guidance to Centers for Medicare & Medicaid Services (CMS) approved accrediting organizations to use in their accreditation of suppliers that provide negative pressure wound therapy (NPWT) equipment to Medicare beneficiaries. These guidelines also apply to suppliers that are furnishing NPWT equipment to Medicare beneficiaries. SE 1222 is also intended to assist the supplier in understanding their responsibilities related to this equipment in order to be in compliance with CMS durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) quality standards.

Background

(NPWT is defined as the application of sub-atmospheric pressure to a wound to remove exudate and debris from the wound(s). NPWT is delivered to a qualified wound through an integrated system that includes:

- A suction pump;
- A separate exudate collection chamber; and
- Dressing sets.

In these systems, the exudate is completely removed from the wound site to the collection chamber.

This special edition article, while assisting the supplier of NPWT to fulfill all CMS DMEPOS quality standards, does not contain a detailed discussion of all coverage and documentation requirements pertinent to this subject. Please consult the appropriate local coverage determination (LCD) (or local coverage article) more complete information using the Medicare coverage database quick search at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Some of the more pertinent LCDs, per DME MAC Jurisdiction, are as follows:

Jurisdiction A:

- L11500 – see (LCD for negative pressure wound therapy pumps) *http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11500&ContrId=137&ver=35&ContrVer=1&Date=&DocID=L11500&bc=iAAAAAgAAAAA&*.
- A35347 – see (LCD for negative pressure wound therapy pumps – policy article – effective October 2011) *http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35347&ver=17&ContrId=137&ContrVer=1&LCDId=11500&Date=&DocID=L11500&IsPopup=y&*.

Jurisdiction B:

- L27025 – see (LCD for negative pressure wound therapy pumps) *http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=27025&ContrId=138&ver=12&ContrVer=1&Date=&DocID=L27025&bc=iAAAAAgAAAAA&*.
- A47111 – see (LCD for negative pressure wound therapy pumps – policy article – effective October

(continued on next page)

Wound *(continued)*

2011) *http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=47111&ver=8&ContrId=138&ContrVer=1&CntrctrSelected=138*1&Date=&DocID=A47111&bc=hAAAAAgAAAAA&*.

Jurisdiction C:

- L5008 – see (LCD for negative pressure wound therapy pumps) *http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=5008&ContrId=140&ver=46&ContrVer=2&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&LCntrctr=140*2&bc=AgACAAIAAAAA&*.
- A35363 – see (LCD for negative pressure wound therapy pumps – policy article – effective October 2011) *http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35363&ver=19&ContrId=140&ContrVer=2&CntrctrSelected=140*2&Date=&DocID=A35363&bc=hAAAAAgAAAAA&*.

Jurisdiction D:

- L11489 – see (LCD for negative pressure wound therapy pumps) *http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11489&ContrId=139&ver=39&ContrVer=1&Date=&DocID=L11489&bc=iAAAAAgAAAAA&*.
- A35425 – see (LCD for negative pressure wound therapy pumps – policy article) *http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35425&ver=17&ContrId=139&ContrVer=1&LCDId=11489&Date=&DocID=L11489&IsPopup=y&*.

Note: These interpretive guidelines do not address clinical aspects of NPWT, nor do they intend to assign clinical responsibilities to DMEPOS suppliers that provide the NPWT equipment to Medicare beneficiaries.

In addition to the LCDs and articles, following are some guidelines for the CMS DMEPOS quality standards that CMS uses to ascertain compliance with standards:

I. Supplier business services requirements

Consumer services

CMS DMEPOS quality standard: Suppliers shall provide information and telephone number(s) for customer service, regular business hours, after-hours access, equipment and/or item(s) repair, and emergency coverage.

Interpretive guidelines: Suppliers shall demonstrate that they have provided the beneficiary/caregiver with the following information:

1. How to contact the supplier for equipment problems both during business hours and after hours through a 24/7 support function provided by the manufacturer or supplier;
2. How to access supplier staff for 24/7 technical product consultation; and
3. That they shall call their physician or 911 if a medical emergency arises.

Product safety

CMS DMEPOS quality standards: Suppliers shall implement and maintain a plan for identifying, monitoring and reporting equipment and item(s) failure, repair and preventive maintenance provided to beneficiaries:

Suppliers shall implement a program that promotes the safe use of equipment and item(s) and minimizes safety risks, infections, and hazards both for its staff and for beneficiaries:

Interpretive guideline: Suppliers shall demonstrate that they have ensured the equipment is cleaned between uses by different beneficiaries per the manufacturers' recommendations.

II. Supplier product-specific service requirements

Intake and assessment

CMS DMEPOS quality standard: The supplier shall consult with the prescribing physician as needed to confirm the order and to recommend any necessary changes, refinements, or additional evaluations to the prescribed equipment, item(s), and/or service(s).

Interpretive guidelines: The supplier shall:

- Ensure the physician order contains all of the documentation requirements in the LCD, including the pump type and necessary supplies.
- If there is a home health agency involved in the patient's care, identify and document in the patient's record the home health care provider by contacting the physician.

CMS DMEPOS quality standard: The supplier shall review the beneficiary's record as appropriate and incorporate any pertinent information, related to the beneficiary's condition(s) which affect the provision of the DMEPOS and collaboration with the prescribing physician.

Interpretative guidelines: The supplier shall:

1. Confirm that the wound type or risk factors in the patient record are not among those listed in the most recent public health notification of the U.S Food and Drug Administration.

(continued on next page)

Wound *(continued)*

Refer to the FDA's link for all of the specific clinical information at *http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm190704.htm*.

2. Confirm that if the wound type or any of the risk factors included in the patient's record are also in the most recent guidance issued by the FDA, there is a written approval from the patient's physician that the NPWT equipment is appropriate for this patient.
3. Not supply the NPWT equipment to a beneficiary without the physician's written approval.

Delivery and set-up

CMS DMEPOS quality standard: Suppliers shall deliver and set-up, or coordinate set-up with another supplier, all equipment and item(s) in a timely manner as agreed upon by the beneficiary and/or caregiver, supplier, and prescribing physician.

Interpretive guidelines: Suppliers shall:

1. Coordinate the delivery of the equipment with the home health care providers' home visit, if there is a home health agency (HHA) involved in the patient's care.
2. Deliver the NPWT pump, dressings, and supplies prior to a beneficiary's discharge from the hospital, if the patient is being discharged from an acute care facility.

CMS DMEPOS quality standard: Suppliers shall provide all equipment and item(s) that are necessary to operate the equipment or item(s) and perform any further adjustments as applicable.

Interpretive guidelines: The supplier shall demonstrate that they have (prior to home delivery):

1. Performed quality checks on pumps, tubing, dressings, drapes, containers, and canisters per the manufacturer maintenance schedule, before delivery;
2. Confirmed that each NPWT component is operational and that equipment and supplies are available and complete prior to setup or at the time of setup;
3. Confirmed that all of the supplies are within expiration date;
4. Confirmed that the number and sizes of dressings are correct and the packaging is sterile;
5. Confirmed that the correct pump, containers/canisters, dressing, tubing is used for the specific brand of equipment according to manufacturer requirements;
6. Confirmed that clamps are available if required;
7. Confirmed that the exudate collection containers or canister are specific to the NPWT system being used;
8. Confirmed that the beneficiary has sufficient number of exudate collection containers to meet his/her wound needs based on the patient's history of drainage amount;
9. Confirmed that the alarms are setup and working properly, capable of sounding an audible alarm and/or visual alarm, dependent upon the pump type when desired pressures are not being achieved (that is, where there is a leak in the dressing seal) or the wound drainage container/canister is full or the battery is low;
10. Confirmed that the pump and the wound system (stationary or portable) are operational during use.

CMS DMEPOS quality standard: Suppliers shall provide, or arrange for, loaner equipment equivalent to the original equipment during any repair period except for orthotics and prosthetics

Interpretive guidelines: The supplier shall demonstrate that they have:

1. Performed or arranged maintenance and repairs or replacement of the pump and supplies;
2. Given information to the beneficiary and/or caregiver(s) on how to obtain service for purchased equipment.

Training/instruction to beneficiary and/or caregiver(s)

CMS DMEPOS quality standards: Suppliers shall provide relevant information and/or instructions about infection control issues related to the use of all equipment and item(s) provided. Suppliers shall provide or coordinate the provision of, appropriate information related to the set-up, features, routine use, troubleshooting, cleaning, infection control practices and maintenance of all equipment and item(s) provided.

Interpretive guidelines: Suppliers shall demonstrate that they have provided training to the beneficiary/caregiver:

- That is specific to the system being used; and
- At a minimum it includes:

1. Verification that new packages are not torn, damaged or opened prior to use;
2. Operation of the pump and its settings;

(continued on next page)

Wound *(continued)*

3. Written instructions that are left with the beneficiary/caregiver on the safety section of the manufacturer's manual after they have been reviewed by the supplier at a comprehension level applicable for the beneficiary/caregiver needs;
4. Instructions on not servicing any of the equipment without calling the supplier first;
5. What to do in case of equipment-related complications, including power failure, dislodged tube, accidental disconnection from pump and low battery;
6. Equipment troubleshooting in case of equipment-related complications, including situations where tube replacement may be required; or alarm will not turn off or other failure of the pump or its supplies;
7. How to contact the supplier if the physician changes settings, or the pump stops working or any review is necessary of the initial instruction;
8. Contacting the supplier if the system shuts off;
9. How to disconnect the system to take a shower or bath;
10. How to disconnect the system when toileting, if the system is not portable;
11. How to respond when the pump is turned off and the alarm sounds after a period of time;
12. Review of the physician's order for the length of time per day that the pump has to be used;
13. What to do if there is a sudden or rapid increase of blood under the drape, in the tubes or container;
14. When to immediately turn off the pump;
15. When to call the physician or other treating practitioner;
16. Contacting the supplier if the NPWT is being discontinued or if the beneficiary is being transferred to another setting;
17. How to arrange with the supplier for pickup or shipment of the system;
18. The function of the clamps on the tubing both open and closed;
19. How to attach, remove, and change the exudates collection container;
20. Importance of infection control procedures such as good hand washing techniques when working with the pump and its supplies;
21. How to keep the pump clean, the importance of not spilling liquids or food on the pump and wipe off spills immediately;
22. Instruction on the frequency of canister changes. No canisters are to be re-used;
23. Disposal procedure of the tubing, dressings and canister according to local waste policy requirements.
24. The beneficiary/caregiver is given written warranty information for purchased equipment.

Follow-up

CMS DMEPOS quality standard: Suppliers shall provide follow-up services to the beneficiary and/or caregiver(s), consistent with the type(s) of equipment, item(s) and service(s) provided, and recommendations from the prescribing physician or healthcare team member(s).

Interpretive guidelines: The supplier shall have an on-going individualized service plan with a defined frequency that addresses, defines or confirms;

1. The ongoing operation and maintenance of the equipment, operation and maintenance of the equipment;
2. The frequency for scheduled/planned delivery or supply of additional supplies
3. That the beneficiary is using the equipment per the physicians order
4. The supplier picks up the equipment when it is no longer needed per the physicians orders.

