Medicare A Connection

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

October 2012

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Medicare outpatient prospective payment system payments exceeding charges

As previously communicated in the May 2012 *Medicare A Connection*, 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 Medicare administrative contractors (MACs).

Audit findings in these reports included:

- Providers reporting incorrect units of service and/or incorrect Healthcare Common Procedure Coding System (HCPCS) codes.
- Use of HCPCS codes that do not reflect the procedures performed.

Based on findings in these reports, the Center for Medicare & Medicaid Services (CMS) implemented a verification policy when the OPPS payment is greater than the billed charges on bill types 12x, 13x and 14x. Starting October 1, 2012, change request (CR) 7771 mandated contractors to verify claims with OPPS payments that meet a reimbursement amount greater than submitted charges.

As a result of the CR, a large volume of development letters requesting provider to submit itemized bills have been issued for claims hitting reason code 39132.

Contractor action

First Coast Service Options (First Coast) is establishing revised editing criteria for reason code 39132 to mirror the OIG audit criteria. This action will significantly decrease the volume of development requests for itemized bills. The revised editing criteria will include only line item payment amounts that exceed the line billed charge amounts by at least $1,000 **and** in which three or more units of service were billed for that line item.

Effective October 26, 2012, claims with reason code 39132 will be placed in location S/M7771 and will be released for processing upon implementation of the new editing criteria (anticipated date November 5, 2012).

First Coast will also be revising the document request letter for claims that will be subject to review based on the revised editing criteria. The revised letter will request the itemized breakdown of charges and applicable medical record documentation that supports the line item billed for the claim line(s) that suspend for reason code 39132.

Provider action

First Coast will identify **pending** claims that do not meet the revised editing criteria and will release those claims for processing.

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Medicare A Connection subscription

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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.

Consistency edit to validate attending physician national provider identifier

Note: This article was revised on October 1, 2012, to reflect a revised change request (CR) 7902 issued September 28. In this article, the CR release date, transmittal number, and the Web address for accessing the CR are changed. In addition, the article notes an exemption for Institutional claims for self-referred screening mammograms, when such services are the only billed services on a claim. This information was previously published in the September 2012 *Medicare A Connection*, Page 9.

Provider types affected

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

Provider action needed

Effective for claims received on or after January 1, 2013, you must submit the national provider identifier (NPI) of the attending provider in the attending provider name and identifiers field (FL76) of your claims. That NPI must not be your billing NPI, unless the claim is for institutional billing of influenza and pneumococcal vaccinations and their administrations when these are the only billed services on the claim or a roster billing of influenza and pneumococcal vaccinations and their administrations when these are the only billed services on the roster claim. In addition, this edit will not be applied to an institutional claim for a self-referred screening mammogram, when that is the only billed service on the claim. Make sure that your billing staffs are aware of this requirement.

Background

Institutional providers are required to indicate the attending provider name and identifiers for the patient's medical care and treatment reported on institutional claims for any services other than non-scheduled transportation claims. Additionally, institutional providers are required on outpatient claims to send the referring provider NPI and name when the referring provider for the services is different than the attending provider.

Additional information

The official instruction, CR 7902 issued to your contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2560CP.pdf*.

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

MLN Matters® Number: MM7902 *Revised*
Related Change Request (CR) #: CR 7902
Related CR Release Date: September 28, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2560CP
Implementation Date: January 7, 2013

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A physician's guide to Medicare Part D Medication Therapy Management programs

Provider types affected

This *MLN Matters*® special edition article about Medication Therapy Management (MTM) services is intended for physicians, pharmacists, nurses, and other health care providers who treat Medicare beneficiaries with Part D coverage.

Provider action needed

This *MLN* release is intended to make you aware of changes in Medicare Part D MTM programs that will affect your patients, and introduce you to three new MTM forms that your patients are likely to share with you.

Your patients may ask you if they would benefit from MTM services. If you have patients enrolled in Part D MTM programs, you may also be contacted by MTM providers who are required to monitor patients' medication therapies from all their health care providers. This may result in recommendations that are shared with you about unsafe or dangerous interactions and therapeutic alternatives. Your patients may also receive recommendations about how to use their medications properly.

MTM providers are important partners with you

MTM providers work with physicians to deliver the best medication therapy to patients and to coordinate their medication therapy across multiple practitioners. The latest clinical information is used by MTM providers when reviewing patients' medication therapy, such as updates to the Beers criteria for high-risk medications and revised monographs for old and new medications. MTM providers also listen to patients' concerns about their medications and may offer recommendations to physicians and patients to help achieve their goals of therapy. As always, physicians make the final decisions about changes in drug therapy.

When will MTM providers contact you?

Your patients enrolled in MTM may receive an interactive comprehensive medication review (CMR) any time during the year.

- The MTM provider may reach out to you in order to clarify your patient's medical history prior to a review or information received from your patient during the review, such as why and how they are supposed to use their medications.
- After a CMR, the MTM provider may contact you with questions or recommendations about your patient's medications, or your patient may call you to discuss suggestions they received from the MTM provider.

Targeted medication reviews (TMRs) are processed throughout the year, no less often than quarterly, to identify specific or potential medication-related problems. You may be contacted by the MTM provider if a TMR identifies a potential medication-related problem for your patient.

Other communications may be sent to you periodically throughout the year. These communications are intended to help resolve other potential medication-related problems or identify other opportunities to optimize your patient's medication use.

What is changing?

Beginning January 2013, if your patients are enrolled in a Part D MTM program, they will receive a printed standardized summary, Form CMS-10396, as a reference about their CMR. This summary will include a cover letter, medication action plan, and personal medication list. Your patients are encouraged to share these documents with you and other healthcare providers at their regular visits and request updates as needed. Examples of the three forms follow:

Cover letter

Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood Medicare Plus

January 30, 2013

Mr. John Smith
999 Straight Road
Washington, DC 80008

Dear Mr. Smith:

Thank you for talking with me on January 14, 2013 about your health and medications. Medicare's MTM (Medication Therapy Management) program helps you make sure that your medications are working.

Along with this letter are an action plan (Medication Action Plan) and a medication list (Personal Medication List). **The action plan has steps you should take to help you get the best results from your medications. The medication list will help you keep track of your medications and how to use them the right way.**

- Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other healthcare providers.
- Ask your doctors, pharmacists, and other healthcare providers to update them at every visit.
- Take your medication list with you if you go to the hospital or emergency room.
- Give a copy of the action plan and medication list to your family or caregivers.

If you want to talk about this letter or any of the papers with it, please call Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday. I look forward to working with you and your doctors to help you stay healthy through the Birchwood Medicare Plus MTM program.

Sincerely,
Jane Doe
Jane Doe, PharmD
Pharmacy Manager

Page 1 of 1

- The cover letter reminds your patient of their CMR, introduces the medication action plan and personal medication list, and describes how to contact the MTM program.

(continued on next page)

Part D *(continued)*

Medication action plan

Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood Medicare Plus

MEDICATION ACTION PLAN FOR Mr. John Smith, DOB: 07/04/1940

This action plan will help you get the best results from your medications if you:

- Read "What we talked about."
- Take the steps listed in the "What I need to do" boxes.
- Fill in "What I did and when I did it."
- Fill in "My follow-up plan" and "Questions I want to ask."

Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers. Share this with your family or caregivers too.

DATE PREPARED: 01/14/2013

What we talked about:	
What I need to do:	What I did and when I did it:
What we talked about:	
What I need to do:	What I did and when I did it:
What we talked about:	
What I need to do:	What I did and when I did it:

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What we talked about:	
What I need to do:	What I did and when I did it:
What we talked about:	
What I need to do:	What I did and when I did it:
What we talked about:	
What I need to do:	What I did and when I did it:

My follow-up plan (add notes about next steps):

Questions I want to ask (include topics about medications or therapy):

If you have any questions about your action plan, call Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday.

Page 2 of 2

- The medication action plan describes the specific action items for your patient to help resolve issues of current drug therapy and achieve the goals of medication treatment. Your patient can keep notes of their progress and use it to clarify and discuss any concerns about their medications and treatment plans with you.
- The MTM provider will send separate recommendations to you if needed.

Personal medication list

Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood Medicare Plus

PERSONAL MEDICATION LIST FOR Mr. John Smith, DOB: 07/04/1940

This medication list was made for you after we talked. We also used information from Medicare Part D claims data.

- Use blank rows to add new medications. Then fill in the dates you started using them.
- Cross out medications when you no longer use them. Then write the date and why you stopped using them.
- Ask your doctors, pharmacists, and other healthcare providers to update this list at every visit.

Keep this list up-to-date with:
- ☐ prescription medications
- ☐ over the counter drugs
- ☐ herbals
- ☐ vitamins
- ☐ minerals

If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

DATE PREPARED: 01/14/2013

Allergies or side effects:	
Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	
Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	

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PERSONAL MEDICATION LIST FOR Mr. John Smith, DOB: 07/04/1940
(Continued)

Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	
Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	
Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	

Other Information:

If you have any questions about your medication list, call Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday.

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- The personal medication list is a reconciled list of the medications used by your patient at the time of the review. Information from your patient, Medicare Part D claims data, or other sources may be used to develop the list. It is intended to help your patient understand their medications and how they relate to their treatment plans. Your patient can make notes on their Personal Medication List such as when and why they stopped taking a medication.
- You can use the personal medication list as verification of your patient's current medication regimen and provide written adjustments, as needed. The medication list can also improve communication with you and other healthcare providers seen by your patient.

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Part D *(continued)*

How do you refer patients to MTM services?

Calling the prescription drug plan directly is the best way to find out if your patient is eligible for that plan's MTM services. You can also refer your patient to their local State Health Insurance Assistance Program (SHIP) office. A local SHIP counselor can be found through a search function at *https://shiptalk.org/public/home.aspx?ReturnUrl=%2fdefault.aspx*.

Summary

Medicare Part D MTM programs promote coordinated care and improve medication use through services that engage the patient, their physicians, and other healthcare providers. Starting in 2013, you will begin to see three new forms that your patients may receive if they are enrolled in a Part D MTM program. These forms are intended to provide the patient with information about their medication use and also be used as a platform for discussion with you and their other health care providers.

Additional information

For additional information about Medicare Part D MTM programs and the standardized CMR summary documents, go to *http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html*.

Please send any general questions about Part D MTM programs to *PartD_MTM@cms.hhs.gov* via e-mail. Questions about a specific plan's MTM services or eligibility criteria should be addressed to that Part D plan.

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Bidding for the Round 1 Recompete of the DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) is soliciting bids for the Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

All bids must be submitted in DBidS, the online bidding system, before 9:00 p.m. prevailing eastern time December 14, 2012. All required hardcopy documents that must be included as part of the bid package must be received by the Competitive Bidding Implementation Contractor (CBIC) on or before December 14, 2012. The contract period for the Round 1 Recompete is January 1, 2014-December 31, 2016.

