

C Medicare A CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

December 2012



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January 2013 update of the hospital outpatient prospective payment system (OPPS)

Provider types affected

This *MLN Matters*® Article is intended for providers who submit claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and/or A/B Medicare administrative contractors (A/B MACs)) for services subject to the outpatient prospective payment system (OPPS) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8141 which describes changes to the OPPS to be implemented in the January 2013 OPPS update. The January 2013 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 8141. Make sure that your billing staffs are aware of these changes.

Background

Change Request (CR) 8141 describes changes to and billing instructions for various payment policies implemented in the January 2013 OPPS update. The January 2013 integrated outpatient code editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment

classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 8141.

The January 2013 revisions to I/OCE data files, instructions, and specifications are provided in the upcoming January 2013 I/OCE CR, which is CR 8137. Upon release of CR 8137, a related *MLN Matters*® Article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8137.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Key changes to and billing instructions for various payment policies implemented in the January 2013 OPPS update are:

Changes to Device Edits in January 2013

The most current list of device edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/> on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

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OPPS (continued)

Current Procedural Terminology® (CPT) Codes for intracoronary stent placement procedures

Effective January 1, 2013, the American Medical Association's (AMA's) *Current Procedural Terminology*® (CPT) editorial panel is deleting CPT® codes 92980 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) and 92981 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel), which are used to describe nondrug-eluting intracoronary stent placement procedures and replacing them with new CPT® codes.

The creation of new CPT® codes involving intracoronary stent placement procedures for 2013 requires CMS to create nine new HCPCS C-codes and to delete two existing HCPCS G-codes in order to maintain existing OPPS policy of differentiating payment for intracoronary stent placement procedures involving nondrug-eluting and drug-eluting stents for 2013.

CMS is updating the "Medicare Claims Processing Manual," Chapter 4, Section 61.5 as an attachment to CR 8141 to reflect these changes to the intracoronary stent placement HCPCS codes and reporting guidelines.

Since 2003, under the OPPS, CMS assigned coronary stent placement procedures to separate APCs based on the use of nondrug-eluting or drug-eluting stents (APC 0104 (Transcatheter Placement of Intracoronary Stents) or APC 0656 (Transcatheter Placement of Intracoronary Drug-Eluting Stents, respectively). In order to effectuate this policy, CMS created HCPCS G-codes G0290 (Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) and G0291 (Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel) for drug-eluting intracoronary stent placement procedures that parallel existing CPT® codes 92980 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) and 92981 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel), which are used to describe nondrug-eluting intracoronary stent placement procedures. For 2012 and years prior, CPT® codes 92980 and 92981 have been assigned to APC 0104, while HCPCS codes G0290 and G0291 have been assigned to APC 0656.

Effective January 1, 2013, the AMA's CPT Editorial Panel is deleting CPT® codes 92980 and 92981 and replacing them with the following new CPT® codes:

- CPT® code 92928 (*Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch*);
- CPT® code 92929 (*Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery* (List separately in addition to code for primary procedure));
- CPT® code 92933 (*Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch*);
- CPT® code 92934 (*Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery* (List separately in addition to code for primary procedure));
- CPT® code 92937 (*Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel*);
- CPT® code 92938 (*Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft* (List separately in addition to code for primary procedure));
- CPT® code 92941 (*Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel*);
- CPT® code 92943 (*Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel*); and
- CPT® code 92944 (*Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft* (List separately in addition to code for primary procedure)).

In order to maintain the existing policy of differentiating payment for intracoronary stent placement procedures involving nondrug-eluting and drug-eluting stents, CMS is deleting HCPCS codes G0290 and G0291

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OPPS (continued)

and replacing them with the following new HCPCS C-codes to parallel the new CPT® codes:

- HCPCS code C9600 (Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch);
- HCPCS code C9601 (Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));
- HCPCS code C9602 (Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch);
- HCPCS code C9603 (Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));
- HCPCS code C9604 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel);

without other therapeutic intervention, any method; single vessel) and 92981 (*Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel*), which are used to describe nondrug-eluting intracoronary stent placement procedures. For 2012 and years prior, CPT® codes 92980 and 92981 have been assigned to APC 0104, while HCPCS codes G0290 and G0291 have been assigned to APC 0656.

Effective January 1, 2013, the AMA's CPT® Editorial Panel is deleting CPT® codes 92980 and 92981 and replacing them with the following new CPT® codes:

- CPT® code 92928 (*Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch*);
- CPT® code 92929 (*Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)*);
- CPT® code 92933 (*Percutaneous transluminal coronary atherectomy, with intracoronary stent, with*

coronary angioplasty when performed; single major coronary artery or branch);

- CPT® code 92934 (*Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)*);
- CPT® code 92937 (*Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel*);
- CPT® code 92938 (*Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)*);
- CPT® code 92941 (*Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel*);
- CPT® code 92943 (*Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel*); and
- CPT® code 92944 (*Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)*).