Additional information

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

MLN Matters® Number: SE1222
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

Physician's guide to Medicare's home health certification, including the face-to-face encounter

Provider types affected

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

What you need to know

1. Requirements which must be met in order for a patient to qualify for Medicare's home health benefit.

The patient must:

- be confined to the home;
- be under the care of a physician;
- receive services under a plan of care established and periodically reviewed by a physician;
- be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology, or have a continuing need for occupational therapy.

2. Physician home health certification requirements

- Physician must be Medicare-enrolled;
    - When a resident is not Medicare-enrolled, the Medicare-enrolled teaching physician, who is supervising the resident, would sign the certification.
- The certifying physician must certify that the patient is receiving home health services under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine; and
- The certifying physician must not have a financial relationship with the home health agency, as defined in 42 CFR 411.354, unless exceptions to the referral prohibition defined in Section1877 of the Social Security Act apply.

3. Timeframe for completion of the certification

- Must be obtained when the plan of treatment is established, or as soon as possible thereafter;
- Must be signed and dated by the physician who established the plan; and
- Must be complete prior to the home health agency billing Medicare.

4. Certification content requirements

The physician must certify that:

- Home health services are or were needed because the patient is homebound.
- The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased. Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan), the physician must include a brief narrative describing the clinical justification of this need as part of the certification and recertification, or as a signed addendum to the certification and recertification.
- A plan of care has been established and is periodically reviewed by a physician.
- The services are or were furnished while the patient is or was under the care of a physician.

5. Face-to-face requirements

- For initial home health certifications, the certifying physician must document that the physician himself or herself, an allowed NPP, or a physician caring for the patient in an acute or post-acute facility who has privileges at the facility had a face-to-face encounter with the patient.
- The face-to-face encounter must occur within 90 days prior to the home health start of care date or within 30 days after the start of care.
- The face-to-face encounter can be performed via a telehealth service, in an approved originating site.
- Prior to billing, the home health agency should ensure that all certifications are complete, including that the face-to-face documentation that has been clearly titled, dated, and signed by the certifying physician.

6. Face-to-face documentation requirements

- Documentation must be clearly titled, dated, and signed by the certifying physician, whether

(continued on next page)

Certification *(continued)*

as part of the certification form itself, or as an addendum. It must also include the date the face-to-face encounter was performed.

- Documentation includes a brief narrative which describes how the patient's clinical condition, as seen during that encounter, supports the patient's homebound status and need for skilled services.
- The face-to-face documentation must be that of the certifying physician, and cannot be altered/changed in any way by the home health agency.

- The face-to-face documentation is part of the certification, and the certification is required at the time the home health agency bills Medicare.
- The face-to-face documentation can include, or exist as, checkboxes so long as it comes from the certifying physician.
- If the physician who cared for the patient in the acute or post-acute facility chooses to use documentation that is compiled from the patient's medical record (e.g. a discharge summary) to inform the certifying physician of how the clinical findings of the face-to-face encounter support Medicare home health eligibility for that patient, the compiled documentation must be reflective of the clinical findings of that face-to-face encounter as observed by that physician caring for the patient in the acute or post-acute facility, thus serving as that physician's communication to the certifying physician. Further, if the certifying physician chooses to use the encounter documentation from the informing physician as his or her documentation of the face-to-face encounter, the certifying physician must sign and date the documentation, demonstrating that the certifying physician received that information from the physician who performed the face-to-face encounter, and that the certifying physician is using that discharge summary or documentation as his or her documentation of the face-to-face encounter. One physician signature, from the certifying physician, suffices if the face-to-face encounter documentation is co-located with the physician's certification of eligibility. Otherwise, if the face-to-face documentation is attached as an addendum to the certification (a separate document), the face-to-face documentation and certification each require a signature from the certifying physician.
- Electronic signatures are acceptable.

7. Who can perform the face-to-face encounter?

- Medicare-enrolled physicians who are also the certifying physician;
- The following physicians are allowed to perform the face-to-face encounter and inform the certifying physician:
  - Physicians (Medicare-enrolled or otherwise) who cared for the patient in an acute or post-acute facility during a recent acute or post-acute stay and have privileges at the facility;
  - Because residents (Medicare-enrolled or otherwise) do not have privileges at acute or post-acute facilities, if they are performing the encounter and informing the certifying physician, they must inform the certifying physician under the supervision of their teaching physician who must have such privileges.
- NPPs allowed to perform the face-to-face encounter include:
  - A nurse practitioner or clinical nurse specialist working in collaboration with the certifying physician in accordance with state law;
  - A certified nurse-midwife under the supervision of the certifying physician, as authorized by state law; and
  - A physician assistant under the supervision of the certifying physician.
- NPPs are subject to the same financial restrictions with the home health agency as the certifying physician.

(continued on next page)

Certification *(continued)*

8. Recertifications

- Face-to-face encounter documentation is only required for the initial certification
- At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode.

Additional information

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

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

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

MLN Matters® Number: SE1219
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

Register for free, hands-on Internet based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, *interactive session* on using Internet-based PECOS to electronically create or update your Medicare enrollment. Select from the following session dates: June 19, July 17, August 21, or September 11, 2012.

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

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

Effective and notice dates

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

Contents

Advance beneficiary notice

- **Modifier GZ** must be used when providers, 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 providers, 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 (LCD) must append the billed service with **modifier GA or GZ.**

Additional Information

Medical nutrition therapy (MNT) – national guidelines

According to the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 4, Section 300 and the *Medicare National Coverage Determinations (NCD) Manual*, Pub. 100-03, Chapter 1, Section 180.1, *Section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permits Medicare coverage of medical nutrition therapy (MNT) services (CPT/*HCPCS codes *97802, 97803, 97804*, G0270, *and* G0271) *when furnished by a registered dietitian or nutrition professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when referral is made by a physician as defined in §1861(r)(l) of the Act*.

- *97802 (Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes)*
- *97803 (Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes)*
- *97804 (Medical nutrition therapy; group [2 or more individual(s)], each 30 minutes)*
- G0270 (Medical nutrition therapy; reassessment and subsequent intervention[s] following second referral in same year for change in diagnosis, medical condition or treatment regimen [including additional hours needed for renal disease], individual, face-to-face with the patient, each 15 minutes)
- G0271 (Medical nutrition therapy; reassessment and subsequent intervention[s] following second referral in same year for change in diagnosis, medical condition or treatment regimen [including additional hours needed for renal disease], group [2 or more individuals], each 30 minutes)

Based on data analysis First Coast Service Options Inc. (FCSO) has determined that claims have been paid in error based on indications not included in NCD 180.1 for MNT services. Therefore, in order to avoid claims from being paid incorrectly in the future, FCSO is implementing editing based on NCD 180.1 effective for claims processed **on or after July 12, 2012**, for services rendered **on or after February 2, 2009**, for Florida and **on or after March 2, 2009**, for Puerto Rico/U.S. Virgin Islands. Additionally, FCSO will be recovering overpayments for those claims identified as having been paid in error.

Medicare A Connection subscription

Medicare A Connection is published monthly and is available online in both *English* and *Spanish.* Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published from October 2011 through September 2012.

To order an annual subscription, complete the *Medicare A Connection Subscription Form.*

Return of claims when there is a name and HICN mismatch

Provider types affected

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

Provider action needed

If Medicare systems reject a claim when the beneficiary name does not match the health insurance claim number (HICN), your Medicare contractor will return the claim to you as unprocessable with the identifying beneficiary information from the submitted claim as follows:

- Your contractor will return to provider (RTP) Part A claims.
- Your contractor will return as unprocessable Part B claims. Your contractor will use reason code 140 (Patient/insured health identification number and name do not match).

When returning these claims as unprocessable, your contractor will utilize remittance advice codes MA130 and MA61. Also, based on CR 7260, you will receive the beneficiary name information you originally submitted when the claim is returned rather than the beneficiary data associated with the potentially incorrectly entered HICN. Previously, Medicare returned the name of the beneficiary that is associated with that HICN within its files.

If an adjustment claim is received where the beneficiary's name does not match the submitted HICN, your contractor will suspend the claim and, upon their review, either correct, develop, or delete the adjustment, as appropriate.

All providers should ensure that their billing staffs are aware of these changes.

Additional information

The official instruction, CR 7260 issued to your FI, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2449CP.pdf*.

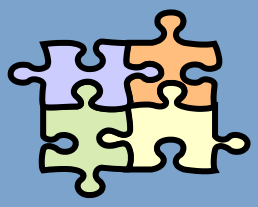
If you have any questions, please contact your carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7260
Related Change Request (CR) #: CR 7260
Related CR Release Date: April 26, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2449CP
Implementation Date: October 1, 2012

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.

Puzzled about your enrollment status?

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



New influenza virus vaccine code

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), Medicare administrative contractors (A/B MAC) and regional home health intermediaries (RHHI) for providing influenza virus vaccines to Medicare beneficiaries.

Provider action needed

Effective for claims with dates of service on or after July 1, 2012, Medicare will pay for influenza virus vaccine code Q2034. Change request (CR) 7794, from which this article is taken, provides instructions for the payment of influenza virus vaccine code Q2034 for claims with dates of service on or after July 1, 2012, processed on or after October 1, 2012. Annual Part B deductible and coinsurance amounts do not apply. You should make sure that your billing staffs are aware of this new code for influenza virus vaccine.

Background

Effective July 1, 2012, your Medicare carrier, FI, A/B MAC, or RHHI will begin accepting influenza virus vaccine code Q2034 (for dates of service on or after that date); and will add it to existing influenza virus vaccine common working file (CWF) edits. For professional claims, for dates of service of July 1, 2012 through September 30, 2012, your contractor will use local pricing guidelines to determine payment rates for Q2034. After September 30, 2012, professional claims will be paid using the Medicare Part B payment limit for Q2034 according to the established payment rate in the October 2012 Part B drug pricing file.

Processing institutional claims

Your contractor will pay for influenza virus vaccine code Q2034 based on reasonable cost

- Hospitals using type of bill (TOB) 12x and 13x;
- Skilled nursing facilities (SNF) using TOB 22x and 23x;
- Home health agencies (HHA) using TOB 34x;
- Hospital-based renal dialysis facilities (RDF) using TOB 72x; and
- Critical access hospitals (CAH) using TOB 85x.

Your contractor will pay for influenza virus vaccine code Q2034 based on the lower of the actual charge or 95 percent of the average wholesale price (AWP)

- Indian Health Service (IHS) hospitals using TOB 12x and 13x; and to:
- IHS CAHs using TOB 85x.
- Comprehensive outpatient rehabilitation facilities (CORF) using TOB 75x; and
- Independent RDFs using TOB 72x.

Until systems are implemented, your contractor will hold institutional claims, containing code Q2034, with dates of service on or after July 1, 2012; and that are received before October 1, 2012. Upon implementation of CR 7794 on October 1, contractors will begin to process the held claims.

Additional information

You can find more information about the new code for influenza virus vaccine (Q2034) by going to CR 7794, located at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2446CP.pdf*.

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

MLN Matters® Number: MM7794
Related Change Request (CR) #: CR 7794
Related CR Release Date: April 26, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R2446CP
Implementation Date: October 1, 2012

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.