All bidders must submit certain required hardcopy documents as specified in the *Request for Bids (RFB) Instructions*. CMS urges all bidders to take advantage of the covered document review process. Under this process, we will notify suppliers that submit their hardcopy financial documents by the covered document review date (CDRD) of any missing financial documents. The CDRD for the Round 1 Recompete is November 14, 2012 – financial documents must be received on or before November 14, 2012, to qualify for the covered document review process. This process only determines if there are any missing financial documents. It does not indicate if the documents are acceptable, accurate, or meet applicable requirements. Suppliers that submit financial documents by the CDRD will be notified of any missing financial documents within 90 days of the CDRD. Suppliers will be required to submit the missing financial document(s) within 10 business days of the notification.

Competitive bidding areas and product categories for the Round 1 Recompete, DBidS information, bid preparation worksheets, educational materials, and complete RFB instructions can be found on the CBIC website. Suppliers should review this information prior to submitting their bids. CMS will send important bidding updates via e-mail, so all suppliers interested in bidding are urged to sign up for email updates on the CBIC website at *www.DMECompetitiveBid.com*. If you have any questions about the bidding process, please contact the CBIC customer service center at 1-877-577-5331.

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Recompete *(continued)*

The target registration dates for authorized officials (AOs) and backup authorized officials (BAOs) to register for a user ID and password in the CMS Individuals Authorized Access to the CMS Computer Services (IACS) system have passed. Only suppliers that have registered in IACS and received a user ID and password will be able to access the online bidding system and submit bids. If your AO does not register, you cannot bid and will not be eligible for a contract. In addition, suppliers whose AOs have not registered are at risk of experiencing delays in accessing the online bidding system to get a bidder number and thereby missing the opportunity to submit financial documents by the CDRD.

Registration closed October 19, 2012 – no AOs, BAOs, or EUs can register after registration closes. Suppliers that have not registered cannot bid and are not eligible for contracts. If you have any questions about the registration process, please contact the CBIC customer service center.

To bid, visit the CBIC website and click on Round 1 Recompete. Next click “BIDDING IS OPEN” above the clocks on that page.

Please note that the RFB instructions initially posted on the CBIC website contained target bid submission deadlines. CMS is in the process of updating these instructions to reflect the actual bid submission deadlines, which are shown in this announcement.

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

Source: CMS PERL 201210-05

Interactive voice response and contact center hours for Puerto Rico and the U.S. Virgin Islands

Effective November 5, 2012, the customer service and interactive voice response (IVR) hours of operation are as follows:

Part A IVR

Monday-Friday
8:00 a.m.-8:00 p.m. Atlantic Time (AT)

Saturday
8:00 a.m.-4:00 p.m. AT

Part B IVR

Monday-Friday
8:00 a.m.-7:30 p.m. AT

Saturday
8:00 a.m.-4:00 p.m. AT

Customer service representatives

The Monday-Friday hours (8:00 a.m.-4:00 p.m. AT), with the exception of training closures, remain unchanged.

Your feedback matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our website enhancements page at *http://medicare.fcso.com/Feedback/201743.asp* . You’ll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast’s Web team.

Partial code freeze prior to ICD-10 implementation

Provider types affected

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

What you need to know

At a meeting September 14, 2011, the ICD-9-CM Coordination & Maintenance (C&M) Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 which would end one year after the implementation of ICD-10. The implementation of ICD-10 was delayed from October 1, 2013, to October 1, 2014 by final rule CMS-0040-F August 24, 2012. This final rule is available at *http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html*.

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

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made October 1, 2011.
- On October 1, 2012, and October 1, 2013 there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by Section 503(a) of Pub. L. 108-173.
- On October 1, 2014, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by Section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
- On October 1, 2015, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2015 once the partial freeze has ended.

The code freeze was initially discussed at the September 15, 2010, meeting of the committee. To view the transcript of that meeting, go to *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html*. From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the "091510_Morning_Transcript" file. This section appears on page 4 of the 78-page document.

To view the Summary Report of the meeting, go to *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html*. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the "091510_ICD9_Meeting_Summary_report.pdf" file. Information on the Code Freeze begins on page 5.

Additional information

CMS has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at *http://www.cms.gov/Medicare/Coding/ICD10/index.html*.

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

- Medicare fee-for-service provider resources Web page: This site links Medicare fee-for-service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this Web page. Bookmark *http://www.cms.gov/Medicare/Coding/ICD10/index.html* and check back regularly for access to ICD-10 implementation information of importance to you. **Note**: Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.
- CMS-sponsored national provider conference calls: During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit *http://www.cms.gov/Medicare/Coding/ICD10/index.html*.
- See *MLN Matters*® special edition article, SE1239, at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf* for an overview of what is needed to implement ICD-10.

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Freeze *(continued)*

- Frequently asked questions (FAQs): To access FAQs related to ICD-10, please visit the CMS ICD-10 Web page at *http://www.cms.gov/Medicare/Coding/ICD10/index.html*, select the "Medicare Fee-for-Service Provider Resources" link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

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

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

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Updated ICD-10 implementation information

Provider types affected

This *MLN Matters*® article is intended for all physicians, providers, suppliers, and other covered entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health care setting.

What you need to know

This *MLN Matters*® special edition article replaces article SE1019 and provides updated information about the implementation of the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/ICD-10-PCS) code sets to help you better understand (and prepare for) the United States health care industry's change from ICD-9-CM to ICD-10 for medical diagnosis and inpatient hospital procedure coding.

The ICD-10-related implementation date is October 1, 2014, as announced in final rule CMS-0040-F issued August 24, 2012. This final rule is available at *http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html*.

On October 1, 2014, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry.

Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

Background

ICD-10 implementation compliance date

On October 1, 2014, CMS will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets.

- ICD-10-CM diagnoses codes will be used by all providers in every health care setting.
- ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures.
- The compliance dates are firm and not subject to change.
  - There will be no delays.
  - There will be no grace period for implementation.

Important, please be aware:

- ***ICD-9-CM codes will not be accepted for services provided on or after October 1, 2014.***
- ***ICD-10 codes will not be accepted for services prior to October 1, 2014.***

  You **must** begin using the ICD-10-CM codes to report diagnoses from all ambulatory and physician services on claims with dates of service on or after October 1, 2014, and for all diagnoses on claims for inpatient settings with dates of discharge that occur on or after October 1, 2014.

  Additionally, you must begin using the ICD-10-PCS (procedure codes) for all hospital claims for inpatient procedures on claims with dates of discharge that occur on or after October 1, 2014.

Note: Only ICD-10-CM, not ICD-10-PCS, will affect physicians. ICD-10-PCS will only be implemented for facility inpatient reporting of procedures – it will not be used for physician reporting. There will be no impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. You should continue to use these codes for physician, outpatient, and ambulatory services. Physician claims for services provided to

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ICD-10 *(continued)*

inpatient patients will continue to report CPT and HCPCS codes.

What are the differences between the ICD-10-CM/ ICD-10-PCS and ICD-9-CM Code Sets?

The differences between the ICD-10 code sets and the ICD-9 code sets are primarily in the overall number of codes, their organization and structure, code composition, and level of detail. There are approximately 70,000 ICD-10-CM codes compared to approximately 14,000 ICD-9-CM diagnosis codes, and approximately 70,000 ICD-10-PCS codes compared to approximately 4,000 ICD-9-CM procedure codes.

In addition, ICD-10 codes are longer and use more alpha characters, which enable them to provide greater clinical detail and specificity in describing diagnoses and procedures. Also, terminology and disease classification have been updated to be consistent with current clinical practice.

Finally, system changes are also required to accommodate the ICD-10 codes.

What are benefits of the ICD-10 coding system?

The new, up-to-date classification system will provide much better data needed to:

- Measure the quality, safety, and efficacy of care
- Reduce the need for attachments to explain the patient's condition
- Design payment systems and process claims for reimbursement
- Conduct research, epidemiological studies, and clinical trials
- Set health policy
- Support operational and strategic planning
- Design health care delivery systems
- Monitor resource utilization
- Improve clinical, financial, and administrative performance
- Prevent and detect health care fraud and abuse
- Track public health and risks

ICD-10-CM code use and structure

The ICD-10-CM (diagnoses) codes are to be used by all providers in all health care settings. Each ICD-10-CM code is 3 to 7 characters, the first being an alpha character (all letters except U are used), the second character is numeric, and characters 3-7 are either alpha or numeric (alpha characters are not case sensitive), with a decimal after the third character. Examples of ICD-10-CM codes follow:

- A78 – Q fever
- A69.21 – Meningitis due to Lyme disease
- O9A.311 – Physical abuse complicating pregnancy, first trimester
- S52.131A – Displaced fracture of neck of right radius, initial encounter for closed fracture

Additionally, the ICD-10-CM coding system has the following new features:

1) Laterality (left, right, bilateral)

For example:

- C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast
- H16.013 – Central corneal ulcer, bilateral
- L89.022 – Pressure ulcer of left elbow, stage II

2) Combination codes for certain conditions and common associated symptoms and manifestations

For example:

- K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding
- E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
- I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

3) Combination codes for poisonings and their associated external cause

For example:

- T42.3x2S – Poisoning by barbiturates, intentional self-harm, sequela

4) Obstetric codes identify trimester instead of episode of care

For example:

- O26.02 – Excessive weight gain in pregnancy, second trimester

5) Character "x" is used as a 5th character placeholder in certain 6 character codes to allow for future expansion and to fill in other empty characters (e.g., character 5 and/or 6) when a code that is less than six characters in length requires a 7th character

For example:

- T46.1x5A – Adverse effect of calcium-channel blockers, initial encounter
- T15.02xD – Foreign body in cornea, left eye, subsequent encounter

6) Two types of excludes notes

Excludes 1 – Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).

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ICD-10 *(continued)*

For example:

- Q03 – Congenital hydrocephalus (Excludes1: Acquired hydrocephalus (G91.-)

Excludes 2 – Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).

- L27.2 – Dermatitis due to ingested food (Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)

7) Inclusion of clinical concepts that do not exist in ICD-9-CM (e.g., underdosing, blood type, blood alcohol level)

For example:

- T45.526D – Underdosing of antithrombotic drugs, subsequent encounter
- Z67.40 – Type O blood, Rh positive
- Y90.6 – Blood alcohol level of 120–199 mg/100 ml

8) A number of codes have been significantly expanded (e.g., injuries, diabetes, substance abuse, postoperative complications)

For example:

- E10.610 – Type 1 diabetes mellitus with diabetic neuropathic arthropathy
- F10.182 – Alcohol abuse with alcohol-induced sleep disorder
- T82.02xA – Displacement of heart valve prosthesis, initial encounter

9) Codes for postoperative complications have been expanded and a distinction made between intraoperative complications and postprocedural disorders

For example:

- D78.01 – Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen
- D78.21 – Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen

Finally, there are additional changes in ICD-10-CM, to include:

- Injuries are grouped by anatomical site rather than by type of injury
- Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM
- Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge
- New code definitions (e.g., definition of acute myocardial infarction is now four weeks rather than eight weeks)
- The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM.

To learn more about the ICD-10-CM coding structure you may review "Basic Introduction to ICD-10-CM" audio or written transcripts from the March 23, 2010 provider outreach conference call, which is available at *http://www.cms.gov/Medicare/Coding/ICD10/index.html*.