In order to maintain the existing policy of differentiating payment for intracoronary stent placement procedures involving nondrug-eluting and drug-eluting stents, CMS is deleting HCPCS codes G0290 and G0291 and replacing them with the following new HCPCS C-codes to parallel the new CPT® codes:

- HCPCS code C9600 (Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch);

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- HCPCS code C9601 (Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));
- HCPCS code C9602 (Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch);
- HCPCS code C9603 (Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));
- HCPCS code C9604 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel);
- HCPCS code C9605 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure));
- HCPCS code C9606 (Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel);
- HCPCS code C9607 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel); and

- HCPCS code C9608 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)).

CPT® codes 92928, 92933, 92929, 92934, 92937, 92938, 92941, 92943, and 92944 should be used to describe nondrug-eluting intracoronary stent placement procedures and are assigned to APC 0104. HCPCS codes C9600, C9601, C9602, C9603, C9604, C9605, C9606, C9607, and C9608 are assigned to APC 0656.

Outpatient payment for Composite APC 8000 (cardiac electrophysiologic evaluation and ablation composite)

CMS is modifying the “Medicare Claims Processing Manual,” Chapter 4, Section 10.2.1 (included as an attachment to CR 8141), to account for coding changes to cardiac electrophysiologic evaluation and ablation codes by the AMA’s CPT® Editorial Panel. The CPT® Editorial Panel deleted CPT® codes 93651 and 93652, effective 1/1/2013, and created new CPT® codes 93653, 93654, and 93656, effective 1/1/2013.

Composite APC	Composite APC Title	Criteria for Composite Payment
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of CPT® code 93619 or 93620 and at least one unit of CPT® code 93650 on the same date of service; or, at least one unit of CPT® codes 93653, 93654, or 93656 (no additional concurrent service codes required).

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OPPS (continued)

New ‘Sometimes Therapy’ Services that May Be Paid as Non-Therapy Services for Hospital Outpatients

Effective January 1, 2013, CMS is adding two HCPCS codes that are new for 2013 to the list of Physical Therapy/Speech-Language Pathology/Occupational Therapy (PT/SLP/OT) “sometimes therapy” services that may be paid under certain circumstances to a facility under the OPPS. They are:

HCPCS Code	Long Descriptor
G0456	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters.
G0457	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters.

The limited set of sometimes therapy services listed in the manual are paid under the OPPS when they are not furnished as therapy, meaning they are not furnished under a certified therapy plan of care. When a hospital furnishes these services to a hospital outpatient as non-therapy, the hospital may submit a claim for facility payment for the services to the OPPS.

Coding changes for partial hospitalization program (PHP) services

In the “Medicare Claims Processing Manual” (Chapter 4, Sections 260.1 and 260.1.1; included as an attachment to CR 8141), several revisions are being made to the PHP billing code set. Effective January 1, 2013, the AMA’s CPT® Editorial Panel deleted 28 psychiatric CPT® codes, including those related to PHP services, and replaced them with 12 new CPT® codes.

As a result of the AMA’s CPT® coding changes to the psychiatric CPT® codes, CMS is making corresponding changes to the PHP code set that is used for billing and documenting PHP services.

Drugs, Biologicals, and Radiopharmaceuticals

For 2013, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in the following:

Table 1 – New 2013 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

2013 HCPCS Code	2013 Long Descriptor	2013 SI	2013 APC
C9294	Injection, taliglucerase alfa, 10 units	G	9294
C9295	Injection, carfilzomib, 1 mg	G	9295
C9296	Injection, ziv-aflibercept, 1 mg	G	9296
J1744	Injection, icatibant, 1 mg	K	1443
J2212	Injection, methylnaltrexone, 0.1 mg	K	1445
J7315	Mitomycin, ophthalmic, 0.2 mg	N	
Q4134	Hmatrix, per square centimeter	E	
Q4135	Mediskin, per square centimeter	E	
Q4136	Ez-derm, per square centimeter	E	
Q9969	Tc-99m from non highly-enriched uranium source, full cost recovery add-on, per study dose	K	1442

Other Changes to 2013 HCPCS and CPT® Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT® codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT® code descriptors that will be effective in 2013. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2012, and replaced with permanent HCPCS codes in 2013. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active 2013 HCPCS and CPT® codes.

Table 2 (also included in Attachment A, CR 8141) notes those drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS/CPT® code, their long descriptor, or both.

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Each product's 2012 HCPCS/CPT® code and long descriptor are noted in the two left hand columns and the 2013 HCPCS/CPT® code and long descriptor are noted in the adjacent right hand columns.