New occurrence code to report date of death

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who bill Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) or A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7792, which announces that the National Uniform Billing Committee (NUBC) approved a new occurrence code to report date of death with an effective/ implementation date of October 1, 2012. Medicare systems will accept and process new occurrence code 55 used to report date of death. Be sure your staffs are aware of this change.

Background

The NUBC approved a new occurrence code to report date of death with an effective/ implementation date of October 1, 2012. Medicare systems will accept and process new occurrence code 55 used to report date of death. For claims submitted effective October 1, 2012, occurrence code 55 and the date of death must be present when patient discharge status code 20 (expired), 40 (expired at home), 41 (expired in a medical facility), or 42 (expired – place unknown) is present.

Additional Information

The official instruction, CR 7792, issued to your FI, RHHI, or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1079OTN.pdf*.

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

MLN Matters® Number: MM7792 Revised
Related Change Request (CR) #: 7792
Related CR Release Date: April 27, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R1079OTN
Implementation Date: October 1, 2012

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.

Ensuring hospice certifying physician identifiers are fully processed

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7755 which informs Medicare contractors about the requirements for hospice providers to code the national provider identifier (NPI) and name of the hospice physician responsible for certifying that the patient is terminally ill.

Hospice agencies are required to report the physician that certified the hospice patient's terminal illness on the claim when the certifying physician differs from the attending physician. The certifying physician is reported on the UB-04 claim in the "Other Physician" field. With the implementation of the electronic claim 837I version 5010A2 format, the field for "other physician" is mapped to three possible physician identifying fields. Hospice agencies reporting the physician certifying the terminal illness using the electronic claim 837I version 5010A2 format should report this information in the 2310F loop of that claim. Be sure billing staff are aware of this requirement.

Additional information

The official instruction, CR 7755 issued to your FI, RHHI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2448CP.pdf*.

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

MLN Matters® Number: MM7755
Related Change Request (CR) #: 7755
Related CR Release Date: April 26, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R2448CP
Implementation Date: October 1, 2012

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.

Temporary directions to accommodate organ donor complications billing on 837I claims

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7816 which instructs providers to use a temporary work around to enable the payment of claims for organ donor complications.

Caution – what you need to know

Traditionally for Medicare claims, the patient is always the beneficiary and therefore the patient relationship has always been a one-to-one match. However, Medicare policy has changed and Medicare will now pay for complication services separately for a person who donates an organ donor to a Medicare beneficiary. In this case the one-to-one patient relationship no longer exists. In order to allow 837I claims for organ donor complications to enter into Medicare systems, a temporary work-around has been developed until a more permanent solution can be found.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding these changes and how to code claims for organ donor complications during this temporary process.

Background

The Centers for Medicare & Medicaid Services (CMS) is instructing that providers submitting institutional electronic claim 837I for organ donor complications will:

- Show the patient relationship of "18" (Self) in Form Locator (FL) 59 (Patient's Relation to Insured) on all 837I claims.
- Submit the Medicare beneficiary's information in the following FLs: 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex).
- Add a value of "39" along with the donor's name to the 837I Loop 2300, Billing Note Segment NTE02 (NTE01 = ADD).

Providers using the UB-04 paper claim and direct data entry will:

- Show the patient relationship of "39" (Organ Donor) in Form Locator (FL) 59 (Patient's Relation to Insured); and
- Submit the Medicare beneficiary's information in the following FLs: 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex).
- Enter the donor's name in FL 80 (Remarks)

Additional information

The official instruction, CR 7816, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1083OTN.pdf*.

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

MLN Matters® Number: MM7816
Related Change Request (CR) #: CR 7816
Related CR Release Date: April 27, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R1083OTN
Implementation Date: October 1, 2012

Revised editing for hepatitis B administration code G0010

Note: This article was revised on April 30, 2012, to reflect the revised change request (CR) 7692 issued on April 4, 2012. The article was revised to reflect a revised CR release date, transmittal number, and Web address for accessing CR 7692. All other information is the same. This information was previously published in the February 2012 *Medicare A Connection*, Page 36.

Provider types affected

All providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), and A/B Medicare administrative contractors (MACs) for services paid under the outpatient prospective payment system (OPPS) are affected.

Provider action needed

This article is based on CR 7692 which informs Medicare contractors that effective for claims processed with dates of service on or after January 1, 2011, OPPS providers should report code G0010 for the administration of hepatitis B vaccine rather than *90471* or *90472* to ensure the correct waiver of coinsurance and deductible for the administration of hepatitis B vaccine. If any claims containing this code were processed incorrectly prior to the implementation of CR 7692, you should bring them to the attention of your contractor on or after July 2, 2012, for adjustment. Please make sure your billing and coding staffs are aware of these changes.

Background

In CR 7342, Transmittal 2174, dated March 18, 2011, the Centers for Medicare & Medicaid Services (CMS) retroactively assigned HCPCS code G0010 to APC 0436, Level I, Drug Administration, and changed the status indicator for HCPCS code G0010 from status indicator "B" to status indicator "S" effective January 1, 2011.

At the time of the release of CR7342, the *Medicare Claims Processing Manual* was not updated to reflect this revised billing guidance. In CR 7692, CMS is updating the *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.1, to reflect the current billing instructions

Additional information

CR 7692, the official instruction issued to your FI and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2438CP.pdf*.

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

MLN Matters® Number: MM7692 Revised
Related Change Request (CR) #: 7692
Related CR Release Date: April 4, 2012
Effective Date: January 1, 2011
Related CR Transmittal #: R2438CP
Implementation Date: July 2, 2012

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.

Calculate the possibililtes ...

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

Clarification of Medicare conditional payment policy and billing procedures for liability, no-fault, and workers' compensation MSP claims

Provider types affected

This *MLN Matters*® article is intended for physicians, hospitals, home health agencies, and other providers who bill Medicare carriers, fiscal intermediaries (FIs) or Medicare administrative contractors (A/B/MACs); and suppliers who bill durable medical equipment MACs (DME MACs) for Medicare beneficiary liability insurance (including self-insurance), no-fault insurance, and workers' compensation (WC) Medicare secondary payer (MSP) claims.

Provider action needed

This article provides clarifications in the procedures for processing liability insurance (including self-insurance), no-fault insurance and WC MSP claims. Not following the procedures identified in this article may impact your reimbursement. Change request (CR) 7355, from which this article is taken, clarifies the procedures you are to follow when billing Medicare for liability insurance (including self-insurance), no-fault insurance, or WC claims, when the liability insurance (including self-insurance), no-fault insurance, or WC carrier does not make prompt payment. It also includes definitions of the promptly payment rules and how contractors will identify conditional payment requests on MSP claims received from you. You should make sure that your billing staffs are aware of these Medicare instructions.

Background

CR 7355, from which this article is taken: 1) Clarifies the procedures to follow when submitting liability insurance (including self-insurance), no-fault insurance and WC claims when the liability insurer (including self-insurance), no-fault insurer and WC carrier does not make prompt payment or cannot reasonably be expected to make prompt payment; 2) Defines the promptly payment rules; and 3) Instructs you how to submit liability insurance (including self-insurance), no-fault insurance and WC claims to your Medicare contractors when requesting Medicare conditional payments on these types of MSP claims.

The term group health plan (GHP) as related to this MLN article means health insurance coverage that is provided by an employer to a Medicare beneficiary based on a beneficiary's own, or family member's, current employment status. The term non-GHP means coverage provided by a liability insurer (including self-insurance), no-fault insurer and WC carrier where the insurer covers for services related to the applicable accident or injury.

Key points

Conditional Medicare payment procedures

Medicare may not make payment on a MSP claim where payment has been made or can reasonably be expected to be made by GHPs, a WC law or plan, liability insurance (including self-insurance), or no-fault insurance.

Medicare can make conditional payments for both Part A and Part B WC, or no-fault, or liability insurance (including self-insurance) claims if payment has not been made or cannot be reasonably expected to be made by the WC, or no-fault, or liability insurance claims (including self-insurance) and the promptly period has expired. Note: If there is a primary GHP, Medicare may not pay conditionally on the liability, no-fault, or WC claim if the claim is not billed to the GHP first. The GHP insurer must be billed first and the primary payer payment information must appear on the claim submitted to Medicare.

These payments are made "on condition" that the trust fund will be reimbursed if it is demonstrated that WC, no-fault, or liability insurance is (or was) responsible for making primary payment (as demonstrated by a judgment; a payment conditioned upon the recipient's compromise, waiver, or release [whether or not there is a determination or admission of liability for payment for items or services included in a claim against the primary payer or the primary payer's insured]; or by other means).

"Promptly" definition

No-fault insurance and WC "promptly" definition

For no-fault insurance and WC, promptly means payment within 120 days after receipt of the claim (for specific items and services) by the no-fault insurance or WC carrier. In the absence of evidence to the contrary, the date of service for specific items and service must be treated as the claim date when determining the promptly period. Further with respect to inpatient services, in the absence of evidence to the contrary, the date of discharge must be treated as the date of service when determining the promptly period.

(*continued on next page*)

MSP (*continued*)

Liability insurance "promptly" definition

For liability insurance (including self-insurance), promptly means payment within 120 days after the earlier of the following:

- The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement; or
- The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

The *Medicare Secondary Payer (MSP) Manual* (*http://www.cms.gov/manuals/downloads/msp105c01.pdf*), Chapter 1 (Background and Overview), Section 20 (Definitions), provides the definition of promptly (with respect to liability, no-fault, and WC) which all Medicare contractors must follow.

Note: For the liability situation, the MSP auxiliary record is usually posted to the Medicare's common working file (CWF) after the beneficiary files a claim against the alleged tortfeasor (the one who committed the tort (civil wrong)) and the associated liability insurance (including self-insurance). In the absence of evidence to the contrary, the date the general liability claim is filed against the liability insurance (including self-insurance) is no later than the date that the record was posted on Medicare's CWF. Therefore, for the purposes of determining the promptly period, Medicare contractors consider the date the Liability record was created on Medicare's CWF to be the date the general liability claim was filed.

How to request a conditional payment

The following summarizes the technical procedures that Part A, and Part B and supplier contractors will use to identify providers' conditional payment requests on MSP claims.

Part A conditional payment requests

Providers of Part A services can request conditional non-GHP payments from Part A contractors on the hardcopy Form CMS-1450, if you have permission from Medicare to bill hardcopy claims, or the 837 institutional electronic claim, using the appropriate insurance value code (i.e., value code 14, 15 or 47) and zero as the value amount. Again, you must bill the non-GHP insurer, and the GHP insurer, if the beneficiary belongs to an employer group health plan, first before billing Medicare.

For hardcopy (CMS-1450) claims, providers must identify the other payer's identity on line A of Form Locator (FL) 50, the identifying information about the insured is shown on line A of FL 58-65, and the address of the insured is shown in FL38 or Remarks (FL 80). All primary payer amounts and appropriate codes must appear on your claim submitted to Medicare.