ICD-10-PCS code use and structure

The ICD-10-PCS codes are for use only on hospital claims for inpatient procedures. ICD-10-PCS codes are not to be used on any type of physician claims for physician services provided to hospitalized patients. These codes differ from the ICD-9-CM procedure codes in that they have 7 characters that can be either alpha (non-case sensitive) or numeric. The numbers 0 - 9 are used (letters O and I are not used to avoid confusion with numbers 0 and 1), and they do not contain decimals. For example:

- 0FB03ZX - Excision of liver, percutaneous approach, diagnostic
- 0DQ10ZZ - Repair, upper esophagus, open approach

Help with converting codes

The general equivalence mappings (GEMs) are a tool that can be used to convert data from ICD-9-CM to ICD-10-CM/PCS and vice versa. Mapping from ICD-10-CM/PCS codes back to ICD-9-CM codes is referred to as backward mapping. Mapping from ICD-9-CM codes to ICD-10-CM/PCS codes is referred to as forward mapping. The GEMs are a comprehensive translation dictionary that can be used to accurately and effectively translate any ICD-9-CM-based data, including data for:

- Tracking quality
- Recording morbidity/mortality
- Calculating reimbursement
- Converting any ICD-9-CM-based application to ICD-10-CM/PCS

The GEMs can be used by anyone who wants to convert coded data, including:

- All payers

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ICD-10 *(continued)*

- All providers
- Medical researchers
- Informatics professionals
- Coding professionals—to convert large data sets
- Software vendors—to use within their own products;
- Organizations—to make mappings that suit their internal purposes or that are based on their own historical data
- Others who use coded data

The GEMs are not a substitute for learning how to use the ICD-10 codes. More information about GEMs and their use can be found on the CMS website at *http://www.cms.gov/Medicare/Coding/ICD10/index.html* (select from the left side of the Web page ICD-10-CM or ICD-10-PCS to find the most recent GEMs).

Additional information about GEMs was provided on the following CMS sponsored conference call - May 19, 2009, "ICD-10 Implementation and General Equivalence Mappings" (*http://www.cms.gov/Medicare/Coding/ICD10/index.html*).

What to do now in preparation for ICD-10 implementation?

If you have not already done so, here are the steps you need to consider to implement ICD-10:

- Learn about the structure, organization, and unique features of ICD-10-CM - all provider types.
- Learn about the structure, organization, and unique features of ICD-10-PCS - inpatient hospital claims.
- Learn about system impact and 5010.
- Use assessment tools to identify areas of strength/weakness in medical terminology and medical record documentation.
- Review and refresh knowledge of medical terminology as needed based on the assessment results.
- Provide additional training to refresh or expand knowledge in the biomedical sciences (anatomy, physiology, pathophysiology, pharmacology, and medical terminology).
- Plan to provide intensive coder training approximately 6 -9 months prior to implementation.
- Allocating 16 hours of ICD-10-CM training will likely be adequate for most coders, and very proficient ICD-9-CM coders may not need that much.

Additional information

To find additional information about ICD-10, visit *http://www.cms.gov/Medicare/Coding/ICD10/index.html*. In addition, CMS makes the following resources available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page**: This site links Medicare fee-for-service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this Web page. Bookmark *http://www.cms.gov/Medicare/Coding/ICD10/index.html* and check back regularly for access to ICD-10 implementation information of importance to you. **Note**: Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.
- **CMS-sponsored national provider conference calls**: During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration.

Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit *http://www.cms.gov/Medicare/Coding/ICD10/index.html*.

- **Frequently asked questions (FAQs)**: To access FAQs related to ICD-10, please visit the CMS ICD-10 Web page at *http://www.cms.gov/Medicare/Coding/ICD10/index.html*, select the "Medicare Fee-for-Service Provider Resources" link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.
- See *MLN Matters*® special edition article, SE1240, at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1240.pdf* for a discussion of a partial freeze on ICD-10 code set prior to implementation.

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

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

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ICD-10 conversion and related code infrastructure as it relates to national coverage determinations

Provider types affected

This *MLN Matters*® article for change request (CR) 7818 is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers and A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on CR 7818, which creates and updates national coverage determination (NCD) hard-coded Medicare shared system edits that contain International Classification of Diseases, 9th Edition (ICD-9) diagnosis codes with comparable International Classification of Diseases, 10th Edition (ICD-10) diagnosis codes. The requirements described in CR 7818 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to numerous Medicare NCDs, which are identified in an attachment to CR 7818. In order to be prepared to meet the timeline to implement the new ICD-10 diagnosis codes October 1, 2014, the Medicare shared systems will begin implementation of the necessary changes to the NCDs in the January 2013 systems release. No DME MAC edits are included in this CR but will be addressed in subsequent CRs. All remaining changes to the Medicare shared systems, as they relate to Medicare NCDs, will be made in subsequent releases. See the *Background* and *Additional information* sections for further details regarding these changes and be sure that you are ready for ICD-10 implementation.

Background

On October 1, 2014, all Medicare claims submissions will convert from the ICD-9 to the ICD-10. The transition will require business and systems changes throughout the health care industry. All covered entities, as defined by the Health Insurance Portability and Accountability Act (HIPAA), must adhere to the conversion.

In accordance with HIPAA, the Secretary of the Department of Health and Human Services adopts standard medical data code sets for use in standard transactions adopted under this law. According to the ICD-10 final rule, published in the *Federal Register* of January 16, 2009 (see *http://www.gpo.gov/fdsys/pkg/FR-2009-01-16/pdf/E9-743.pdf*), the Secretary adopts the ICD-10-CM and ICD-10-PCS code sets for use in appropriate HIPAA standard transactions. Entities covered under HIPAA (which include Medicare and its providers submitting claims electronically) are bound by these requirements and must comply. Medicare will also require submitters of paper claims to use ICD-10 codes on their claims according to the same compliance date.

The purpose of CR 7818 is to both create and update NCD hard-coded Medicare shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes, plus all associated editing such as procedure codes, HCPCS/CPT codes, denial messages, frequency edits, place of service (POS)/ type of bill (TOB)/provider specialty editing, etc. The requirements described in CR 7818 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the Medicare NCDs listed as an attachment to CR 7818.

Note: This exercise is in no way intended to expand, restrict, or alter existing Medicare national coverage. Also, it is not intended to minimize the authority granted to MACs in their discretionary implementation of NCDs or local coverage determinations (LCDs). However, where hard-coded edits were not initially implemented due to time and/or resource constraints, doing so at this time will better serve the intent and integrity of national coverage and the Medicare program overall.

Additional information

The official instruction, CR 7818 issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1122OTN.pdf*.

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

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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.

National coverage determination for transcatheter aortic valve replacement

Note: This article was revised on September 25, 2012, to reflect the revised change request (CR) 7897 issued on September 24. In this article, the CR release date, transmittal numbers, and the Web addresses for accessing the transmittals have been changed. All other information remains the same. This information was previously published in the August 2012 *Medicare A Connection*, Pages 8-11.

Provider types affected

This *MLN Matters*® article is intended for physicians and hospitals who provide transcatheter aortic valve replacement (TAVR) services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Effective for claims with dates of service on and after May 1, 2012, Medicare carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (A/B MACs) will reimburse for TAVR under Coverage with Evidence Development (CED).

Caution – what you need to know

CR 7897, from which this article is taken, announces that on May 1, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a national coverage determination (NCD) covering TAVR under CED and CR 7897 details requirements that must be met when claims are submitted to Medicare for these services.

Go – what you need to do

You should make sure that your billing staffs are aware of this decision and its requirements, which are summarized in the *Background* section.

Background

TAVR (also known as TAVI or transcatheter aortic valve implantation) is a new technology for use in treating certain patients with aortic stenosis. A bioprosthetic valve is inserted percutaneously using a catheter and implanted in the orifice of the native aortic valve.

CR 7879 announces that on May 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a NCD covering TAVR under CED and only when specific requirements are met.

CMS covers TAVR for the treatment of symptomatic aortic valve stenosis under CED with the following conditions:

CED coverage conditions with registry participation

1. It is furnished according to a Food and Drug Administration (FDA)-approved indication and when all of the following conditions are met:
   a. It is furnished with a complete aortic valve and implantation system that has received FDA premarket approval (PMA) for that system's FDA-approved indication
   b. Two cardiac surgeons have independently examined the patient face-to-face and evaluated the patient's suitability for open aortic valve replacement (AVR) surgery; and both surgeons have documented the rationale for their clinical judgment, and this rationale is available to the heart team
   c. The patient (preoperatively and postoperatively) is under the care of a heart team: a cohesive, multi-disciplinary, team of medical professionals that embodies collaboration and dedication across medical specialties to offer optimal patient-centered care
   d. It is furnished in a hospital with the appropriate infrastructure that includes (but not limited to):
      - On-site heart valve surgery program
      - Cardiac catheterization lab or hybrid operating room/catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering quality imaging
      - Non-invasive imaging such as echocardiography, vascular ultrasound, computed tomography (CT) and magnetic resonance (MR)
      - Sufficient space, in a sterile environment, to accommodate necessary equipment for cases with and without complications
      - Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures, and
      - Appropriate volume requirements per the applicable qualifications (specifically, for hospitals without TAVR experience and for those with experience performing the procedure), which follow.
2. Required qualifications for the hospitals and heart teams performing the procedure.

Hospitals <u>without</u> TAVR experience must have the following qualifications to begin a TAVR program:

a. ≥ 50 total AVRs in the previous year prior to TAVR, including ≥ 10 high-risk patients
b. ≥ Two physicians with cardiac surgery privileges, and
c. ≥ 1000 catheterizations per year, including ≥ 400 Percutaneous Coronary Interventions (PCIs) per year.

Heart teams <u>without</u> TAVR experience must include the following to begin a TAVR program:

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a. A cardiovascular surgeon with: 1) ≥ 100 career AVRs including 10 high-risk patients; or, 2) ≥ 25 AVRs in one year; or, 3) ≥ 50 AVRs in two years; and which include at least 20 AVRs in the last year prior to TAVR initiation; and,

b. An interventional cardiologist with: 1) Professional experience with 100 structural heart disease procedures lifetime; or, 2) 30 left-sided structural procedures per year of which 60 percent should be balloon aortic valvuloplasty (BAV). Atrial septal defect and patent foramen ovale closure are not considered left-sided procedures, as well as

c. Additional members of the heart team such as echocardiographers, imaging specialists, heart failure specialists, cardiac anesthesiologists, intensivists, nurses, and social workers, and

d. Device-specific training as required by the manufacturer.

Hospital programs with TAVR experience must have the following qualifications:

a. Maintain ≥ two physicians with cardiac surgery privileges

b. Perform ≥ 20 AVRs per year or ≥ 40 AVRs every two years, and

c. Perform ≥ 1000 catheterizations per year, including ≥ 400 percutaneous coronary interventions (PCIs) per year.

Heart teams with TAVR experience must have the following qualifications:

a. Include a cardiovascular surgeon and an interventional cardiologist whose combined experience maintains: 1) ≥ 20 TAVR procedures in the prior year, or 2) ≥ 40 TAVR procedures in the prior two years

b. Include additional members of the heart team such as echocardiographers, imaging specialists, heart failure specialists, cardiac anesthesiologists, intensivists, nurses, and social workers, and

c. The interventional cardiologist(s) and cardiac surgeon(s) must jointly participate in the intra-operative technical aspects of TAVR.