Table 2			
2012 HCPCS/ CPT	2012 Long Descriptor	2013 HCPCS/ CPT	2013 Long Descriptor
C9279	Injection, ibuprofen, 100 mg	J1741	Injection, ibuprofen, 100 mg
C9286	Injection, belatacept, 1 mg	J0485	Injection, belatacept, 1 mg
C9287	Injection, brentuximab vedotin, 1 mg	J9042	Injection, brentuximab vedotin, 1 mg
C9288	Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vial	J0716	Injection, centruroides immune f(ab)2, up to 120 milligrams
C9289	Injection, asparaginase erwinia chrysanthemi, 1,000 international units (i.u.)	J9019	Injection, asparaginase (Erwinaze), 1,000 IU
C9366	EpiFix, per square centimeter	Q4131	Epifix, per square centimeter
C9368	Grafix core, per square centimeter	Q4132	Grafix core, per square centimeter
C9369	Grafix prime, per square centimeter	Q4133	Grafix prime, per square centimeter
J1051	Injection, medroxyprogesterone acetate, 50 mg	J1050	Injection, medroxyprogesterone acetate, 1 mg
J8561	Everolimus, oral, 0.25 mg	J7527	Everolimus, oral, 0.25 mg
J9020	Injection, asparaginase, 10,000 units	J9020	Injection, Asparaginase, Not Otherwise Specified, 10,000 Units
J9280	Mitomycin, 5 mg	J9280	Injection, mitomycin, 5 mg
Q2045*	Injection, human fibrinogen concentrate, 1 mg	J7178	Injection, human fibrinogen concentrate, 1 mg
Q2046*	Injection, aflibercept, 1 mg	J0178	Injection, aflibercept, 1 mg
Q2047	Injection, peginesatide, 0.1 mg (for esrd on dialysis)	J0890	Injection, peginesatide, 0.1 mg (for esrd on dialysis)
Q2048*	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg	J9002	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg
Q4119	Matristem wound matrix, per square centimeter	Q4119	Matristem wound matrix, psmx, rs, or psm, per square centimeter
Q4126	Memoderm, per square centimeter	Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter
Q4128	Flexhd or allopatch hd, per square centimeter	Q4128	Flex hd, allopatch hd, or matrix hd, per square centimeter

OPPS (continued)

*HCPCS code J1680 was replaced with HCPCS code Q2045 effective July 1, 2012. HCPCS code Q2045 was subsequently replaced with HCPCS code J7178, effective January 1, 2013.

*HCPCS code C9291 was replaced with HCPCS code Q2046 effective July 1, 2012. HCPCS code Q2046 was subsequently replaced with HCPCS code J0178, effective January 1, 2013.

*HCPCS code J9001 was replaced with HCPCS code Q2048 effective July 1, 2012. HCPCS code Q2048 was subsequently replaced with HCPCS code J9002, effective January 1, 2013.

Drugs and Biologicals with payments based on average sales price (ASP) Effective January 1, 2013

For 2013, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In 2013, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2013, payment rates for many drugs and biologicals have changed from the values published in the 2013 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of 2012. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2013 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request implementing the January 2013 update of the OPPS. However, the updated payment rates effective January 1, 2013, can be found in the January 2013 update of the OPPS Addendum A and Addendum B at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website.

Updated payment rate for a HCPCS code effective April 1, through June 30, 2012

The payment rate for one HCPCS code was incorrect in the April 2012 OPPS Pricer. The corrected payment rate is listed in Table 3 and has been installed in the January 2013 OPPS Pricer, effective for services furnished on April 1, 2012, through June 30, 2012.

Table 3 – Updated payment Rates for Certain HCPCS Codes Effective

April 1, 2012, through June 30, 2012

HCPCS Code	Q4112
Status indicator	K
APC	1250
Short Description	Cymetra allograft
Corrected Payment Rate	\$271.12
Corrected Minimum Unadjusted Copayment	\$54.22

If you had claims incorrectly processed due to the incorrect rate, your Medicare contractor will adjust the claims if you bring them to the contractor’s attention.

Updated Payment Rate for a HCPCS Code Effective July 1, 2012, through September 30, 2012

The payment rate for one HCPCS code was incorrect in the July 2012 OPPS Pricer. The corrected payment rate is listed in Table 4 below and has been installed in the January 2013 OPPS Pricer, effective for services furnished on July 1, 2012, through September 30, 2012.

Table 4 – Updated payment Rates for Certain HCPCS Codes Effective

July 1, 2012, through September 30, 2012

HCPCS Code	Q4112
Status Indicator	K
APC	1250
Short Descriptor	Cymetra allograft
Corrected Payment Rate	\$323.65
Corrected Minimum Unadjusted Copayment	\$64.73

If you had claims incorrectly processed due to the incorrect rate, your Medicare contractor will adjust the claims if you bring them to the contractor’s attention.

2013 OPPS Payment Adjustment for Certain Cancer Hospitals

Consistent with Section 3138 of the Affordable Care Act, CMS adopted a policy beginning in 2012 to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital’s final Payment to Cost Ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR

OPPS *(continued)*

(which CMS refers to as the “target PCR”) for other hospitals paid under the OPPS. The target PCR is set in advance of the calendar year and is calculated using the most recent submitted or settled cost report data that are available at the time of final rulemaking for the calendar year. CMS is updating the “Medicare Claims Processing Manual” (Chapter 4, Section 10.6.3.1) to reflect that the target PCR for 2013, for purposes of the cancer hospital payment adjustment, is 0.91 for outpatient services furnished on or after January 1, 2013, through December 31, 2013.