For 837 institutional claims, providers must provide the primary payer's zero value code paid amount and occurrence code in the 2300 HI. (The appropriate occurrence code (2300 HI), coupled with the zeroed paid amount and MSP value code (2300 HI), must be used in billing situations where you attempted to bill a primary payer in non-GHP (i.e., liability, no-fault and workers' compensation) situations, but the primary payer did not make a payment in the promptly period). **Note:** Beginning July 1, 2012 Medicare contractors will no longer be accepting 4010 claims; providers must submit claims in the 5010 format beginning on this date.

Table 1 displays the required information of the electronic claim in which a Part A provider is requesting conditional payments.

(*continued on next page*)

MSP (*continued*)

Table 1

Data requirements for conditional payment for Part A electronic claims

Type of insurance	CAS	Part A value code (2300 HI)	Value amount (2300 HI)	Occurrence code (2300 HI)	Condition code (2300 HI)
No-fault/ liability	2320 – valid information why NGHP or GHP did not make payment	14 or 47	$0	01-Auto accident & date 02-No-fault insurance involved & date 24-date insurance denied	
WC	2320 – valid information why NGHP or GHP did not make payment	15	$0	04-accident/tort liability & date 24-date insurance denied	02-Condition is Employment Related

Part B conditional payment requests (Table 2)

Since the electronic Part B claim (837 4010 professional claim) does not contain value codes or condition codes, the physician or supplier must complete the: 1) 2320AMT02 = $0 if the entire claim is a non-GHP claim and conditional payment is being requested for the entire claim; or 2) 2430 SVD02 for line level conditional payment requests if the claim also contains other service line activity not related to the accident or injury, so that the contractor can determine if conditional payment should be granted for Part B services related to the accident or injury.

For version 4010, physicians and other suppliers may include CP – Medicare conditionally primary, AP – auto insurance policy, or OT – other in the 2320 SBR05 field. The 2320 SBR09 may contain the claim filing indicator code of AM – automobile medical, LI – liability, LM – liability medical or WC – workers' compensation health claim. Any one of these claim filing indicators are acceptable for the non-GHP MSP claim types.

The 2300 DTP identifies the date of the accident with appropriate value. The "accident related causes code" is found in 2300 CLM 11-1 through CLM 11-3. **Note:** Beginning July 1, 2012, Medicare contractors will no longer accept 4010 claims; providers must submit claims in the 5010 format beginning on this date.

Table 2 displays the required information for a MSP 4010 professional in which a physician/supplier is requesting conditional payments.

Table 2

Data requirements for conditional payments for MSP 4010 professional claims

Type of insurance	CAS	Insurance type code (2320 SBR05)	Claim filing indicator (2320 SBR09)	Paid amount (2320 AMT or 2430 SVD02)	Insurance type code (2000B SBR05)	Date of accident
No-fault/ liability	2320 or 2430 valid information why NGHP or GHP did not make payment	AP or CP	AM, LI, or LM	$0.00	14	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA, AP or OA

(*continued on next page*)

MSP (*continued*)

Type of insurance	CAS	Insurance type code (2320 SBR05)	Claim filing indicator (2320 SBR09)	Paid amount (2320 AMT or 2430 SVD02)	Insurance type code (2000B SBR05)	Date of accident
WC	2320 or 2430 valid information why NGHP or GHP did not make payment	OT	WC	$0.00	15	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Please note that for 837 5010 professional claims, the insurance codes changed and the acceptable information for Medicare conditional payment request is modified as displayed in

Table 3

Data requirements for conditional payment for 837 5010 professional claims

Type of insurance	CAS	Insurance type code 2320 SBR05 from previous payer(s)	Claim filing indicator (2320 SBR09)	Paid amount (2320 AMT or 2430 SVD02)	Condition code (2300 HI)	Date of accident
No-fault/ liability	2320 or 2430 – valid information why NGHP or GHP did not make payment	14 / 47	AM or LM	$0.00		2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 – valid information why NGHP or GHP did not make payment	15	WC	$0.00	02- Condition is Employment Related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Note: Medicare beneficiaries are not required to file a claim with a liability insurer or required to cooperate with a provider in filing such a claim, but they are required to cooperate in the filing of no-fault claims. If the beneficiary refuses to cooperate in filing of no-fault claims Medicare does not pay.

Situations where a conditional payment can be made for no-fault and WC claims

Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates the no-fault insurance or WC is involved for that specific item or service;
- There is/was no open GHP record on the Medicare CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the no-fault insurer or WC entity first; and
- There is information on the claim that indicates the no-fault insurer or WC entity did not pay the claim during the promptly period.

(*continued on next page*)

MSP (*continued*)

Note: When a conditional payment is made to you, Medicare contractors will use remittance advice remark code M32 to indicate a conditional payment is being made.

Situations where a conditional payment can be made for liability (including self-insurance) claims

Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates liability insurance (including self-insurance) is involved for that specific item or service;
- There is/was no open GHP record on the Medicare's CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the liability insurer (including the self-insurer) first, and
- There is information on the claim that indicates the liability insurer (including the self-insurer) did not make payment on the claim during the promptly period.

Conditional primary Medicare benefits paid when a GHP is a primary payer to Medicare

Conditional primary Medicare benefits may be paid if the beneficiary has GHP coverage primary to Medicare and the following conditions are NOT present:

- It is alleged that the GHP is secondary to Medicare;
- The GHP limits its payment when the individual is entitled to Medicare;
- The services are covered by the GHP for younger employees and spouses but not for employees and spouses age 65 or over;
- If the GHP asserts it is secondary to the liability (including self-insurance), no-fault or workers' compensation insurer.

Situations where conditional payment is denied

Liability, no-fault, or WC claims denied

1. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - You did not send the claim to the employer GHP first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, or WC entity, but the insurer entity did not pay the claim.
2. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - The employer GHP denied the claim because the GHP asserted that the liability insurer (including the self-insurer), no-fault insurer or WC entity should pay first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, insurer or WC entity, but the insurer entity did not pay the claim.

Denial codes

To indicate that claims were denied by Medicare because the claim was not submitted to the appropriate primary GHP for payment, Medicare contractors will use the following codes on the remittance advice sent to you:

- Claim adjustment reason code 22 – "This care may be covered by another payer per coordination of benefits" and
- Remittance advice remark code MA04 – "Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible."

(*continued on next page*)

MSP (*continued*)

Additional information

You can find official instruction, CR 7355, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R86MSP.pdf*.

You will find the following revised Chapters of the *Medicare Secondary Payer Manual*, as an attachment to that CR:

Chapter 1 (Background and Overview):

- Section 10.7 (Conditional Primary Medicare Benefits),
- Section 10.7.1 (When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare), and
- Section 10.7.2 (When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare).

Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements):

- Section 30.2.1.1 (No-Fault Insurance Does Not Pay), and
- Section 30.2.2 (Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation).

Chapter 5 (Contractor Prepayment Processing Requirements):

- Section 40.6 (Conditional Primary Medicare Benefits),
- Section 40.6.1 (Conditional Medicare Payment), and
- Section 40.6.2 (When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable).

MLN Matters® Number: MM7355 Revised
Related Change Request (CR) #: 7355
Related CR Release Date: May 25, 2012
Effective Date: October 1, 2012, for professional claims and DME supplier claims; January 1, 2013, for institutional claims
Related CR Transmittal #: R86MSP
Implementation Date: January 7, 2013, for professional and DME supplier claims; January 7, 2013, for institutional claims

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

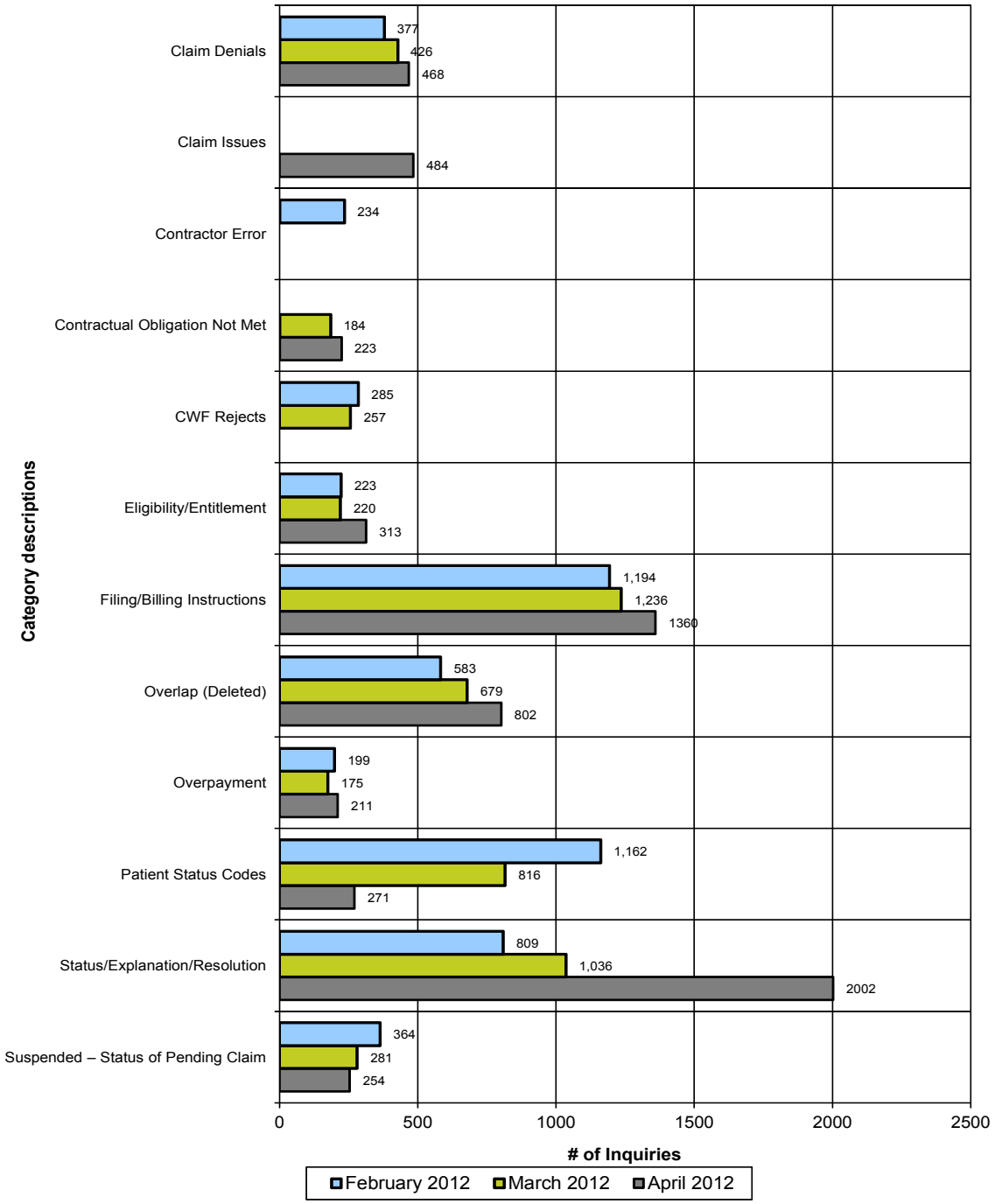
Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You'll find FCSO's most popular self-audit resources, including the E/M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