In addition, the heart team and hospital must be participating in a prospective, national, audited registry. The complete list of requirements for a qualifying registry can be found in the NCD, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R147NCD.pdf*. To date, CMS has approved one registry, the Transcatheter Valve Therapy Registry operated by the Society of Thoracic Surgeons and the American College of Cardiology.

Coverage conditions with clinical studies

For indications that are not approved by the FDA, CMS covers TAVR under CED when patients are enrolled in qualifying clinical studies. The clinical study requirements are available in the NCD, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R147NCD.pdf*. Approved studies are listed at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html*.

Note: TAVR is not covered for patients in whom existing co-morbidities would preclude the expected benefit from correction of the aortic stenosis.

Coding requirements – professional claims

For TAVR services furnished on or after May 1, 2012, you should bill with the appropriate temporary level III *Current Procedural Terminology* (*CPT*) code:

- *0256T: Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach*
- *0257T: Implantation of catheter-delivered prosthetic aortic heart valve; open thoracic approach (eg, transapical, transventricular)*
- *0258T: Transthoracic cardiac exposure (i.e. sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; without cardiopulmonary bypass*
- *0259T: Transthoracic cardiac exposure (i.e. sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass*

Beginning January 1, 2013, CMS anticipates permanent *CPT* level 1 codes will replace the above four codes for processing TAVR claims, and will issue instructions for the permanent *CPT* level 1 codes in a future CR.

You should be aware that, on or after May 1, 2012, your carrier or A/B MAC will only reimburse your professional claims for TAVR services (for *CPT* codes *0256T, 0257T, 0258T*, and *0259T*) when used with place of service (POS) code 21 (inpatient hospital). They will deny all other POS codes. Should they deny your claim because of an incorrect POS, they will use the following messages:

- **Claim adjustment reason code (CARC) 58**: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;"
- **Remittance advice remark code (RARC) N428**: "Not covered when performed in this place of service;" and

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- **Group code**: Contractual obligation (CO).

Similarly, Medicare will only pay claim lines with these TAVR *CPT* codes when billed with modifier 62 (two surgeons/co-surgeons). They will return all others as unprocessable. Should they return such claims, they will use:

- **CARC 4**: "The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;"
- **RARC N29**: "Missing documentation/orders/notes/summary/report/chart;" and
- **Group code**: Contractual obligation (CO).

Medicare will only pay claim lines for these codes in a clinical trial when billed with modifier Q0 (zero). For TAVR services, use of modifier Q0 signifies CED participation (qualified registry or qualified clinical study).They will return such claims billed without modifier Q0 as unprocessable using:

- **CARC 4**: "The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present; "
- **RARC N29**: "Missing documentation/orders/notes/summary/report/chart," and
- **Group code**: Contractual obligation (CO).

Medicare will only pay claims for these codes in a clinical trial when billed with ICD-9-CM secondary diagnosis code V70.7 (routine general medical examination at a health care facility) (ICD-10 = Z00.6 – encounter for examination for normal comparison and control in clinical research program). For TAVR services, use of V70.7 signifies CED participation (qualified registry or qualified clinical study).They will return claim lines billed without secondary diagnosis code V70.7 as unprocessable, using:

- **CARC 16**: "Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or RARC that is not an ALERT);"
- **RARC N29**: "Missing documentation/orders/notes/summary/report/chart;" and
- **Group code**: Contractual obligation (CO).

Coding requirements – inpatient hospital claims

Hospitals should bill for TAVR services on an 11x type of bill (TOB), effective for discharges on or after May 1, 2012. Your FI or A/B MAC will reimburse such claims containing ICD-9 procedure codes 35.05 (Endovascular replacement of aortic valve) or 35.06 (Transapical replacement of aortic valve) only when billed with secondary diagnosis code V70.7 (Examination of participant in clinical trial) and condition code 30 (qualifying clinical trial). For TAVR services, use of the latter two codes signifies CED participation (qualified registry or qualified clinical study).

Claims from hospitals without those latter two codes will be rejected using:

- **CARC: 50**: "These are non-covered services because this is not deemed a "medical necessity" by the payer;"
- **RARC N386**: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. If you do not have Web access, you may contact the contractor to request a copy of the NCD;" and
- **Group code**: Contractual obligation (CO).

The following are the ICD-10 procedure codes applicable for TAVR:

TAVR ICD-9 procedure codes	TAVR ICD-10 procedure codes
35.05	02RF37Z, 02RF38Z, 02RF3JZ, 02RF3KZ
35.06	02RF37H, 02RF38H, 02RF3JH, 02RF3KH

Additional information

CR 7897 was issued to your Medicare contractor in two transmittals. The first transmittal modifies the *Medicare National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R147NCD.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2552CP.pdf*.

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

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Documentation deficiencies in interpretation and report of diagnostic imaging services

Seventy percent of plain film studies, computed tomography, and magnetic resonance imaging scans did not follow one or more documentation practice guidelines promoted by the American

College of Radiology (ACR), according to a 2008 Office of Inspector General (OIG) report. Three major documentation deficiencies missing from the interpretation and reports as noted by the OIG were: the time the exam was performed, the time the report was dictated and the date the report dictated.

Medicare expects the radiologist's report (may be on separate paper or within the body of the patient's record) to follow the ACR guidelines and include a minimum of the following:

- The name of the patient and other identification such as birth date and social security number
- The name of referring physician, if any
- The name or type of examination performed
- The date on which the X-ray was performed
- The name of the interpreting physician
- Authentication of non-handwritten note (e.g., legible initials, legible signature, electronic signature, etc.)
- The body of the report
  - Procedure and materials
  - Findings
  - Limitations
  - Clinical Issues
  - Comparative data, if indicated
- The diagnosis:
  - A prescribing diagnosis should be provided when possible
  - A differential diagnosis should be provided when appropriate

Documentation is essential to establish that the results of the interpretation and report were communicated in a timely manner to the treating physician in the emergency department. First Coast Service Options is encouraging providers to review their current documentation practices. The ACR Practice Guideline for Communication of Diagnostic Imaging Findings may be found at: *ACR Practice Guideline for Communication of Diagnostic Imaging Findings*.

ICD-10 (continued)

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

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

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.

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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.**

Revision to LCD

ATHERSVCS: Therapy and rehabilitation services – revision to the LCD

LCD ID number: L28992 (Florida)
LCD ID number: L29024 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for therapy and rehabilitation services was most recently revised March 1, 2012. Since that time, based on change request 7785, language was added to the Centers for Medicare & Medicaid Services (CMS) Manual System, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5, Sections 10.3-10.5 (Financial Limitations). Therefore, the "Financial Limitations for Therapy Caps" section of the LCD was revised to replace CMS language with specific website links to the Internet-only manual (IOM) sections. In addition, the LCD was updated to reflect current CMS language and verbiage consistent with the Part B LCD.

Effective date

This LCD revision is effective for services rendered **on and after October 1, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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

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 First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

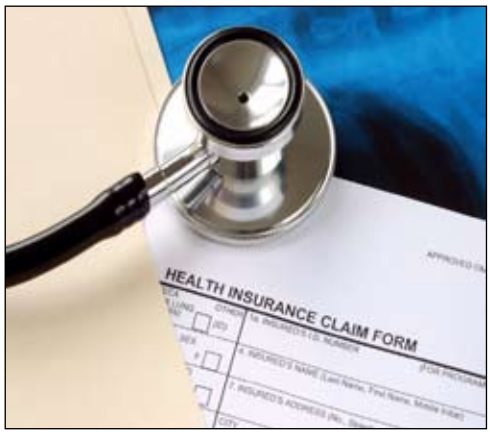
Correct provider billing of line item rendering physician on the paper UB-04 claim form

Provider types affected

This *MLN Matters*® special edition article is intended for providers who submit claims on the paper UB-04 claim form to fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

In collaboration with the National Uniform Billing Committee's (NUBC) reporting of the line item rendering physician element on paper claims, the Centers for Medicare & Medicaid Services (CMS) would like to inform you of the correct process for paper claims received on or after January 1, 2012. This change does not apply for claims received prior to January 1, 2012.



This special article informs you of the following for reporting the line item rendering physician element on paper claims when the line item rendering physician is required.

The claim level rendering provider (loop ID 2310D) is required when the rendering provider is different than the attending provider. For Medicare purposes this is required under federal regulatory requirements that call for a "combined claim", that is, a claim that includes both facility and professional components (critical access hospital claim billing under Method II, federally qualified health centers, and rural health clinics). The line level rendering provider is required when the rendering provider for this line is different than the rendering provider reported in loop ID 2310D (claim level). Again, for Medicare purposes this is required under federal regulatory requirements that call for a "combined claim," that is, a claim that includes both facility and professional components (critical access hospital claim billing under Method II, federally qualified health centers, and rural health clinics*).

- Place the line item rendering physician national provider identifier (NPI) in form locator 43 (revenue code description) for the line item that contains the services identified.

Medicare's fiscal intermediary shared system (FISS) edits require that the line item rendering physician information be transmitted when providers submit a combined claim; that is, claims that include both facility and professional components, need to report the rendering physician or other practitioner at the line level if it differs from the rendering physician/practitioner reported at the claim level. Affected Medicare providers are critical access hospitals billing under Method II and federally qualified health centers. For the 5010 version of the 837 I, FISS shall accept the line level rendering physician/practitioner information at the line level (loop 2420C). As a reminder, you should verify your systems edit logic for correct application of this data element.

* Rural health clinics are not impacted at this time since they do not do detailed billing.

Additional information

You may also want to review the *MLN Matters*® article related to change request 7578. That article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7578.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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: SE1241
Related Change Request (CR) #: 7578
Related CR Release Date: February 17, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R1046OTN
Implementation Date: July 2, 2012

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Review of Medicare payments exceeding charges for outpatient services for the period January 2008 through June 2009

The Office of Inspector General (OIG) recently completed a review of outpatient claims processed by First Coast Service Options Inc. (First Coast) in Jurisdiction 9 (J9) for the period January 1, 2008, through June 30, 2009. The OIG's goal with this review was to determine whether certain Medicare payments that First Coast made to providers in excess of charges for outpatient services were correct.

Medicare guidelines require providers to submit accurate claims for outpatient services. Medicare uses an outpatient prospective payment system (OPPS) to pay certain outpatient providers. With this method of reimbursement, the Medicare payment is not based on the amount the provider charges, therefore the billed charges generally do not affect the current Medicare prospective payment amounts. Billed charges usually exceed the Medicare payment amount; therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

Summary of findings

During the audit period, approximately 78 million line items for outpatient services were processed by First Coast. Of the 295 line items selected for review, 179 were correct. Providers refunded overpayments on three line items totaling more than $544K. The remaining 113 line items were incorrect and included overpayments totaling over $847K.

Of the 113 incorrect line items:

- Providers reported incorrect units of service on 71 line items, resulting in overpayments totaling more than $485K.
- Providers reported a combination of incorrect units of service claimed and incorrect Healthcare Common Procedure Coding System (HCPCS) codes on 29 line items, resulting in overpayments totaling nearly $206K.
- Providers used HCPCS codes that did not reflect the procedures performed on 10 line items, resulting in overpayments totaling nearly $151K.
- Providers did not provide the supporting documentation for three line items, resulting in overpayments totaling nearly $5,700.