Changes to OPPS Pricer Logic

- Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in 2013. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13)(B) of the Act, as added by section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).
- New OPPS payment rates and copayment amounts will be effective January 1, 2013. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the 2013 inpatient deductible.
- For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2013. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is $(\text{cost} - (\text{APC payment} \times 1.75)) / 2$.
- There will be no change in the fixed-dollar threshold in 2013. The estimated cost of a service must be greater than the APC payment amount plus \$2,025 in order to qualify for outlier payments.
- For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2012. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is $(\text{cost} - (\text{APC 0173 payment} \times 3.4)) / 2$.

- Effective January 1, 2013, three devices are eligible for pass-through payment in the OPPS Pricer logic. Category C1830 (Powered bone marrow biopsy needle), has an offset amount of \$0, because CMS is not able to identify portions of the APC payment amounts associated with the cost of the device. Category C1840 (Lens, intraocular (implantable)) and C1886 (Catheter, extravascular tissue ablation, any modality (insertable)) have offset amounts included in the Pricer for 2013. Pass-through offset amounts are adjusted annually. For outlier purposes, when C1830, C1840, or C1886 are billed with a service included in APC 0003, APC 0234 or APC 0415, respectively, they will be associated with a specific HCPCS code in those APCs for outlier eligibility and payment.
- Effective January 1, 2013, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.
- Effective January 1, 2013, there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the 2013 APC payments for nuclear medicine procedures and may be found on the CMS website.
- Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.
- Effective January 1, 2013, CMS is adopting the FY 2013 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals. Further discussion of this is available in CR 8141 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2611CP.pdf> on the CMS website.

(continued on next page)

OPPS (continued)

Medicare Coverage for Drugs, Devices, Procedures, and Services

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. FIs/MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 8141 issued to your FIs, RHHIs, A/B MACs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2611CP.pdf> on the CMS website.

If you have any questions, please contact your FIs, RHHIs, and/or A/B MACs at their toll-free number,

which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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Learn the secrets to billing Medicare correctly

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Prescription drug monitoring programs: a resource to help address prescription drug abuse and diversion

Provider types affected

This *MLN Matters*[®] special edition article about prescription drug monitoring programs (PDMPs) is intended for physicians, pharmacists, nurses, and other health care providers that prescribe or dispense scheduled drugs.

What You Need to Know

Prescription drug abuse and diversion are acute problems in the area of pain management. Efforts to improve the management of pain create a dilemma for physicians and other providers, who have to balance legitimate patient therapeutic needs against what may be potential abuse or drug diversion activities due to the drug-seeking behavior of their patients.

Most States have operational PDMPs that collect data on prescriptions of controlled substances in order to provide resources to reduce prescription drug abuse and diversion. If you enroll in your state's PDMP, you may get reports to help you identify patients who are obtaining prescriptions from other doctors or from multiple pharmacies, or who may be at risk for prescription drug abuse. A PDMP report may be particularly useful before prescribing controlled substances for new patients. Visit from multiple pharmacies, or who may be at risk for prescription drug abuse. A PDMP report may be particularly useful before prescribing controlled substances for new patients. Visit from multiple pharmacies, or who may be at risk for prescription drug abuse. A PDMP report may be particularly useful before prescribing controlled substances for new patients. Visit <http://www.pmpalliance.org/content/prescription-monitoring-frequently-asked-questions-faq> for more information and links to your state's PDMP.

Background

PDMPs are statewide electronic databases that collect prescription dispensing data of controlled substances. Legislation authorizing collection of data is currently in place in 49 states with 41 states having a functional PDMP.¹ These databases were originally implemented as an effort to address controlled substance abuse and reduce diversion.

Despite the proliferation of PDMPs, not all of them function in the same manner. The agencies that are responsible for housing and monitoring these programs vary across states but are typically located in either the state's board of pharmacy, Department of Health and Human Services, or law enforcement agencies. States have a say on what type of controlled substances are tracked (CII-V) and may include other

prescription drugs such as tramadol, carisoprodol, or butalbital.

Many PDMPs provide secure online access to authorized users including physicians and pharmacists. These monitoring programs can report dispensing dates, prescriber, pharmacy, drug name, quantity, and strength of controlled substance prescriptions, including opioids.

Although the focus of PDMPs was originally intended to help reduce drug diversion and abuse, they can also be used for improving medical care and ensuring safe use of controlled substances. Improving the prescribing of controlled substances can reduce their diversion and abuse. Identifying abusers for treatment can improve the public's health.

Need for Action

Abuse of prescription drugs is considered the nation's fastest growing drug-problem. Average sales of opioids per person have increased from 74 milligrams to 369 milligrams between 1997 and 2007, a 402 percent increase. The Centers for Disease Control and Prevention (CDC) reported that the estimated number of emergency department visits for non-medical use of opioid analgesics increased 111 percent during 2004-2008 (from 144,600 to 305,900 visits). In addition, drug overdoses, including those from prescription drugs, were the second leading cause of deaths from unintentional injuries in the United States during 2007, exceeded only by motor vehicle fatalities.