Top inquiries, rejects, and return to provider claims – February-April 2012

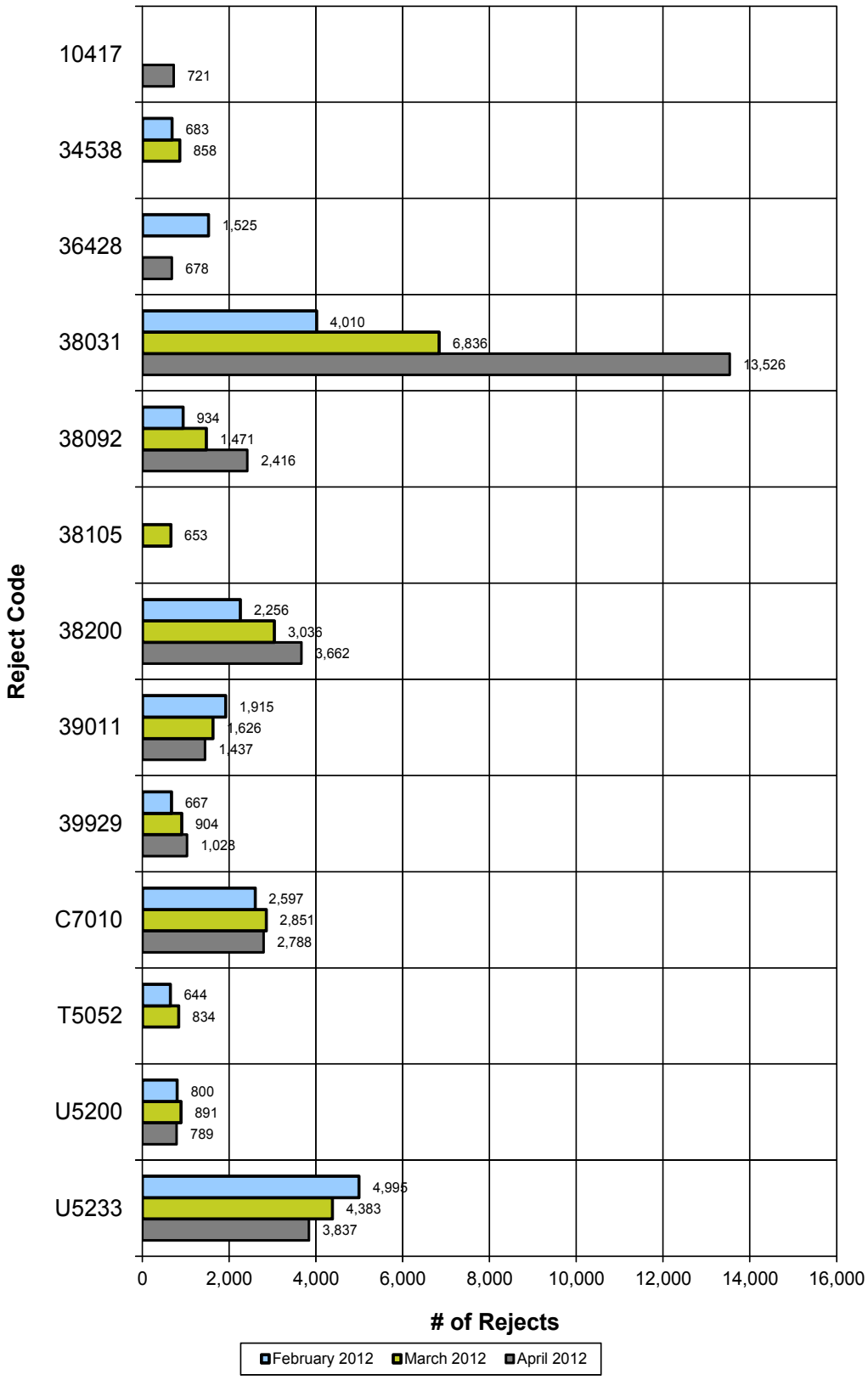
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (FCSO), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during February through April 2012.

For tips and resources to help providers to 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*.

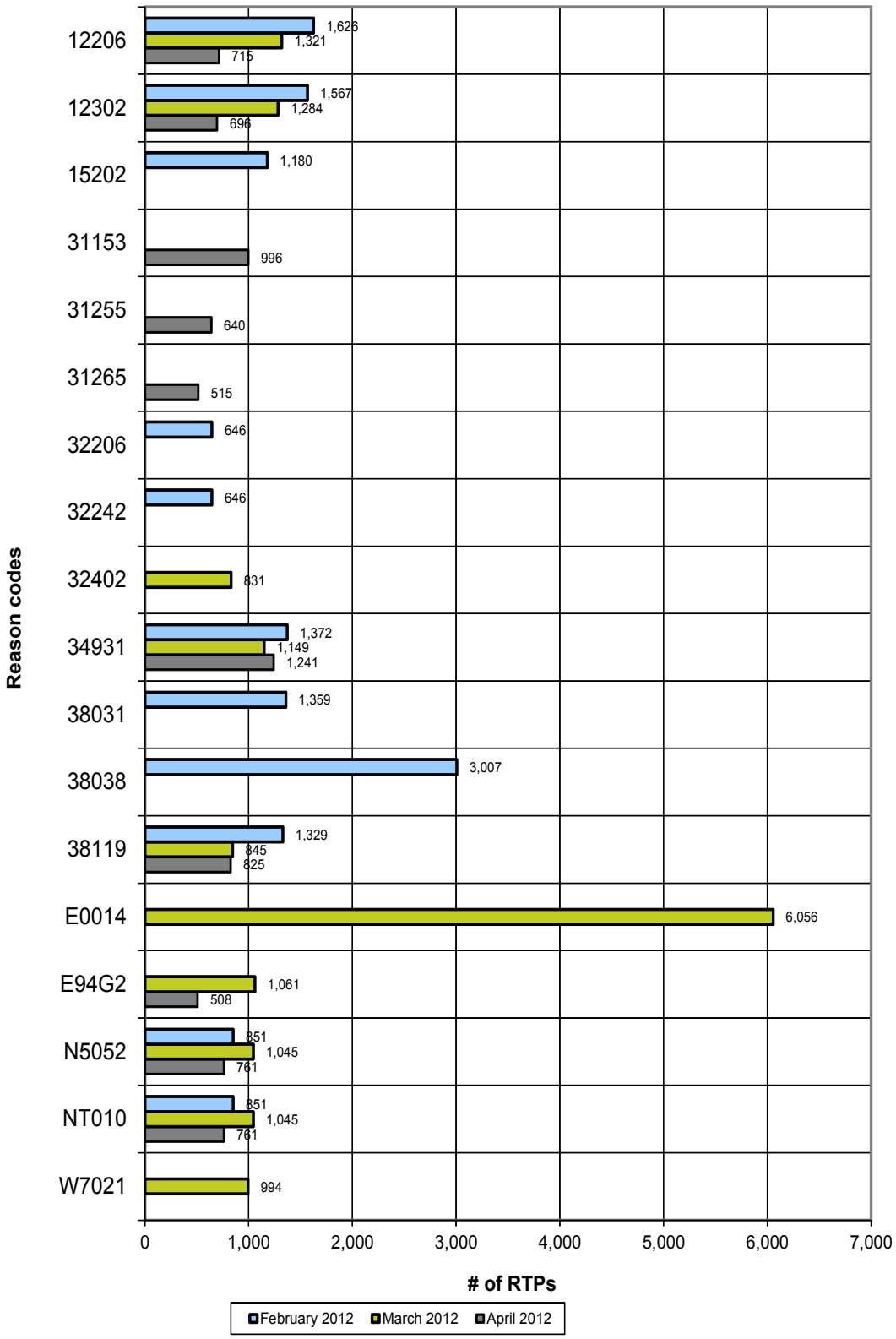
Part A top inquiries for February-April 2012



Part A top rejects for February-April 2012



Part A top return to providers (RTPs) for February-April 2012



Systematic validation of payment group codes for PPS based on patient assessments

Provider types affected

This *MLN Matters*® article is intended for hospitals that bill fiscal intermediaries (FIs), A/B Medicare administrative contractors (MACs), and regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7760, which instructs Medicare contractors to implement changes required to create an interface between the fiscal intermediary shared system (FISS) and the quality improvement evaluation system (QIES). Currently, the FISS does not have access to the assessment databases. This inability to validate the submitted health insurance prospective payment system (HIPPS) code(s) against the associated assessment creates significant payment vulnerability for the Medicare program.

Background

The Balanced Budget Act of 1997 created prospective payment systems (PPSs) for post-acute care settings. CR 7760 will more completely implement PPSs for skilled nursing facilities (SNFs) (required by regulation in 1998), home health agencies (required by regulation in 2000) and inpatient rehabilitation facilities (IRF) (required by regulation in 2002). All three payment systems have been subject to periodic regulatory refinement since implementation.

Current status

The PPS case-mix groups used to determine payments under home health PPS, SNF PPS, and IRF PPS are based on clinical assessments of the beneficiary.

In all three payment systems, the assessments are entered into software at the provider site that encodes the data from the individual assessments into a standard transmission format and transmits the assessments to the State survey agency or a national repository. In addition, the software runs the data from the individual assessments through grouping software that generates a case-mix group to be used on Medicare PPS claims via a HIPPS code. Although the Centers for Medicare & Medicaid Services (CMS) provides grouping software, many providers create their own software due to their need to integrate these data entry and grouping functions with their own administrative systems.

Currently, the transmission of assessment data and transmission of HIPPS codes on claims to Medicare contractors are entirely separate processes. The FISS does not have access to the assessment databases. This results in:

- An inability to validate the submitted HIPPS code against the associated assessment; and
- An inability to fully enforce the late submission penalty for IRF claims.

These limitations create significant payment vulnerability for the Medicare program. These vulnerabilities have been the subject of studies by the Office of Inspector General.

To prevent inaccurate payments, FISS will suspend claims with HIPPS codes and create a finder file of claim information on the mainframe at each MAC's enterprise data center (EDC). A file exchange mechanism will be created to transmit these files to the Data Center where the assessments are housed. There the corresponding assessment information will be found in the QIES and an updated file returned to the EDC for further FISS processing.

The validation process

As mentioned, FISS will suspend claims with HIPPS codes in order to obtain corresponding assessment information in QIES. For IRF claims, Medicare will suspend types of bill (TOB) 111 and 117 with CMS certification numbers (CCNs) in the range of XX3025-XX3099, XXTXXX, or XXRXXX with a patient status code not equal to 30 and a statement covers "Through" date on or after October 1, 2012. (System changes will also be made to address HH, SNF, and SB claims by October 1, 2012, but those edits will be activated at a future date.)

Upon receipt of the response information from QIES, Medicare will do the following with the IRF claim:

- If the submission date in the assessment response matches the occurrence code 50 date on the IRF claim, Medicare will release the claim for processing.