Incorrect payments were made due to the following reasons:

- Providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors.
- The Medicare Fiscal Intermediary Shared System (FISS) and common working file (CWF) had insufficient edits in place during the audit to prevent or detect overpayments.

Issues identified as overpayments

- Incorrect number of units of service
  - **Example**: Incorrect service units for intravenous immune globulin treatment.
  - **Example**: Clerical error. Billed 500 units of service instead of 200.
- Combination of incorrect number of units of service and incorrect HCPCS codes
  - **Example**: Billed cancer treatment procedure with 440 units of service, however treatment coded incorrectly. A different code should have been billed with 15 units of service.
- Incorrect HCPCS
  - **Example**: Provider billed infusion therapy using incorrect chemotherapy injection code.
- Unsupported services
  - Providers did not provide supporting documentation.

First Coast implemented edits to address excessive charges; many of those edits were revised or implemented after the OIG audit concluded.

Provider education resources

Providers are responsible for ensuring that the appropriate HCPCS codes and units of service are billed correctly for services rendered to Medicare beneficiaries, and are in accordance with coding guidelines. Providers are to

(continued on next page)

2008-2009 *(continued)*

use the appropriate HCPCS codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS is associated with a drug, the number of units administered.

The following resources provide information that will assist you with proper billing of outpatient services.

- *Medicare Claims Processing Manual* Publication 100-04
  - Chapter 1 - General Billing Requirements, Section 80.3.2.2 FI Consistency Edits – *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf*
  - Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, Section 20.2 Reporting of Service Units with HCPCS (A – D) – *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf*
  - Chapter 12 - Physicians/Nonphysician Practitioners – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf*
  - Chapter 17 - Drugs and Biologicals, Section 70 Claims Processing Requirements - General – *http://www.cms.gov/manuals/downloads/clm104c17.pdf*
  - Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.3 Use and Acceptance of HCPCS Codes and Modifiers – *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*
- Medically Unlikely Edits (MUEs) - billing the correct number of units – *http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp*

Review of Medicare payments exceeding charges for outpatient services January 2006 through December 2007

The Office of Inspector General (OIG) recently completed a review of outpatient claims processed by First Coast Service Options Inc. (First Coast) in Jurisdiction 9 (J9) for the period January 1, 2006, through December 31, 2007. The OIG's goal with this review was to determine whether certain Medicare payments that First Coast made to providers in excess of charges for outpatient services were correct.

Medicare guidelines require providers to submit accurate claims for outpatient services. Medicare uses an outpatient prospective payment system (OPPS) to pay certain outpatient providers. With this method of reimbursement, the Medicare payment is not based on the amount the provider charges; therefore, the billed charges generally do not affect the current Medicare prospective payment amounts. Billed charges usually exceed the Medicare payment amount; therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

Summary of findings

During the audit period, approximately 91 million line items for outpatient services were processed by First Coast. Of the 326 line items selected for review, 67 were correct. Providers refunded overpayments on six line items totaling nearly $73K. The remaining 253 line items were incorrect and included overpayments totaling almost $1.7M.

Of the 253 incorrect line items:

- Providers reported incorrect units of service on 203 line items, resulting in overpayments totaling more than $1.4M.
- Providers reported a combination of incorrect units of service claimed and incorrect Healthcare Common Procedure Coding System (HCPCS) codes on 22 line items, resulting in overpayments totaling more than $93K.
- Providers used HCPCS codes that did not reflect the procedures performed on 17 line items, resulting in overpayments totaling more than $101K.

(continued on next page)

2006-2007 *(continued)*

- Providers did not provide the supporting documentation for 11 line items, resulting in overpayments totaling nearly $86K.

Incorrect payments were made due to the following reasons:

- Providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors.
- The Medicare Fiscal Intermediary Shared System (FISS) and common working file (CWF) had insufficient edits in place during the audit to prevent or detect overpayments.

Issues identified as overpayments

- Incorrect number of units of service
  - **Example**: One provider billed Medicare for incorrect service units on six line items. Rather than billing between one and 485 service units (the correct HCPCS codes associated with these line items), the provider billed between 250 and 4,850 service units. The units were overstated because the pharmacy's drug conversion factor table was not current.
  - **Example**: Another provider billed Medicare for incorrect service units on eight line items. The provider incorrectly charged multiple service units for increments of operating room time instead of one service unit for the ambulatory surgery performed. These errors occurred because the provider did not have electronic edits in place.
- Combination of incorrect number of units of service and incorrect HCPCS codes
  - Example: One provider billed Medicare for a procedure with 200 units of service. However, both the procedure billed and the units of service were incorrect. The provider should have billed using a different procedure code with one unit of service.
- Incorrect HCPCS
  - Example: Because of human error, a provider billed Medicare for nine line items of infusion therapy using incorrect HCPCS codes.
- Unsupported services
  - Providers did not provide supporting documentation.

First Coast currently has threshold edits in place that target excessive charges; many of these edits were revised and/or implemented since the end of the review period.

Provider education resources

Providers are responsible for ensuring that the appropriate HCPCS codes and units of service are billed correctly for services rendered to Medicare beneficiaries, and are in accordance with coding guidelines. Providers are to use the appropriate HCPCS codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS is associated with a drug, the number of units administered.

The following resources provide information that will assist you with proper billing of outpatient services.

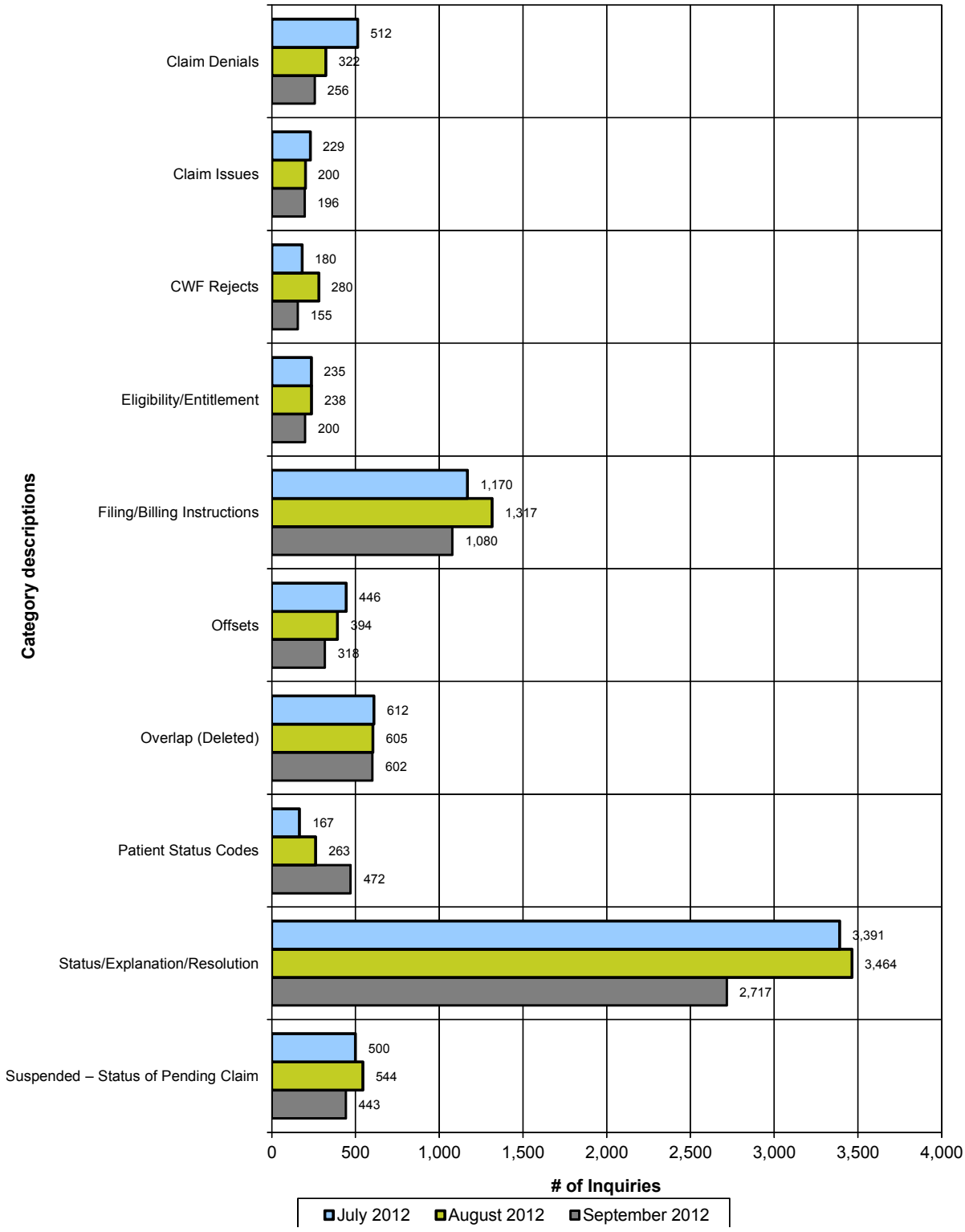
- *Medicare Claims Processing Manual* Publication 100-04
  - Chapter 1 - General Billing Requirements, Section 80.3.2.2 FI Consistency Edits – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf*
  - Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, Section 20.2 Reporting of Service Units with HCPCS (A – D) – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf*
  - Chapter 12 - Physicians/Nonphysician Practitioners – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf*
  - Chapter 17 - Drugs and Biologicals, Section 70 Claims Processing Requirements - General – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf*
  - Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.3 Use and Acceptance of HCPCS Codes and Modifiers – *https://www.cms.gov/manuals/downloads/clm104c23.pdf*
- Medically Unlikely Edits (MUEs) - billing the correct number of units – *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*