Movements to improve pain assessment and control have increased the awareness among physicians and patients on the need for analgesics, fueling the nation's consumption, which ranks among the highest in the world. This increased attention to better managing pain creates a dilemma for prescribers who must appropriately prescribe potent opioids for the treatment of pain while being mindful of the possibility that certain individuals may be seeking prescriptions for non-medical purposes or to satisfy an addiction.

Don't be duped into believing "not my Medicare patient." A recent U.S. Government Accountability Office (GAO) report titled "Medicare Part D: Instances of Questionable Access to Prescription Drugs," identified 170,000 Medicare beneficiaries who received prescriptions from five or more prescribers and often receiving 2-4 times a normal year's supply. The most frequently prescribed drugs were hydrocodone with acetaminophen and oxycodone alone or in combination. When samples of these

(continued on next page)

Diversion (continued)

cases were reviewed with the prescribing physicians, none were aware of the other prescribers. In many cases, the beneficiary had signed a pain management agreement but continued to 'doctor shop.'

Beginning in 2013, due to the risks of adverse effects from misuse of opioid analgesics, the Centers for Medicare & Medicaid Services (CMS) will require Medicare Part D plans to contact prescribers to ascertain the medical necessity of potentially unsafe, high opioid dosages used for chronic, non-cancer pain. For more information about the requirements for Medicare Part D sponsors to manage the use of opioids in their prescription drug plans, go to <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html> on the CMS website.

With added involvement and interventions from prescribers and pharmacists, PDMPs are one step towards resolving inappropriate or unsafe controlled substance prescription use by the identification of 'doctor shoppers' and detecting therapeutic duplication. Most states require pharmacies to report controlled substance prescription data at least biweekly to their PDMP. This consistent and up-to-date monitoring could prevent the dispensing of unnecessarily high amounts of controlled substance prescriptions at either the physician visit or dispensing pharmacy - a more direct and time efficient method.

A recent report assessing the best practices of PDMPs identified six areas for further development.³ One area of special note was increasing medical provider education and encouraging the use of PDMPs as a clinical tool. This second area is the natural extension of PDMP data into the broader areas of improving public health and safety.

Provider action

PDMP records may help you determine if a patient is obtaining prescriptions from other doctors or from multiple pharmacies. We encourage you to actively participate in your state's PDMP:

- Determine if your state has a PDMP and how you can access the data by visiting <http://www.pmpalliance.org/content/state-pmp-websites> on the Internet.
- Consider developing an office protocol to request a PDMP report for all new patients receiving a controlled substance. Additionally, a periodic PDMP report could be requested if pain control is for a chronic condition to assure that the patient is properly managing their medications.

Beginning in 2013, due to the risks of adverse effects from misuse of opioid analgesics, the Centers for Medicare & Medicaid Services (CMS) will require Medicare Part D plans to contact prescribers to ascertain the medical necessity of potentially unsafe, high opioid dosages used for chronic, non-cancer pain.

Additional information

If you use a software vendor or clearinghouse to access Medicare beneficiary health insurance eligibility information, you should direct questions to your vendor or clearinghouse. If you have any questions about HETS, please contact the MCARE Help Desk at 1-866-324-7315.

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1 Clark T, Eadie J, Kreiner P, Strickler G. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices. The PDMP Center of Excellence, Heller School for Social Policy and Management, Brandeis University. September 20, 2012.

2 Unintentional drug poisoning in the United States [July 2010]. National Center for Injury Prevention and Control. Centers for Disease Control and Prevention. <http://www.cdc.gov/HomeandRecreationalSafety/pdf/poison-issue-brief.pdf>.

3 Clark T, Eadie J, Kreiner P, Strickler G. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices. The PDMP Center of Excellence, Heller School for Social Policy and Management, Brandeis University. September 20, 2012.

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Importance of preparing/maintaining legible medical records

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and other providers who document treatment for Medicare beneficiaries and/or submit claims for Medicare fee-for-service (FFS) reimbursement.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is publishing this article to highlight the importance of legible documentation in avoiding claim denials. This SE1237 article is informational only and does not alter existing Medicare policy, and does not introduce new policy.

Background

Many claim denials occur because the providers or suppliers do not submit sufficient documentation to support the service or supply billed. Frequently, this documentation is insufficient to demonstrate medical necessity. In accordance with Section 1862(a)(1)(A) of the Social Security Act, CMS must deny an item or service if it is not reasonable and necessary. (See item 1 in the “References” section.) When determining the medical necessity of the item or service billed, Medicare’s review contractors must rely on the medical documentation submitted by the provider in support of a given claim. Therefore, legibility of clinical notes and other supporting documentation is critical to avoid Medicare FFS claim payment denials. (See item 2 in the “References” section.)