(continued on next page)

Assessment *(continued)*

- If the submission date in the response information is later that the occurrence code 50 date, no condition code D2 is present, and greater than 27 days from the discharge date, Medicare will release the IRF claim for processing, but apply the late submission penalty.
- If the submission date is not present in the assessment response, Medicare will return to provider (RTP) the IRF claim indicating there is no assessment on file.
- Medicare will also compare the provider-submitted HIPPS code on the claim to the HIPPS code on the assessment response. If the HIPPS codes agree, Medicare will release the claim for processing.
- If the provider-submitted code is A5001, Medicare will release the IRF claim (though the submission date comparisons are still made).
- If the HIPPS code in the assessment is ZZZZZ, Medicare will release the IRF claim for processing.
- If the HIPPS codes do not agree, Medicare will use the HIPPS code from the assessment information to calculate the payment for the IRF claim. When this occurs, the resultant remittance advice will contain a remark code of N69 (PPS (prospective payment system) code changed by claims processing system.

Phased implementation of validation process

As proposed in the analysis, implementation of this validation process will be conducted in phases.

- The first phase, effective October 1, 2012, will implement the process for IRF claims only. Contractors will also make system changes for the HH and SNF phases in CR 7760 and the resulting edits will be left inactive at the Medicare contractor sites.
- CMS will issue future instructions to test and activate the HH and SNF processes at dates to be determined.

Additional information

The official instruction, CR 7760, issued to your FI, RHHI, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2458CP.pdf*.

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

MLN Matters® Number: MM7760
Related Change Request (CR) #: 7760
Related CR Release Date: April 27, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2458CP
Implementation Date: October 1, 2012

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.

Get motivated by Medicare …

Find out about provider incentive programs

- e-Prescribing (eRx)
- Electronic Health Records (EHR)
- Health Professional Shortage Area (HPSA)
- Primary Care Incentive Program (PCIP)

July 2012 integrated outpatient code editor specifications version 13.2

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for providing Medicare beneficiaries outpatient services that are paid under the outpatient prospective payment system (OPPS), and for outpatient claims from any non-OPPS provider that are not paid under the OPPS, including hospital outpatient departments and community mental health centers, and for claims for limited services when provided in a home health agency not under the home health prospective payment system (HHPPS) or for services to a hospice patient for the treatment of a non-terminal illness.

Provider action needed

Change request (CR) 7841, from which this article is taken, provides Medicare contractors instructions and specifications for the integrated code editor (OCE) that will be utilized under the OPPS and non-OPPS for all institutional outpatient claims, including non-OPPS hospital claims.

You should make sure that your billing staffs are aware of these changes.

Background

CR 7841, from which this article is taken, informs the Medicare contractors that the I/OCE is being updated for July 1, 2012 for: 1) hospital outpatient departments, 2) community mental health centers, 3) all non-OPPS providers, and 4) for limited services when provided in a home health agency not under the HHPPS or to a hospice patient for the treatment of a non-terminal illness.

Note: The full list of I/OCE specifications can now be found at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html*. In addition, numerous changes to ambulatory payment classification (APC), HCPCS and *CPT* codes, effective with the July 2012 I/OCE, are also listed in the summary of data changes document attached to CR 7841. The CR is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2468CP.pdf*.

A summary of the I/OCE modifications for July 2012 is within Appendix M, which is attached to CR 7841 and is summarized as follows:

- Effective October 1, 2011, Medicare will apply payment adjustment flag (PAF) 9 (Deductible/coinsurance not applicable) to any claim lines when modifier Q3 is present on the line.
- Effective October 1, 2005, the I/OCE deactivates edits described as mutually exclusive to earliest non-archived version. (Mutually exclusive National Correct Coding Initiative (NCCI) edits retroactively merged with code 1/code 2 edits.)
- Effective April 1, 2012, skin substitute codes C9368, C9369, Q4123, Q4125, Q4128, and Q4129 are added to the skin substitute logic.
- Effective July 1, 2012, implement version 18.2 of the NCCI (as modified for applicable institutional providers).
- Effective January 1, 2012, the list of primary procedures reportable with add-on code *33225* is updated to remove *33222* and to add *33228*, *33229, 33263,* and *33264*.
- Effective July 1, 2012, the I/OCE will update the device code used for edit 85, replacing deleted code C9732 with new code *0308T*.

Additional information

The official instruction, CR 7841 issued to your FI, RHHI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2468CP.pdf*. If you have any questions, please contact your FI, RHHI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7841
Related Change Request (CR) #: CR 7841
Related CR Release Date: May, 11, 2012
Effective Date: July 1, 2012 (unless otherwise noted)
Related CR Transmittal #: R2468CP
Implementation Date: July 2, 2012

July quarterly update for 2012 DMEPOS fee schedule

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7822 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Note: Claims for codes L6715 and L6880 with dates of service on or after January 1, 2012, that were previously processed, will be adjusted to reflect the newly established fees if you bring those claims to your contractor's attention.

Background

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

Key points of CR 7822

Healthcare Common Procedure Coding System (HCPCS) codes L6715 and L6880 were added to the HCPCS file effective January 1, 2012. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2012. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for codes L6715 and L6880 with dates of service on or after January 1, 2012, that have already been processed, may be adjusted to reflect the newly established fees if you bring those claims to your contractor's attention.

Per CR 7679, the claims filling jurisdiction for the following HCPCS codes is changed from DME MAC to joint local carrier and DME MAC jurisdiction, effective January 1, 2012:

- L8511 – insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only
- L8512 – gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10
- L8513 – cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each
- L8514 – tracheoesophageal puncture dilator, replacement only, each
- L8515 – gelatin capsule, application device for use with tracheoesophageal voice prosthesis, each

Additional information

The official instruction, CR 7822 issued to your FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2467CP.pdf*. If you have any questions, please contact your FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

Current and past DMEPOS fee schedules can be viewed at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html*.

MLN Matters® Number: MM7822
Related Change Request (CR) #: CR 7822
Related CR Release Date: May 11, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R2467CP
Implementation Date: July 2, 2012

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.

October 2012 quarterly update for the DMEPOS competitive bidding program

Provider types affected

This *MLN Matters*® article is intended for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers and suppliers submitting claims to Medicare durable medical equipment Medicare administrative contractors (DME MACs) or Medicare regional home health intermediaries (RHHIs) for DMEPOS provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7768, which provides the DMEPOS October 2012 quarterly update. CR 7768 provides specific instructions for implementing updates to the DMEPOS round one rebid competitive bidding program (CBP) Healthcare Common Procedure Coding System (HCPCS), ZIP code, and single payment amount files.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new competitive bidding program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and the Centers for Medicare & Medicaid Services (CMS) awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Under the MMA, the DMEPOS competitive bidding program was to be phased in so that competition under the program would first occur in 10 areas in 2007. As required by law, CMS conducted the round one competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks before the contracts were terminated by subsequent law.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008, terminated the round one contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referring to it as the round one rebid.

The round one rebid competitive bidding program was implemented on January 1, 2011, in competitive bidding areas (CBA) defined by ZIP codes within nine of the largest metropolitan statistical areas (MSAs). The CBAs in the round one rebid include: Charlotte-Gastonia-Concord, NC-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth- Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Pompano Beach, FL; Orlando-Kissimmee, FL; Pittsburgh, PA; and Riverside-San Bernardino-Ontario, CA.

The round one rebid competitive bidding product categories are: oxygen supplies and equipment; standard power wheelchairs, scooters, and related accessories; group 2 complex rehabilitative power wheelchairs and related accessories; mail-order diabetic supplies; enteral nutrients, equipment and supplies; continuous positive airway pressure (CPAP) devices, respiratory assist devices, and related supplies and accessories; hospital beds and related accessories; walkers and related accessories; and, in the Miami-Fort Lauderdale-Pompano Beach CBA only, support surfaces (group 2 mattresses and overlays). A list of the HCPCS codes that are included in each of the round one rebid product categories can be accessed by visiting the competitive bidding implementation contractor's (CBIC) website at *http://www.dmecompetitivebid.com/palmetto/cbic.nsf*.

MIPPA required the competition for round two to occur in 2011 in 70 additional MSAs and authorizes competition for national mail order items and services after 2010. The Affordable Care Act expands the number of round two MSAs from 70 to 91 areas and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. You can find additional information on the DMEPOS CBP at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html*.

Additional information

The official instruction, CR 7768, issued to your DME MAC and RHHI regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2470CP.pdf*. If you have any questions, please contact your DME MAC or RHHI at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7768
Related Change Request (CR) #: 7768
Related CR Release Date: May 18, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2470CP
Implementation Date: October 1, 2012

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.

July 2012 quarterly HCPCS drug/biological code changes

Provider types affected

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

Provider action needed

Change request (CR) 7831 announces the quarterly updating of specific Healthcare Common Procedure Coding System (HCPCS) codes, effective for claims with dates of service on or after July 1, 2012. You should make sure that your billing staffs are aware of these HCPCS code changes.

Background

The HCPCS code set is updated on a quarterly basis. CR 7831 describes the Centers for Medicare & Medicaid Services (CMS) process for updating specific HCPCS codes.

Key points of CR 7831

Effective for claims with dates of service on or after July 1, 2012, the following HCPCS codes will no longer be payable for Medicare:

HCPCS code	Short description	Long description	MPFSDB* status indicator
J1680	Human fibrinogen conc inj	Injection, human fibrinogen concentrate, 100 MG	I
J9001	Doxorubicin hcl liposome inj	Injection, doxorubicin hydrochloride, all lipid formulations, 10 MG	I

* Medicare physician fee schedule database (MPFSDB)

Effective for claims with dates of service on or after July 1, 2012, the following HCPCS codes will be payable for Medicare:

HCPCS code	Short description	Long description	Type of service (TOS) code	MPFSDB status indicator
Q2034	Agriflu vaccine	Influenza virus vaccine, split virus, for intramuscular use (agriflu)	V	X
Q2045	Human fibrinogen conc inj	Injection, human fibrinogen concentrate, 1 MG	1,9	E
Q2046	Aflibercept injection	Injection, aflibercept, 1 MG	1,9	E
Q2047	Peginesatide injection	Injection, peginesatide, 0.1 mg (for ESRD on dialysis)	L	E
Q2048	Doxil injection	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 MG	1,9	E
Q2049	Imported Lipodox inj	Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 MG	1,9	E

Additional information

The official instruction, CR 7831, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2450CP.pdf*.

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

(continued on next page)

Drug/biological *(continued)*

MLN Matters® Number: MM7831
Related Change Request (CR) #: CR 7831
Related CR Release Date: April 26, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R2450CP
Implementation Date: July 2, 2012

Revisions of the financial limitation for outpatient therapy services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7785, which extends the therapy cap exceptions process through December 31, 2012, adds therapy services provided in outpatient hospital settings other than critical access hospitals (CAHs) to the therapy cap effective October 1, 2012, requires the national provider identifier (NPI) of the physician certifying therapy plan of care on the claim, and addresses new thresholds for mandatory medical review.

Caution – what you need to know

The therapy cap amounts for 2012 are $1880 for occupational therapy services, and $1880 for the combined services for physical therapy and speech-language pathology. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy caps on claims that are over these amounts. The use of the KX modifier indicates that the services are reasonable and necessary, and there is documentation of medical necessity in the patient's medical record. For services provided on or after October 1, 2012 and before January 1, 2013, there will be two new therapy services thresholds of $3700 per year: one annual threshold each for 1) Occupational therapy (OT) services, and 2) Physical therapy (PT) services and speech-language pathology (SLP) services combined. Per-beneficiary services above these thresholds will require mandatory medical review.