Top inquiries, rejects, and return to provider claims – July-September 2012

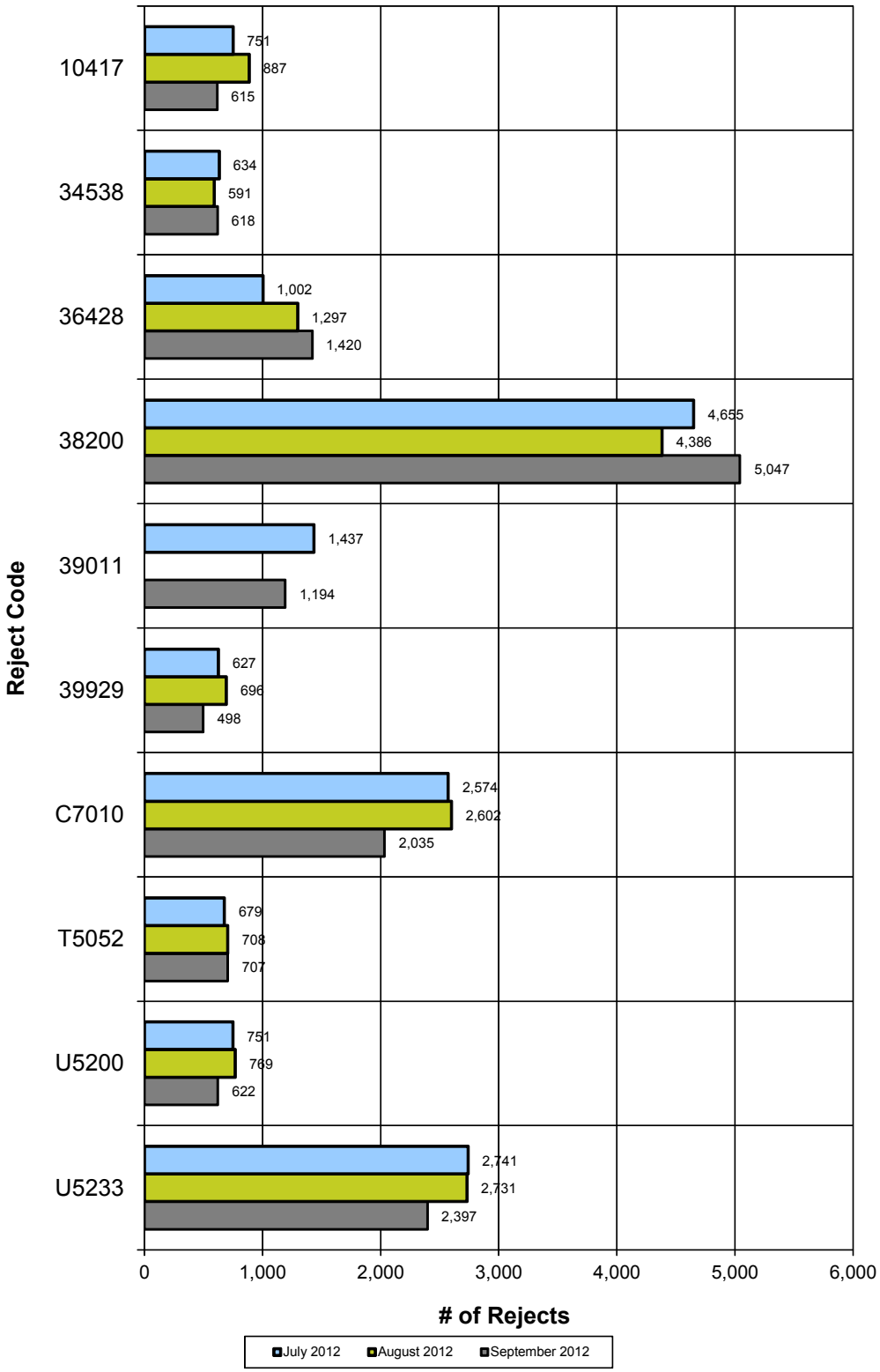
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during July through September 2012.

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*.

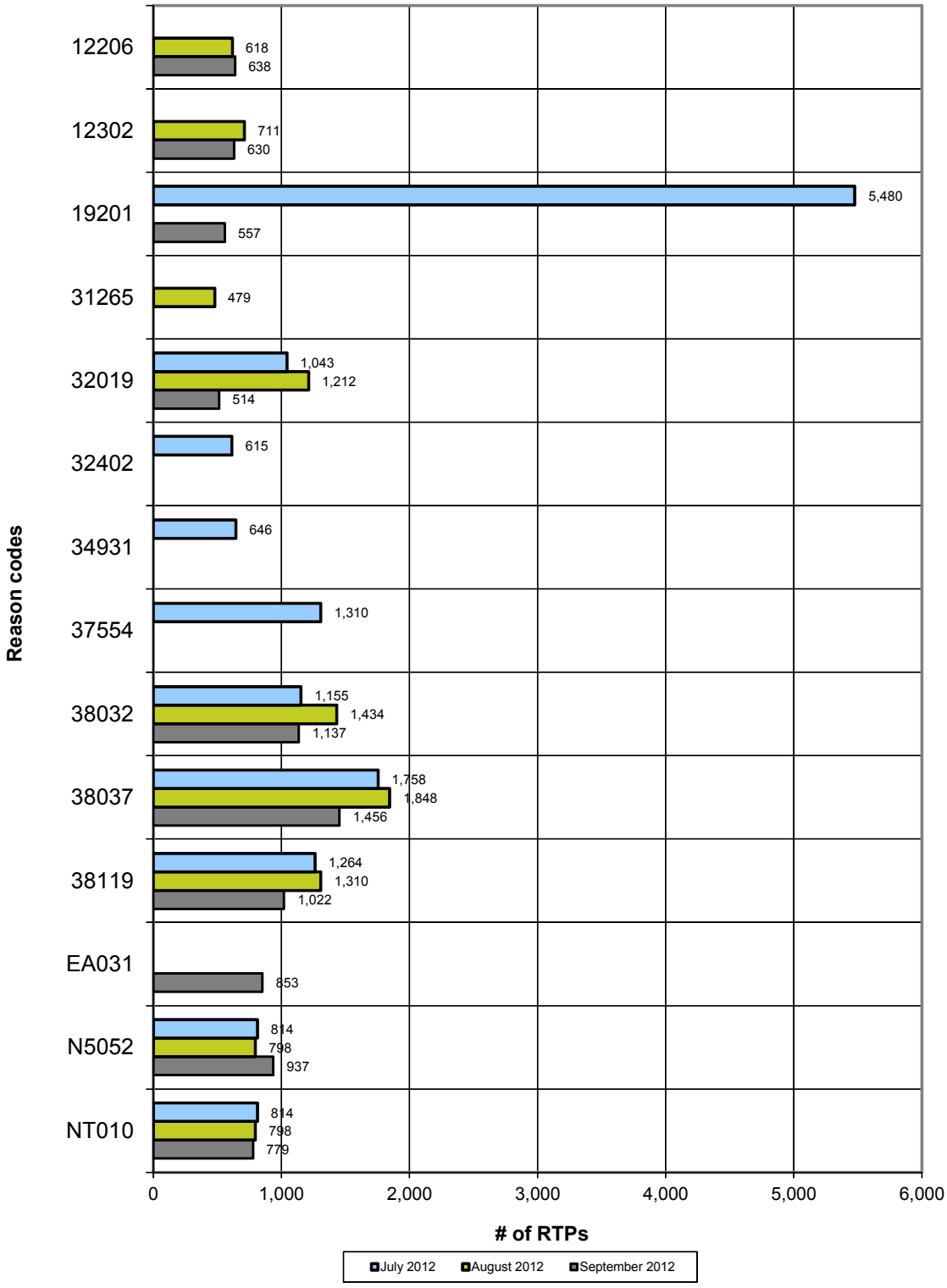
Part A top inquiries for July-September 2012



Part A top rejects for July-September 2012



Part A top return to providers (RTPs) for July-September 2012



October 2012 integrated outpatient code editor specifications version 13.3

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 outpatient services provided to Medicare beneficiaries that are paid under the outpatient prospective payment system (OPPS) and also for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services provided by a home health agency not under the home health prospective payment system, or for claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider action needed

Caution – what you need to know

This article is based on change request (CR) 8035, which describes changes to be implemented in the October 2012 outpatient prospective payment system (OPPS) and integrated outpatient code editor (I/OCE) updates. Be sure your billing staff is aware of these changes.

Background

Medicare's I/OCE routes all institutional outpatient claims (including non-OPPS hospital claims) through a single integrated OCE which eliminates the need to update, install, and quarterly maintain two separate OCE software packages. It will be utilized under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided by a home health agency not under the home health prospective payment system, or to a hospice patient for the treatment of a non-terminal illness.

CR 8035, from which this article is taken, informs the FIs, A/B MACs, RHHIs and the fiscal intermediary shared system (FISS) that the I/OCE was updated for October 1, 2012, and provides them with the instruction and specification changes to be implemented in the October 2012 OPPS and I/OCE updates.

The full list of I/OCE specifications can now be found at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html*.

A summary of the changes for October 2012 can be found in Appendix M, and the "Preliminary Summary of Data Changes Integrated OCE v 13.3" document that are attachments to CR 8305, and that summary is captured in the following key points:

- Effective January 1, 2006, Medicare removed ICD-9-CM diagnosis code 7511 (Atresia and stenosis of small intestine) from the list of pediatric diagnoses, age 0-17 years old. Edit 2 is affected.
- Effective January 1, 2012, Medicare removed the procedure/device code pair requirements for procedure code *57288*
- Effective June 27, 2012, apply a mid-quarter national coverage determination approval date to code *43755*
- Implement version 18.3 of the NCCI (as modified for applicable institutional providers

Additional information

The official instruction, CR 8035 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/R2540CP.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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8035
Related Change Request (CR) #: CR 8035
Related CR Release Date: August 31, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2540CP
Implementation Date: October 1, 2012

Annual clotting factor furnishing fee update 2013

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers billing Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services related to the administration of clotting factors to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8049 and announces that for calendar year 2013, the clotting factor furnishing fee of $0.188 per unit is included in the published payment limit for clotting factors. For dates of service in 2013, the clotting factor furnishing fee of $0.188 per unit is added to the payment when no payment limit for the clotting factor is included in the average sales price (ASP) or not otherwise classified (NOC) drug pricing files. Please be sure your billing staffs are aware of this fee update.

Background

Section 1842(o)(5)(C) of the Social Security Act (added by the Medicare Modernization Act Section 303(e)(1)) requires, beginning January 1, 2005, that a clotting factor furnishing fee be paid separately if you furnish clotting factor; unless the costs associated with furnishing the clotting factor are paid through another payment system.

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the ASP Medicare Part B drug pricing file, or the NOC pricing file; your carrier, FI, RHHI, or A/B MAC must make payment for the clotting factor as well as make payment for the furnishing fee.

The clotting factor furnishing fees applicable for dates of service in each calendar year (CY) are listed below:

Clotting factor	Furnishing fee
CY 2005	$0.140 per unit
CY 2006	$0.146 per unit
CY 2007	$0.152 per unit
CY 2008	$0.158 per unit
CY 2009	$0.164 per unit
CY 2010	$0.170 per unit
CY 2011	$0.176 per unit
CY 2012	$0.181 per unit
CY 2013	$0.188 per unit

Additional information

The official instruction, CR 8049 issued to your Medicare carrier, FI, RHHI, or A/B MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2554CP.pdf*.

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

MLN Matters® Number: MM8049
Related Change Request (CR) #: 8049
Related CR Release Date: September 28, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2554CP
Implementation Date: January 7, 2013

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Charges *(continued)*

If you already received a development request for itemized bills and have **not** yet responded, you will only need to submit the requested documentation if the claim line payment exceeded the line billed charge amounts by at least $1,000 **and** three or more units of service were billed for that line item. First Coast requests that providers submit the itemized breakdown of charges and the applicable medical record documentation that supports the line item billed for the claim line(s) that suspend for reason code 39132.

If you have already responded to the documentation request, First Coast will adjudicate the claims after review of the itemized bills.

It is not necessary to contact customer service regarding this reason code.

For more information, refer to *MLN Matters*® article *MM7771*.

Reasonable charge update for 2013 for splints, casts, and certain IOLs

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers billing Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs)) for splints, casts, and certain intraocular lenses (IOLs) provided to Medicare beneficiaries.

What you need to know

This article, based on change request (CR) 8051, instructs Medicare contractors regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2013.