Key Points

General Principles of Medical Record Documentation (See items 3,4,5 in the “References” section below.)
—Be Aware The general principles of medical record documentation to support a service or supply billed for Medicare payment includes the following (as applicable to the specific setting/encounter):

1. Medical records should be complete and legible;
2. Medical records should include the legible identity of the provider and the date of service.

Amendments, Corrections and Delayed Entries in Medical Documentation (See item 6 in the “References” section below.)

Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles:

1. Clearly and permanently identify any amendments, corrections or addenda.
2. Clearly indicate the date and author of any amendments, corrections, or addenda.

3. Clearly identify all original content (do not delete).

Medicare Signature Requirements

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature.

- If the signature is illegible or missing from the medical documentation (other than an order), the review contractor shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, the review contractor shall disregard the order during the review of the claim (i.e., the reviewer will proceed as if the order was not received). Signature attestations are not allowable for orders.

References

1. See the testimony of Thursday, July 15, 2010 to the United States Senate Committee on Homeland Security and Government Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and Internet. “Preventing and Recovering Medicare Payment Errors” at <http://www.hhs.gov/asl/testify/2010/07/t20100715a.html> on the CMS website.
2. See the CMS “Medicare Program Integrity Manual” Section 3.6.2.1 - Coverage Determinations at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf> on the CMS website.
3. See the “Medicare Benefit Policy Manual” Chapter 2, Section 30, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c02.pdf> on the CMS website.
4. See Change Request (CR) 2520, Provider Education Article, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/AB03037.pdf> on the CMS website.
5. See the *MLN Matters*® Special Edition article, SE1027, entitled “Recovery Audit Contractor (RAC) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals” at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1027.pdf> on the CMS website.

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Legible (continued)

6. See the “Medicare Program Integrity Manual” Section 3.3.2.5 – Amendments, Corrections and Delayed Entries in Medical Documentation at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf> on the CMS website.

7. See the “Medicare Program Integrity Manual” Section 3.3.2.4 - Signature Requirements

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf> on the CMS website.

Additional information

If you have any questions, please contact your carrier, FI, DME MAC 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> on the CMS website.

For additional information and educational materials related to provider compliance, visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html> on the CMS website.

To review specific rules for signature guidelines for medical review purposes and language for E-Prescribing you may go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf> on the CMS website.

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Expansion of Medicare telehealth services for 2013

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), and/or A/B Medicare administrative contractors (A/B MACs) for telehealth services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7900 which updates the list of Medicare telehealth services in the “Medicare Benefit Policy Manual” and the “Medicare Claims Processing Manual”.

In the 2013 physician fee schedule proposed rule with comment period, the Centers for Medicare & Medicaid Services (CMS) is proposing to add 8 codes to the list of Medicare distant site telehealth services. Additionally, the 2013 Healthcare Procedural Coding System (HCPCS) update will replace several *Current Procedural Terminology*® (CPT®) codes related to psychotherapy services and a number of these services are on the list of approved telehealth services.

Therefore, CR 7900 updates the list of approved telehealth services to reflect these code changes

and it replaces several CPT® codes related to psychotherapy services. See the *Background* and *Additional Information* sections of this article for further details regarding these changes.

Background

Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT® codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners were instructed to bill a new or established patient office/outpatient visit CPT® code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits.

CMS has approved the use of a telecommunications system to substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. The conditions of payment for Medicare telehealth services, including qualifying originating sites and the types of telecommunications systems recognized by Medicare, are subject to the provisions of 42 CFR

(continued on next page)

Telehealth (continued)

410.78 (see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr410_main_02.tpl on the Internet). Payment for these services is subject to the provisions of 42 CFR 414.65 (see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl on the Internet).

In the calendar year 2013 PFS proposed rule with comment period, CMS is proposing to add 8 codes to the list of Medicare distant site telehealth services. Additionally, the 2013 HCPCS update will replace several CPT procedure codes related to psychotherapy services, and a number of these services are on the list of approved telehealth services. The established policy for these telehealth services has not changed.

CMS is proposing to add the eight services contained in the following table to the List of Medicare Telehealth Services for 2013. CR 7900 instructs that the HCPCS codes for these services should be added to the List of Medicare Telehealth Services:

HCPCS code descriptor

G0396: Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and brief intervention, 15 to 30 minutes

G0397: Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and intervention greater than 30 minutes

G0442: Annual alcohol misuse screening, 15 minutes

G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes.

G0444: Annual depression screening, 15 minutes.

G0445: High-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes.

G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes.

G0447: Face-to-face behavioral counseling for obesity, 15 minutes.

CR 7900 also adds relevant policy instructions to the manuals regarding the addition of these codes.

The following CPT® codes should be added to the List of Telehealth Services to replace codes that will be deleted for 2013:

• CPT® codes 90832, 90833, 90834, 90836, 90837,

90838 to report individual psychotherapy services, reported with CPT® codes 90804 – 90809 prior to 2013; and

• CPT® codes 90791, 90792 to report psychiatric diagnostic interview examination, reported with CPT® code 90801 prior to 2013.