Go – what you need to do

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

Background

The Balanced Budget Act of 1997 (see *http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf*) enacted financial limitations on outpatient PT, OT, and SLP services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act (see *http://www.gpo.gov/fdsys/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf*), and have been extended by legislation several times.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, Section 3005; see *http://www.gpo.gov/fdsys/pkg/BILLS-112hr3630enr/pdf/BILLS-112hr3630enr.pdf*) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services.

The therapy cap amounts for 2012 are:

- $1880 for OT services, and
- $1880 for the combined services for PT and SL P.

CR 7785 instructs Medicare suppliers and providers to continue to use the KX modifier to request an exception to the therapy cap on claims that are over these amounts. Note that use of the KX modifier is an attestation from the provider or supplier that:

1. The services are reasonable and necessary, and
2. There is documentation of medical necessity in the patient's medical record.

Therapy services furnished in an outpatient hospital setting have been exempt from the application of the therapy caps. However, MCTRJCA requires original

(continued on next page)

Drug/biological *(continued)*

Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital between October 1, 2012, and December 31, 2012.

Although the therapy caps are only applicable to hospitals for services provided on or after October 1, 2012, in applying the caps after October 1, 2012, claims paid for outpatient therapy services since January 1, 2012, will be included in the caps accrual totals.

In addition, MCTRJCA contains two requirements that become effective on October 1, 2012.

- The first of these requires that suppliers and providers report on the beneficiary's claim for therapy services the national provider identifier (NPI) of the physician (or non-physician practitioner (NPP) where applicable) who is responsible for reviewing the therapy plan of care. For implementation purposes, the physician (or NPP as applicable) certifying the therapy plan of care is reported. NPPs who can certify the therapy plan of care include nurse practitioners, physician assistants and clinical nurse specialists.
- The second requires a manual medical review process for those exceptions where the beneficiary therapy services for the year reach a threshold of $3,700. The two separate thresholds triggering manual medical reviews build upon the separate therapy caps as follows:
  - One for OT services, and
  - One for PT and SLP services combined.

Although PT and SLP services are combined for triggering the threshold, medical review is conducted separately by discipline.

Claims with the KX modifier requesting exceptions for services above either threshold are subject to a manual medical review process. The count of services to which these thresholds apply begins on January 1, 2012. Absent congressional action, manual medical review expires when the exceptions process expires on December 31, 2012.

Claims for services at or above the therapy caps or thresholds for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Although Medicare suppliers and providers are not required to issue an advance beneficiary notice (ABN) for these benefit category denials, they are encouraged to issue the voluntary ABN as a courtesy to their patients requiring services over the therapy cap amounts ($1,880 for each cap in CY 2012) to alert them of their possible financial liability.

Key billing points

Remember the caps will apply to outpatient hospitals as detected via:

- Types of bill (TOB) 12x (excluding CAHs with CMS certification numbers (CCNs) in the range of 1300-1399) or 13x;
- A revenue code of 042x, 043x, or 044x;
- Modifier GN, GO, or GP; and
- Date of service on or after October 1, 2012.

Other important points are as follows:

- The new thresholds will accrue for claims with dates of service from January 1, 2012, through December 31, 2012. Medicare will display the total amount applied toward the therapy caps and thresholds on all applicable inquiry screens and mechanisms.
- Providers should report the NPI of the physician/NPP certifying the therapy plan of care in the Attending Physician field on institutional claims for outpatient therapy services, for dates of service on or after October 1, 2012.
- In cases where different physicians/NPPs certify the OT, PT, or SLP plan of care, report the additional NPI in the Referring Physician field (loop 2310F) on institutional claims for outpatient therapy services for dates of service on or after October 1, 2012.
- On professional claims, providers are to report the physician/NPP certifying the therapy plan of

(continued on next page)

Drug/biological *(continued)*

care, including his/her NPI, for outpatient therapy services on or after October 1, 2012.

- For claims processing purposes, the certifying physician/NPP is considered a referring provider and such providers must follow the instructions in Chapter 15, Section 220.1.1 of the *Medicare Benefit Policy Manual* (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*) for reporting the referring provider on a claim.
- On electronic professional claims, report the referring provider, including NPI, per the instructions in the appropriate ASC X12 837 Technical Report 3 (TR3).
- For paper claims, report the referring provider, including NPI, per the instructions in Chapter 26, Section 10 of the *Medicare Claims Processing Manual* at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf*.

Claims without at least one referring provider, including his/her NPI, will be returned as unprocessable with the following codes:

- Claim adjustment reason code 165 (Referral absent or exceeded).
- Remittance advice remark code of N285 (Missing/incomplete/invalid referring provider name) and/or N286 (Missing/incomplete/invalid referring provider number).

Additional information

The official instruction, CR 7785, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2457CP.pdf*.

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

MLN Matters® Number: MM7785
Related Change Request (CR) #: CR 7785
Related CR Release Date: April 27, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2457CP
Implementation Date: October 1, 2012

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.

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our new "time limit" calculators on our Appeals of claim decisions page. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Clinical laboratory fee schedule update to include Kansas payment locality structure

Provider types affected

This *MLN Matters*® article is intended for providers who bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs) for providing clinical laboratory services to Medicare beneficiaries in the state of Kansas.

Provider action needed

Stop – impact to you

Change request (CR) 7815, from which this article is taken, corrects an inconsistency in the payment rates for clinical laboratory claims submitted in an east Kansas locality, effective October 1, 2012.

Caution – what you need to know

The Centers for Medicare & Medicaid Services (CMS) discovered that there is an inconsistency in the payment rates for claims for clinical laboratory fee schedule services that are submitted in the east Kansas locality. In this inconsistency, providers are being paid only one Kansas rate rather than one rate for the west Kansas locality and another for the east Kansas locality. CR 7815 instructs your FI or A/B MAC to incorporate an additional Kansas clinical laboratory fee schedule payment locality into their system (effective October 1, 2012) to ensure correct pricing for laboratory services submitted in Kansas. This change will be retroactive to January 1, 2010.

Go – what you need to do

You should make sure that your billing staffs are aware of the change in the Kansas clinical laboratory fee schedule.

Background

For 2010, CMS provided a clinical laboratory fee schedule which included two payment locality numbers for east and west Kansas (Contractor #05202/Locality 12 indicates west Kansas and contractor #05202/ locality 15 indicates east Kansas. See *MLN Matters*® article MM6787 "Revised Clinical Laboratory Fee Schedule and ZIP Code File to Include New Kansas Payment Locality Structure," released on February 12, 2010, which you can find at *http://www.cms.gov/MLNMattersArticles/downloads/MM6787.pdf*).

The fiscal intermediary shared system (FISS), however, does not use locality codes to pay clinical laboratory services, so although there are two localities within the state, claims are being paid at only a single Kansas rate. CR 7815, from which this article is taken, instructs the FISS contractor to develop a work-around process in order to pay providers within the two localities their different rates, effective October 1, 2012.

In this process, the FISS contractor will create a second carrier code for Kansas to handle clinical laboratory fee schedule services payment for the two localities within the state. (Similar to the process used for Missouri). They are to make this change retroactive to January 1, 2010.

Additionally, it instructs FIs and A/B MACs to incorporate an additional Kansas clinical laboratory fee schedule payment locality in the into their system by creating a second proxy carrier number, instead of using locality codes, to ensure correct pricing for laboratory services submitted in Kansas. Your Medicare contractor will adjust claims paid the incorrect amount if you bring such claims to their attention.

Additional Information

You can find the official instruction, CR 7815, issued to your FI or A/B MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1082OTN.pdf*. If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7815
Related Change Request (CR) #: CR 7815
Related CR Release Date: April 27, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R1082OTN
Implementation Date: October 1, 2012

Reporting of recoupment for overpayment on the remittance advice (RA) with patient control number

Note: This article was revised on May 14, 2012, to reflect a revised change request (CR) 7499 issued on May 10. The article was revised to show (above) the correct implementation date of October 1, 2012 for claims submitted to durable medical equipment Medicare administrative contractors (DME MACs). In addition, the transmittal number, release date, and the Web address for accessing CR 7499 were revised. All other information is the same. The information was previously published in the November 2011 *Medicare A Connection*, Page 76.

Provider types affected

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

Provider action needed

This article is based on CR 7499 which instructs Medicare's claims processing systems maintainers to replace the health insurance claim (HIC) number being sent on the ASC X12 transaction 835) with the patient control number received on the original claim, whenever the electronic remittance advice (ERA) is reporting the recovery of an overpayment.

Background

The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR 6870 and CR 7068. The *MLN Matters* article corresponding to CR 6870 can be reviewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6870.pdf* and CR 7068 can be reviewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R812OTN.pdf*.

It has been brought to the attention of CMS that providing the patient control number as received on the original claim rather than the health insurance claim (HIC) number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

CR 7499 instructs the shared systems to replace the HIC number being sent on the ERA with the patient control number, received on the original claim. The ERA will continue to report the HIC number if the patient control number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the accounts receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA.

Note: Instructions in CR 7499 apply to the 005010A1 version of ASC X12 transaction 835 only and do not apply to the standard paper remit or the 004010A1 version of ASC X12 transaction 835.

Additional information

The official instruction, CR 7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1088OTN.pdf*.

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

MLN Matters® Number: MM7499 Revised
Related Change Request (CR) #: CR 7499
Related CR Release Date: May 10, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R1088OTN
Implementation Date: January 3, 2012, for professional claims billed to carriers or B MACs; April 2, 2012, for institutional claims billed to fiscal intermediaries or A MACs; October 1, 2012, for supplier claims submitted to DME MACs

Hospital dialysis services for patients with and without end-stage renal disease

Provider types affected

This *MLN Matters*® article is intended for hospitals that bill fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (MACs) for acute dialysis services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7762, which informs hospitals about correctly billing Medicare for acute dialysis services furnished to hospital inpatients with end-stage renal disease (ESRD). This article also clarifies how hospitals should report dialysis for outpatients who do not have ESRD but who need hemodialysis treatment.

Background

Current billing practice

Hospitals have been billing Medicare on a 12x claim for acute dialysis services (those not covered and paid under the ESRD benefit described in 42 CFR 413.174) that are furnished to hospital inpatients with ESRD, using Healthcare Common Procedure Coding System (HCPCS) code G0257 (Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility).

While Medicare covers these services under the outpatient prospective payment system (OPPS), you should instead be reporting them under HCPCS code *90935* (*Hemodialysis procedure with single physician evaluation*). HCPCS G0257, by definition, is reserved for outpatients with ESRD and should be used only when the criteria specified in the *Medicare Claims Processing Manual*, Chapter 4, Section 200.2, as revised and attached to CR 7762.

HCPCS code G0257 may only be reported on type of bill (TOB) 13x (hospital outpatient service) or TOB 85x (critical access hospital) because HCPCS code G0257 only reports services for hospital outpatients with ESRD and only these bill types are used to report services to hospital outpatients.