Background

Payment is made on a reasonable charge basis for splints and casts, as well as IOLs implanted in a physician's office.

- For splints and casts, the Q-codes are used when supplies are indicated for cast and splint purposes. Payment is in addition to payment made under the physician fee schedule for the procedure for applying the splint or cast.
- For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office (codes V2630, V2631, and V2632).

The 2013 payment limits for splints and casts will be based on the 2012 limits that were announced in CR 7628 last year, increased by 1.7 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2012. (You may view the article related to CR 7628 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//MM7628.pdf*.) The IIC update factor for 2013 is 1.7 percent.

A list of the 2013 payment limits for splints and casts is as follows:

2013 Payment Limits for Splints and Casts							
Code	**Allowance**	**Code**	**Allowance**	**Code**	**Allowance**	**Code**	**Allowance**
A4565	$8.26	Q4013	$15.13	Q4026	$113.30	Q4039	$7.91
Q4001	$47.00	Q4014	$25.51	Q4027	$18.15	Q4040	$19.77
Q4002	$177.62	Q4015	$7.57	Q4028	$56.67	Q4041	$19.20
Q4003	$33.75	Q4016	$12.75	Q4029	$27.75	Q4042	$32.78
Q4004	$116.86	Q4017	$8.75	Q4030	$73.05	Q4043	$9.61
Q4005	$12.45	Q4018	$13.94	Q4031	$13.87	Q4044	$16.39
Q4006	$28.05	Q4019	$4.38	Q4032	$36.52	Q4045	$11.15
Q4007	$6.23	Q4020	$6.98	Q4033	$25.88	Q4046	$17.93
Q4008	$14.02	Q4021	$6.47	Q4034	$64.38	Q4047	$5.56
Q4009	$8.31	Q4022	$11.68	Q4035	$12.94	Q4048	$8.97
Q4010	$18.70	Q4023	$3.25	Q4036	$32.20	Q4049	$2.03
Q4011	$4.15	Q4024	$5.84	Q4037	$15.79	Q4012	$9.36
Q4025	$36.29	Q4038	$39.56				

Medicare contractors will make payments for splints and casts furnished in 2013 based on the lower of the actual charge or the above payment limits.

The official instruction, CR 8015, 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/R2565CP.pdf*.

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

MLN Matters® Number: MM8051
Related Change Request (CR) #: CR 8051
Related CR Release Date: October 12, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2565CP
Implementation Date: January 7, 2013

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Influenza vaccine payment allowances – annual update for 2012-2013 season

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8047 in order to update payment allowances, effective August 1, 2012, for seasonal influenza virus vaccines when payment is based on 95 percent of the average wholesale price (AWP). Be sure your billing staffs are aware of this update.

Background

CR 8047 provides payment allowances for the following seasonal influenza virus vaccine codes when payment is based on 95 percent of the AWP (except for when payment is based on reasonable cost where the vaccine is furnished in a hospital outpatient department, a rural health clinic, or a federally qualified health center):

- *Current Procedural Terminology* (*CPT*) codes *90654, 90655, 90656, 90657, 90660*, and *90662*; and
- Healthcare Common Procedure Coding System (HCPCS) codes Q2034, Q2035, Q2036, Q2037, and Q2038.

Effective for dates of service on or after August 1, 2012, the Medicare Part B payment allowance for:

- *CPT 90655* is $16.456
- *CPT 90656* is $12.398
- *CPT 90657* is $6.023
- HCPCS Q2035 (Afluria®) is $11.543
- HCPCS Q2036 (Flulaval®) is $9.833
- HCPCS Q2037 (Fluvirin®) is $14.051
- HCPCS Q2038 (Fluzone®) is $12.046

Note: The Medicare Part B payment allowance for HCPCS Q2034 (Agriflu®) and HCPCS Q2039 (Flu vaccine adult - not otherwise classified) will be determined by the local claims processing contractor.

Payment for the following may be made if the local claims processing contractor determines its use is medically reasonable and necessary for the beneficiary:

- *CPT 90654* (Flu vaccine, intradermal, preservative free (Fluzone ID®));
- *CPT 90660* (FluMist®, a nasal influenza vaccine); or
- *CPT 90662* (Fluzone high-dose®).

Effective for dates of service on or after August 1, 2012, when payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for:

- *CPT 90654* is $18.981
- *CPT 90660* is $23.456
- *CPT 90662* is $30.923

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files.

Note: Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

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

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Influenza *(continued)*

Additional information

The official instruction, CR 8047, issued to your Medicare contractor (carrier, (FI), and A/B MAC) regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2562CP.pdf*.

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

MLN Matters® Number: MM8047
Related Change Request (CR) #: CR 8047
Related CR Release Date: October 3, 2012
Effective Date: August 1, 2012
Related CR Transmittal #: R2562CP
Implementation Date: No later than December 28, 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 update to the Medicare physician fee schedule database

Note: This article was revised on October 1, 2012, to reflect a revised change request (CR). The CR changes include additional instructions clarifying the effective date for HCPCS code *43775*, which is June 27, 2012. The CR number, transmittal number and link to the CR are also changed. All other information is unchanged. This information was previously published in the September 2012 *Medicare A Connection*, Page 44.

Provider types affected

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

Provider action needed

This article is based on CR 8017 which informs Medicare contractors that, in order to reflect appropriate payment policy in line with the calendar year (CY) 2012 Medicare physician fee schedule (MPFS) final rule, the MPFS database (MPFSDB) has been updated effective October 1, 2012, and new payment files have been created. CR 8017 instructs Medicare contractors to retrieve and implement the revised payment files when they are notified that these files are available for retrieval. Contractors will also give providers 30-day notice before implementing the changes identified in CR 8017. Changes will be retroactive to January 1, 2012, unless otherwise stated in CR 8017.

CR 8017 also points out that the Office of Clinical Standards and Quality (OCSQ-CMS) has updated their national coverage determination (NCD) concerning Healthcare Common Procedure Coding System (HCPCS) code *43775* (Lap sleeve gastrectomy). This HCPCS code was previously a non-covered Service (N), and CR 8017 now instructs that it will be carrier priced (C).

Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the U.S. Secretary of Health and Human Services (HHS) to establish ancillary policies necessary to implement relative values for the services of physicians. In order to reflect appropriate payment policy in line with the calendar year (CY) 2012 Medicare physician fee schedule (MPFS) final rule, the MPFS database (MPFSDB) has been updated effective October 1, 2012.

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MPFSDB *(continued)*

On December 23, 2011, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA; see *http://www.gpo.gov/fdsys/pkg/PLAW-112publ78/pdf/PLAW-112publ78.pdf*) became law and suspended the automatic negative update that would have taken effect with current law. The TPTCCA temporarily allowed for a zero percent update to the MPFS from January 1, 2012, until February 29, 2012. On February 22, 2012, the TPTCCA was signed into law and extended the zero percent update to the end of the calendar year, to December 31, 2012.

The Centers for Medicare & Medicaid Services (CMS) updated these payment files in July through CR 7844. You can review the *MLN Matters*® article, MM7844, which corresponds to CR 7844 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7844.pdf*.

CR 8017 constitutes the October amendment to those payment files, and unless otherwise stated in CR 8017, changes will be retroactive to January 1, 2012.

Additional information

The official instruction, CR 8017, issued to your carrier, FI, A/B MAC, or RHHI regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2559CP.pdf*. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8017 *Revised*
Related Change Request (CR) #: CR 8017
Related CR Release Date: September 28, 2012
Effective Date: June 27, 2012
Related CR Transmittal #: R2559CP
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.

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

Note: This article was revised on September 20, 2012, to reflect the revised change request (CR) 7760 issued on July 18. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the May 2012 *Medicare A Connection*, Pages 29-30.

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 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.

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Assessment *(continued)*

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
- 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.
- 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 the claim processing system.

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Assessment *(continued)*

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/R2495CP.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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM7760 *Revised*
Related Change Request (CR) #: 7760
Related CR Release Date: July 18, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2495CP
Implementation Date: October 1, 2012

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

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

Prepayment medical review of inpatient hospital claims – webcast follow-up

The following questions originated as a result of a webcast held on *September 19*. Each question is followed by the appropriate answer and all of the applicable sources are provided at the end of the document. For additional information on this topic, please refer to the *"Improper payments and inpatient prepayment medical review – update"* article and the *Inpatient diagnosis-related group (DRG) page* on the First Coast Service Options Medicare provider website.

1Q. To what address will the letters go?

1A. The notification letters will be sent to the provider's physical address on file, as well as the demand letters.

2Q. What is the percentage for the one-day stay audits?

2A. The percentage is 10 percent

3Q. What if the hospital doesn't file an appeal – can the Part B physician still file an appeal?

3A. Yes.

4Q. Where can a provider find its percentage denial rate for each diagnosis-related group (DRG)?

4A. Unfortunately, this information is not available from First Coast Service Options. We encourage providers to monitor and track their denial rates.

5Q. Why must the hospital and the physician file an appeal separately when it's the same patient and the same documentation?

5A. Hospital and physician appeals must be filed separately because the claims are processed within two unique claim systems.

6Q. If the physician and hospital are required to appeal separately, then how would a hospital's appeal impact the physician's appeal?

6A. The outcome of the hospital's appeal does not affect the physician's appeal.

7Q. Is there a way to know which hospitals have been excluded due to single digit error rate?

7A. No.

8Q. If you deny a Part A claim for wrong setting, do you also take back the Part B payment from the surgeon?

8A. If hospital claim is denied due to technical, administrative reasons other than medical necessity then no Part B recoupment will occur.

9Q. We received two additional development requests (ADRs) for DRG 069 within the last two weeks. How can we tell if this ADR is from First Coast or the Recovery Auditor (RA)?

9A. First Coast ADRs will be on First Coast Service Options letterhead. If the request is from the RA, it will be on Connolly's letterhead.

10Q. Is there an acceptable timeframe for conservative treatment to be documented in order for total knee replacement to be covered? If so, what is that timeframe?

10A. The LCD for total knee replacements (*L32078*) provides that documentation should demonstrate a history of a reasonable attempt (usually three months or more) at conservative therapy as appropriate for the patient in their current episode of care. First Coast also places reliance upon subspecialty and the Agency for Healthcare Research and Quality (AHRQ) clinical practice guidelines (*www.guidelines.gov*) to determine medical necessity and coverage for total knee replacements.

11Q. If the hospital's appeal is approved after we have been issued our demand letter, will we be notified?

11A. No. Hospital and physician appeals must be filed separately because the claims are processed within two unique systems.

Follow-up *(continued)*

12Q. If office staff identify that a physician has left out information, can an addendum be made to the medical records for the appeal process?

12A. You may include an addendum which must be clearly dated as of the time of submission. The original medical record may not be altered. Other documentation within this episode of care will be taken into consideration.

13Q. Does First Coast forward documentation to the RA?

13A. No. The RA sends its documentation to First Coast upon completion of their reviews.

14Q. Can you explain the appeals and recoupment process timeline?

14A. Once the provider receives a demand letter, the provider may start the appeal on day one. The provider has from day one until day 15 to write a rebuttal letter (keep in mind the hospital has already been denied for this claim and a rebuttal letter does not stop the recoupment process). On day 31, interest will be assessed until the debt is resolved, unless an appeal is filed. Day 41 the recoupment process begins. The provider has 120 days to file an appeal from the date of the demand letter, but interest will accrue from day 31 of the demand letter.