CR 7900 revises the “Medicare Claims Processing Manual” (Chapter 12, Section 190.3 (List of Medicare Telehealth Services)) and the “Medicare Benefit Policy Manual” (Chapter 15, Section 270.2 (List of Medicare Telehealth Services)) which are included as attachments to CR 7900.

Additional information

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

You can also find information about submitting requests for adding services to the list of Medicare telehealth services at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Criteria.html> on the CMS website.

The official instruction, CR 7900, was issued to your FI, carrier, or A/B MAC via two transmittals. The first updates the “Medicare Benefit Policy Manual” and it is at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R164BP.pdf> on the CMS website. The second transmittal updates the “Medicare Claims Processing Manual,” which is available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2606CP.pdf> on the CMS website.

If you have any questions, please contact your FI, carrier and/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> on the CMS website.

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Related Change Request (CR) #: CR 7900

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Phase 2 of ordering/referring requirement

Note: This article was revised on December 10, 2012, to delete language relating to portable X-ray services. All other information remains the same. This information was previously published in the November 2012 Medicare A Connection, Pages 10-13.

Provider types affected

This *MLN Matters*[®] special edition article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,
- Part B providers and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A home health agency (HHA) services who submit claims to RHHIs, fiscal intermediaries (who still maintain an HHA workload), and Part A/B MACs.

Stop – impact to you

CMS will soon begin denying Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. These edits ensure that physicians and others who are eligible to order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60 day advanced notice prior to turning on the ordering/referring edits. CMS does not have a date at this time.

Caution – what you need to know

CMS shall authorize A/B MACs and DME MACs to begin editing Medicare claims with phase 2 ordering/referring edits. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral from a provider who does not have a Medicare enrollment record.

Go – what you need to do

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O).

Background

The Affordable Care Act requires physicians or other eligible professionals to be enrolled in the Medicare Program to order/ refer items or services for Medicare beneficiaries. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the national provider identifier (NPI).

CMS began expanding the claims editing to meet these requirements for ordering and referring providers as follows:

- **Phase 1:** Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message in the remittance advice indicating that the claim failed the ordering/referring provider edits.

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry)
- Physician assistant
- Clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Interns, residents, and fellows
- Certified nurse midwife
- Clinical social worker

The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

(continued on next page)

Phase 2 *(continued)*

For Part B providers and suppliers who submit claims to carriers:

N264 Missing/incomplete/invalid ordering physician provider name

N265 Missing/incomplete/invalid ordering physician primary identifier

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used. DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544 **Alert:** Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272 Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

Note: if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

Phase 2: CMS has not announced a date when the edits for phase 2 will become active. CMS will give the provider community at least a 60-day notice prior to turning on these edits. During phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to be enrolled in Medicare and must be of a specialty that is eligible to order and refer. If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, but is not enrolled in Medicare, the claim will not be paid. In addition, if the ordering/referring provider is on the claim, but is not of a specialty that is eligible to order and refer, the claim will not be paid. Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

- 254D** | Referring/Ordering Provider Not Allowed To Refer
- 255D** | Referring/Ordering Provider Mismatch
- 289D** | Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265

shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

37236 – This reason code will assign when:

- The statement “From” date on the claim is on or after the date the phase 2 edits are turned on.
- The type of bill is ‘32’ or ‘33’

Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code

37237 - This reason code will assign when:

- The statement “From” date on the claim is on or after the date the phase 2 edits are turned on.
- The type of bill is ‘32’ or ‘33’
- The type of bill frequency code is ‘7’ or ‘F-P’
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

CMS published the final rule, CMS-6010-F, RIN 0938-AQ01, “Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements,” on April 24, 2012, permitting phase 2 edits to be implemented.

CMS will announce the date via an updated article when it shall authorize Part A/B and DME MACs and Part A RHHIs to implement phase 2 edits.

Additional information

A note on terminology: Part B claims use the term “ordering/referring provider” to denote the person who ordered, referred or certified an item or service reported in that claim. CMS has used this term on its website and in educational products. The final rule uses technically correct terms: 1) a provider “orders” non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider “certifies” home health services for a beneficiary. The terms “ordered” “referred” and “certified” are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the

(continued on next page)

Phase 2 (continued)

term “ordered/referred” in materials directed to a broad provider audience.

For more information about the Medicare enrollment process, visit <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>, or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf.

The *Medicare Learning Network*[®] fact sheet, “Medicare Enrollment Guidelines for Ordering/Referring Providers” provides information about the requirements for eligible ordering/referring providers and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf.

You may find the following articles helpful in understanding this matter:

- *MLN Matters*[®] article MM6417, “Expansion of the Current Scope of Editing for Ordering /Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs),” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6417.pdf>.
- *MLN Matters*[®] article MM6421, “Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers’ Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs),” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6421.pdf>.
- *MLN Matters*[®] article MM6856, “Expansion of the Current Scope of Editing for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) claims processed by Medicare Regional Home Health Intermediaries (RHHIs),” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf>.
- *MLN Matters*[®] article MM7097, “Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items

and Services for Medicare Beneficiaries,” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7097.pdf>.