New billing policy

Effective for services furnished on and after October 1, 2012, claims that are for a TOB other than 13x (hospital outpatient) or 85x (critical access hospital) will be returned to you for correction if HCPCS G0257 is reported on the claim. In these cases, either you have reported the incorrect code for the service furnished or you have reported the incorrect type of bill. The returned claim will include a remittance reason code of M20 showing "Missing/incomplete/invalid HCPCS."

In CR 7762, CMS revises Section 200.2 of Chapter 4 of the *Medicare Claims Processing Manual* to clarify that HCPCS code *90935* (*Hemodialysis procedure with single physician evaluation*) may be reported and paid only if one of the following two conditions is met:

- The patient is a hospital inpatient with or without ESRD and has no coverage under Part A, but has Part B coverage. The charge for hemodialysis is a charge for the use of a prosthetic device. See the *Medicare Benefits Policy Manual*, Chapter 15, Section 120. A, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//bp102c15.pdf*. The service must be reported on a type of bill 12x or 85x. See Chapter 6, Section 10 of the *Medicare Benefits Policy Manual* available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//bp102c06.pdf* for the criteria that must be met for services to be paid when a hospital inpatient has Part B coverage but does not have coverage under Part A; or
- A hospital outpatient does not have ESRD and is receiving hemodialysis in the hospital outpatient department. The service is reported on a TOB 13x or l 85x.

Additional information

The official instruction, CR 7762, issued to your FI and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2455CP.pdf*. If you have any questions, please contact your FI or MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7762
Related Change Request (CR) #: 7762
Related CR Release Date: April 26, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2455CP
Implementation Date: October 1, 2012

Processing for the ESRD quality incentive program (QIP) for children's hospitals

Provider types affected

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

What you need to know

This article is based on change request (CR) 7798 which informs Medicare contractors about changes to Medicare claims processing. Medicare systems will no longer default the "Quality Indicator" field on the outpatient provider specific file (OPSF) to blank each year for children's hospitals (series XX3300-XX3399). Medicare contractors will ensure a blank is sent to the end stage renal disease (ESRD) Pricer for the "Quality Indicator," field 74, for children's hospitals (series XX3300-XX3399). Medicare contractors will not apply a QIP reduction based on the OPSF quality indicator to the ESRD prospective payment system (PPS) payment for children's hospitals (series XX3300-XX3399) for the separately billable services under the ESRD PPS transitional payment as referenced in CR 7460.5.

In addition, children's hospitals may have received incorrect outmigration adjustments on their ESRD claims due to the fact that the "Special Payment Indicator" and "Special Wage Index" fields are shared with ESRD facilities and outpatient hospitals. Medicare contractors will ensure a blank is sent to the ESRD Pricer for the "Special Wage Index" and the "Special Payment Indicator" (fields 90 and 96 on the OPSF) for children's Hospitals (series XX3300-XX3399) for dates of service beginning January 1, 2011, and beyond.

Medicare contractors will automatically adjust any ESRD claims (TOB 72x) for children's hospitals (series XX3300-XX3399) that were processed with dates of service in 2012 that received QIP reductions incorrectly. They will also automatically adjust any claims for dates of service beginning January 1, 2011, and beyond that were processed with outmigration adjustments incorrectly.

Medicare contractors will complete these adjustments within 60 days upon the successful implementation of CR 7798 (or by December 1, 2012). Please make sure your billing staff is aware of these changes.

Background

Section 153c of the Medicare Improvements for Patients and Providers Act (MIPPA), required the Centers for Medicare & Medicaid Services (CMS) to implement a quality based payment program for dialysis services with payment consequences effective January 1, 2012. CR 7460 included a requirement for the FISS to default the "Quality Indicator" field on the outpatient provider specific file (OPSF) for ESRD facilities to blank each year. Because children's hospitals bill both outpatient hospital claims and ESRD claims assigned to the same provider number (series 3300-3399), defaulting the quality indicator to blank may have created incorrect payments for their outpatient hospital claims. For payment years 2012 and 2013, the measures applicable to the ESRD QIP do not impact pediatric patients and, therefore, it is not expected that a children's hospital would have an ESRD QIP adjustment.

This instruction does not change existing policy for the QIP and outmigration adjustments.

Additional information

The official instruction, CR 7798 issued to your FI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1077OTN.pdf*.

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

MLN Matters® Number: MM7798
Related Change Request (CR) #: 7798
Related CR Release Date: April 26, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R1077OTN
Implementation Date: October 1, 2012

Anesthesiologist services with a modifier GC in a method II critical access hospital

Provider types affected

This *MLN Matters*® article is intended for method II critical access hospitals (CAHs) that bill Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for anesthesiologist services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7764, which implements a revised payment methodology for anesthesiology claims submitted with modifier GC (Resident /teaching physician service) for CAH method II providers.

Key information from CR 7764

Teaching anesthesiologists rendering services in a method II CAH (also referred to as CAHs that have elected the optional method) have the option of reassigning their billing rights to the CAH. When billing rights are reassigned, the method II CAH submits an 85x bill type with revenue code 0963 (professional fees for anesthesiologist (MD)) for payment of the anesthesia services.

Payment is currently calculated for anesthesia services performed by a teaching anesthesiologist with a modifier of GC in a method II CAH on a 20 percent reduction of the fee schedule amount before deductible and coinsurance are calculated. CR 7764 removes the 20 percent reduction that should not be applied in the payment calculation for these services.

Teaching physicians report the GC modifier to indicate that he or she rendered the service in compliance with the teaching physician requirements in the *Medicare Claims Processing Manual*, Chapter 12, Section 100.1.2, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//clm104c12.pdf*. One of the payment modifiers must be used in conjunction with the GC modifier. The teaching anesthesiologist should use modifier AA (Anesthesia services performed by the anesthesiologist) with the GC modifier to report such cases.

Effective for services furnished on or after January 1, 2010, payment may be made under Section 139 of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) based on the regular fee schedule amount for the teaching anesthesiologist's involvement in the training of residents in either a single anesthesia case or two concurrent anesthesia cases. CMS is applying this same policy if the teaching anesthesiologist is involved in one resident case that is concurrent to another case that is paid under the medical direction payment rules.

In order for the special payment rule for teaching anesthesiologists to apply, the teaching anesthesiologist (or different anesthesiologists in the same physician group) must be present during all critical or key portions of the anesthesia service. Where different teaching anesthesiologists in the anesthesia group are present during the key or critical periods, the performing physician, for purposes of claims reporting, is the teaching anesthesiologist who started the case. The teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure.

You should note that Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date of CR 7764. However, contractors will adjust claims brought to their attention.

Additional information

The official instruction, CR 7764, issued to your FI and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2452CP.pdf*. You should also review Chapter 12, Section 50 (Payment for Anesthesiology Services) of the *Medicare Claims Processing Manual* at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//clm104c12.pdf*.

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

MLN Matters® Number: 7764
Related Change Request (CR) #: 7764
Related CR Release Date: April 26, 2012
Effective Date: January 1, 2010
Related CR Transmittal #: R2452CP
Implementation Date: October 1, 2012

Allowing physician assistants to perform SNF level of care certifications and recertifications

Note: This article was revised on April 23, 2012, to reflect a revised change request (CR) 7701, which was issued on April 20. The article was revised to reflect a new CR release date, transmittal number, and Web address for accessing the CR. All other information is the same. This information was previously published in the January 2012 *Medicare A Connection*, Page 71.

Provider types affected

Skilled nursing facilities (SNFs) and swing-bed hospitals that bill Medicare contractors (fiscal intermediaries (FIs) or A/B Medicare administrative contractors (A/B MACs)) for providing Part A SNF services to Medicare beneficiaries are affected.

What providers need to know

This article is based on CR 7701, which implements Section 3108 of the Affordable Care Act. This section adds physician assistants to the list of practitioners who can perform SNF level of care certifications and recertifications. Performing this function is a requirement for Medicare coverage of SNF services under Part A.

CR 7701 directs Medicare contractors to recognize that, effective with services furnished on or after January 1, 2011, physician assistants can perform the required initial certification and periodic recertifications of a beneficiary's need for a SNF level of care.

Note: Contractors will reopen and reprocess any claims brought to their attention for Part A SNF services that were mistakenly denied (prior to this update) based on having a physician assistant complete the required SNF level of care certification or recertification. However, contractors will not search claims history to identify these claims.

Additional information

The official instruction, CR 7701, was issued to your FI or A/B MAC regarding this change via two transmittals. The first modifies the *Medicare General Information, Eligibility, and Entitlement Manual* and it may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R76GI.pdf*. The second updates the *Medicare Benefit Policy Manual*, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R155BP.pdf*.

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

MLN Matters® Number: MM7701
Related Change Request (CR) #: 7701
Related CR Release Date: April 20, 2012
Effective Date: January 1, 2011
Related CR Transmittal #: R76GI and R155BP
Implementation Date: February 13, 2012

Educational Events

Upcoming provider outreach and educational events – June 2012

Internet-based PECOS class (A/B)
When: June 19
Time: 8 a.m. – noon ET **Delivery language:** English
Type of Event: Face-to-face **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Two easy ways to register

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

2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 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 the *Education* section of our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you 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 *medicare.fcso.com*, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. Our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Explore our catalog of online courses and learn more at *fcsouniversity.com*.

Addresses

First Coast Service Options

American Diabetes Association certificates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

Claims/correspondence
Florida:
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

U.S. Virgin Islands:
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

Electronic claim filing
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

Fraud and abuse
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests
(relative to cost reports and audits)

Provider Audit and Reimbursement (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

Local coverage determinations
Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)
General information, conditional payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital protocols, admission questionnaires, audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, automobile accident cases, settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections
Repayment plans, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, interim rate determinations, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Post-pay medical review
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

Redetermination
Florida:
Medicare Part A Redetermination and Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Special delivery mail and courier services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

Durable medical equipment regional carrier (DMERC)
DME, orthotic and prosthetic device, take-home supply, and oral anti-cancer drug claims

CIGNA Government Services
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare
Palmetto Government Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health and hospice intermediary
Palmetto Government Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Phone numbers

Customer service/IVR
Providers:
888-664-4112
Speech and hearing impaired
877-660-1759

Beneficiaries:
800-MEDICARE (800-633-4227)
Speech and hearing impaired
800-754-7820

Credit balance report
Debt recovery
904-791-6281
Fax
904-361-0359

Electronic data interchange
888-670-0940

Option 1 – Transaction support

Option 2 – PC-ACE support

Option 3 – Direct data entry (DDE)

Option 4 – Enrollment support

Option 5 – 5010 testing

Option 6 – Automated response line

Provider audit and reimbursement
904-791-8430

Provider education and outreach
Seminar registration hotline
904-791-8103
Seminar registration fax
904-361-0407

Provider enrollment
877-602-8816

Websites

First Coast Service Options Inc. (Florida and U.S. Virgin Islands Medicare contractor)
medicare.fcso.com

Centers for Medicare & Medicaid Services
Providers:
www.cms.gov

Beneficiaries:
www.medicare.gov

Medicare A *Connection*

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