15Q. A patient is admitted to the hospital and a cardiologist is consulted. It is determined there is medical necessity for a cardiac procedure to be performed. First Coast review found the medical record submitted does not warrant an inpatient stay and denied the claim. Per the scenario described, the patient status is inpatient. Can the Part B cardiologist still bill for an inpatient evaluation?

15A. Yes.

16Q. Based on the scenario in 15Q above, can the Part B provider submit an appeal for the catheterization as an outpatient procedure? Again, per the scenario described, the patient status is inpatient.

16A. Heart catheterization is not included within the scope of the current audit.

17Q. How many days from the time the hospital receives its notification letter does the Part B provider receive a notification letter?

17A. The hospital receives a denial not a notification letter. The Part B notification letter is issued 60-90 days after review of the hospital claim.

Source: First Coast Medical policy and review; First Coast Office of the Medical Director; Comprehensive Error Rate Testing (CERT) program; Recovery Audit (RA) program

Find out first: Subscribe to First Coast *eNews*

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

Reminders before completing the pre-approval of therapy services form

First Coast Service Options' (First Coast's) Medical Review department is returning a high volume of *pre-approval requests for therapy services forms* due to inaccurate, incomplete, or invalid information. Requests that are returned will not be processed. Corrections must be completed and a new request submitted. The following list has been developed to assist you in avoiding this situation.

These are some things you should check for before faxing or mailing your form:

- Verify that you are submitting the pre-approval request during your appropriate phase. Pre-approvals may not be submitted earlier than 15 days prior to the beginning of your applicable phase.
- Do not send in documentation without the completed pre-approval request form.
- Do not use your own coversheet when faxing the pre-approval form. The completed pre-approval form will serve as your coversheet.
- Do not split a single request into multiple faxes. All documentation for a single pre-approval request must be submitted together. Do not submit duplicate requests.
- Physical therapy (PT), occupational therapy (OT), or speech language pathology (SLP) must be checked on the pre-approval form to indicate the therapy discipline that the additional days are being requested for.
- If a patient is receiving multiple disciplines (e.g., OT, PT) that you are requesting additional therapy days for, two separate requests must be submitted.
- Provide the correct provider transaction access number (PTAN) and/or national provider identifier (NPI) of the applicable facility or individual depending on whether this is for a Part A facility/entity or Part B individual/performing provider. If listing a facility/entity, report the legal business name as reported to the Internal Revenue Service (IRS).
- You must include the name and telephone number of the person to contact regarding the pre-approval request.
- Providers and therapists that are currently on any type of corrective action (e.g., probe, prepayment review, probe, prepayment review, zone program integrity contractor, etc.) process are not exempt from prepayment review and should consider whether the pre-approval process is beneficial for your office. Regardless of whether you receive a confirmation for approval or denial of additional therapy days, once the services are rendered and a claim is submitted, First Coast will request the medical records for review prior to determining whether payment will be made.

How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at *http://medicare.fcso.com/PDS/index.asp.*

Educational Events

Upcoming provider outreach and educational events – December 2012

Medicare Part A changes and regulations

When: Tuesday, December 18
Time: 11:30 a.m.-1:00 p.m. ET **Delivery language:** English
Type of Event: **Webcast** **Focus:** Florida, Puerto Rico, and the 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 First Coast 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*.

Educational Resources

CMS Medicare Provider e-News

The Centers for Medicare & Medicaid Services (CMS) Medicare Provider e-News is an official *Medicare Learning Network*® (*MLN*)-branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate. To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS is extending it until further notice. The following are links to the latest e-News:

- 'CMS Medicare FFS Provider e-News': September 26, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-26-e-News.pdf*
- 'CMS Medicare FFS Provider e-News': October 4, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-04-e-News.pdf*
- CMS e-News for Wednesday, October 11, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-11-e-News.pdf*
- 'CMS Medicare FFS Provider e-News': October 18, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-18-e-News.pdf*

Source: CMS PERL 201209-09, 201210-01, 201210-03, 201210-06

2012-2013 seasonal influenza resources for health care professionals

Provider types affected

All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries

What you need to know

- Keep this *MLN Matters*® special edition article and refer to it throughout the 2012 - 2013 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the New Year.
- Don't forget to immunize yourself and your staff.

Introduction

Annual outbreaks of seasonal flu typically occur as early as October and as late as May, with peak months in January and February. Illness from seasonal flu usually lasts one to two weeks, and flu-related complications include pneumonia and dehydration. Approximately 5 to 20 percent of Americans catch the seasonal flu each year. Getting the flu vaccine is your best protection against the flu.[1]

[1] Flu.gov. 2012. Seasonal Flu [online]. Washington D.C.: The U.S. Department of Health and Human Services, 2010 [cited 3 October 2012]. Available from the World Wide Web: http://www.flu.gov/about_the_flu/seasonal/index.html

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

Protect you and your family from the flu

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff.

Influenza *(continued)*

Educational products for health care professionals

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for seasonal flu vaccines and their administration.

MLN Seasonal Influenza Related Products for Health Care Professionals

- ***MLN Matters*® article MM8047: Influenza Vaccine Payment Allowances – Annual Update for 2012-2013 Season**: This article contains the payment allowances for the 2012-2013 flu season. You can download it at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8047.pdf*.
- ***Quick Reference Information: Medicare Part B Immunization Billing***: This educational tool is designed to provide education on Medicare-covered preventive immunizations. Available in print and as a downloadable PDF at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf*.
- ***Quick Reference Information: Preventive Services***: This educational tool is designed to provide education on the Medicare-covered preventive services. Available as a downloadable PDF at *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf*.
- ***MLN* Preventive Services Educational Products Web Page**: This *Medicare Learning Network*® (*MLN*®) Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. View this page at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html*.
- ***Preventive Services Educational Products***: This PDF provides a list of all *MLN* products related to Medicare-covered preventive services. View this PDF at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf*.

Other CMS resources

- Seasonal influenza vaccines 2012 pricing is at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2012ASPFiles.html*.
- Prevention General Information Overview is at *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*.
- CMS frequently asked questions are available at *http://questions.cms.gov/faq.php*.
- *Medicare Benefit Policy Manual* – Chapter 15, Section 50.4.4.2 – Immunizations available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*.
- *Medicare Claims Processing Manual* – Chapter 18, Preventive and Screening Services available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*.

Other resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2012–2013 flu season:

- Advisory Committee on Immunization Practices is at *http://www.cdc.gov/vaccines/recs/acip/default.htm*.
- American Lung Association's Influenza (Flu) Center is at *http://www.lungusa.org*. This website provides a flu clinic locator at *http://www.fluclinicslocator.org*. Individuals can enter their ZIP code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- Other sites with helpful information include:
  - **Centers for Disease Control and Prevention** – *http://www.cdc.gov/flu*
  - **Flu.gov** – *http://www.flu.gov*
  - **Food and Drug Administration** – *http://www.fda.gov*
  - **Immunization Action Coalition** – *http://www.immunize.org*
  - **Indian Health Services** – *http://www.ihs.gov/*

(continued on next page

Influenza *(continued)*

- **National Alliance for Hispanic Health** – *http://www.hispanichealth.org*
- **National Foundation For Infectious Diseases** – *http://www.nfid.org/influenza*
- **National Library of Medicine and NIH Medline Plus** – *http://www.nlm.nih.gov/medlineplus/immunization.html*
- **National Network for Immunization Information** – *http:/www.immunizationinfo.org*
- **National Vaccine Program** – *http://www.hhs.gov/nvpo*
- **Office of Disease Prevention and Health Promotion** – *http://odphp.osophs.dhhs.gov*
- **Partnership for Prevention** – *http://www.prevent.org*
- **World Health Organization** – *http://www.who.int/en*

Beneficiary information

For information to share with your Medicare patients, please visit *http://www.medicare.gov*.

MLN Matters® Number: SE1242
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation Date: NA

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Education materials for Round 1 Recompete bidders

New educational materials for the Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program are now available on the Competitive Bidding Implementation Contractor (CBIC) website at *www.DMECompetitiveBid.com*. CMS urges all bidders to take advantage of these new materials as well as the many other helpful tools and resources on the CBIC website.

First, the *Quick Step by Step User Guide* to Submitting a Bid DBidS has been issued. This guide provides step-by-step instructions for using the DMEPOS Bidding System (DBidS), the online bidding system.

Second, three new educational webcasts are now available for viewing. The first webcast, titled *Financial Documentation Requirements*, goes over the rules and requirements for the financial documents that you must submit in addition to your online bid. The second webcast, titled *How a Bid is Evaluated*, describes each step of the bid evaluation process, from receipt of electronic bid data and hardcopy documents through awarding of contracts. The final in this series of webcasts, titled *How to Submit a Bid*, explains how to submit a bid using the online bidding system, DBidS.

All webcasts are available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcasts, and a transcript for each webcast is also posted on the website. To view the webcasts, select Round 1 Recompete, then click *Educational Information*, and choose *Education Events*.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9am to 9pm prevailing Eastern Time, Monday through Friday, throughout the registration and bidding periods.

Source: CMS PERL 201210-04

CMS fraud prevention training modules for providers

In June 2012, the Centers for Medicare & Medicaid Services (CMS) produced two fraud prevention training modules that are currently available on the Medscape website. These modules provide key information to health care practitioners and professionals on how they can assist CMS in preventing fraud and abuse, as well as highlight CMS' efforts to fight fraud and abuse and explain how health care professionals can be part of these efforts.

The first module, "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients," presents CMS' provider-focused fraud awareness and prevention initiatives. The goal of this activity is to provide health care professionals with actionable ideas for working with CMS and other agencies that investigate suspected fraud and abuse. This module also informs providers about how they can reduce the risk of fraud and abuse for their practices and patients. This module can be found at *http://www.medscape.org/viewarticle/764496*.

The goal of the second module, "How CMS Is Fighting Fraud: Major Program Integrity Initiatives," describes recent and on-going strategies that CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. The goal of this activity is to increase awareness amongst providers about the strategies CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. This module can be found at *http://www.medscape.org/viewarticle/764791*.

The modules feature Dr. Peter Budetti, Deputy Administrator of the Center for Program Integrity; Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity; and Mary Agnes Laureno, former Deputy Director of the Center for Program Integrity.

A total of 1.25 hours of continuing medical education (CME) credit can be earned for any Medscape user registered as a doctor or health care professional. Medscape accounts are free, and users do not have to be health care professionals to register for them. Registration is on the landing page of *www.medscape.com*.

Instructions for accessing the Medscape modules

Step 1: Access the website *www.medscape.org*. Medscape accounts are free of charge.

Step 2: Registration is on the upper right hand corner of the home page of *www.medscape.org* next to the log in field.

Step 3: To access the modules, first enter your membership log in information.

Step 4: To view the "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients" module, use this link: *http://www.medscape.org/viewarticle/764496*.

Step 5: To view the "How CMS Is Fighting Fraud: Major Program Integrity Initiatives" module, use this link: *http://www.medscape.org/viewarticle/764791* .

Source: TDL 12472

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