- *MLN Matters*[®] article MM6129, “New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services,” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6129.pdf>.
- *MLN Matters*[®] special edition article SE1011, “Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696),” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf>.
- *MLN Matters*[®] special edition article SE1201 “Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf>.
- *MLN Matters*[®] special edition article SE1208, “855-O Medicare Enrollment Application Ordering and Referring Physicians or Other Eligible Professionals,” is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1208.pdf>.

If you have any questions, please contact your carrier, Part A/B MAC, RHHI, fiscal intermediary, or DME 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: SE1221 Revised
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A

Implementation Date: N/A

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Services and items ordered or referred by other providers and suppliers

Note: This article was revised on December 13, 2012, to add clarifying language to the bullet point related to optometrists. All other information remains the same. This information was previously published in the September 2012 Medicare A Connection, Pages 22-23.

Provider types affected

This *MLN Matters*[®] special edition article is intended for providers and suppliers (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries.

Provider action needed

Stop – impact to you

Medicare will only pay for items or services for Medicare beneficiaries that have been ordered by a physician or eligible professional who is enrolled in Medicare and their individual national provider identifier (NPI) has been provided on the claim. The ordering provider or supplier (physician or eligible professional) must also be enrolled with a specialty type that is eligible (per Medicare statute and regulation) to order and refer those particular items or services.

Caution – what you need to know

Make sure you follow Medicare directives when providing services ordered for the services outlined below.

Go – what you need to do

You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide.

Background

The Centers for Medicare & Medicaid Services (CMS) emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home health agency (HHA) services may only be ordered or referred by a doctor of medicine (M.D.), doctor of osteopathy (D.O.) or doctor of podiatric medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Optometrists may only order and refer DMEPOS products/services and laboratory and X-ray services payable under Medicare Part B.

MLN Matters[®] special edition articles SE1011 and SE1221 provide further details about edits on the ordering/referring provider information on claims. SE1011 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf> and SE1221 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1221.pdf>.

Additional information

For more information about the Medicare enrollment process, visit <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html> or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf.

The *Medicare Learning Network*[®] (MLN) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf.

MLN Matters[®] article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf>.

MLN Matters[®] article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf>.

MLN Matters[®] article MM6421, "Expansion of the

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Services (continued)

Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf>;

MLN Matters® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf>.

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Further details on the revalidation of provider enrollment information

Note: This article was revised on December 3, 2012, to provide the calendar year 2013 fee amount of \$532.00. All other information remains the same. This information was previously published in the November 2011 Medicare A Connection, Pages 11-12

Provider types affected

This *Medicare Learning Network (MLN) Matters*® special edition article is intended for all providers and suppliers who enrolled in Medicare prior to March 25, 2011, via Medicare's contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed**Stop – impact to you**

In change request (CR) 7350, the Centers for Medicare & Medicaid Services (CMS) discussed the final rule with comment period, titled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the *Federal Register*. A related *MLN Matters*® article is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf>. This article provides no new policy, but only provides further information regarding the revalidation requirements based on Section 6401 (a) of the

Affordable Care Act.

What you need to know

All providers and suppliers enrolled with Medicare prior to March 25, 2011, must revalidate their enrollment information, but only after receiving notification from their MAC.

Special note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers should continue to submit routine changes – address updates, reassignments, additions to practices, changes in authorized officials, information updates, etc. – as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

Go – what you need to do

When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based PECOS or complete the 855;
- Sign the certification statement on the application;
- If applicable, pay your fee by going to <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>; and
- Mail your supporting documents and certification statement to your MAC.

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

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Enrollment *(continued)***Background**

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are generally not impacted.

CMS has reevaluated the revalidation requirement in the Affordable Care Act, and believes it affords the flexibility to extend the revalidation period for another 2 years. This will allow for a smoother process for providers and contractors. Revalidation notices will now be sent through March of 2015.

Important: This does not affect those providers which have already received a revalidation notice. If you have received a revalidation notice from your contractor respond to the request by completing the application either through Internet-based PECOS or by completing the appropriate 855 application form.

Therefore, between now and 2015, MACs will send out revalidation notices on an intermittent, but regular basis to begin the revalidation process for each -provider and supplier. Providers and suppliers must submit the revalidation application only after being asked by their MAC to do so. Please note that 42 CFR 424.515(d) provides CMS the authority to conduct these off-cycle revalidations.

The first set of revalidation notices went to providers who are billing, but are not currently in PECOS. To identify these providers, contractors searched their local systems and if a Provider Transaction Access Number (PTAN) for a physician was not in PECOS, a revalidation request for that physician was sent. CMS asks all providers who receive a request for revalidation to respond to that request.

For providers **not** in PECOS – the revalidation letter will be sent to the special payments or primary practice address because CMS does not have a correspondence address.

For providers in PECOS – the revalidation letter will be sent to the special payments and correspondence addresses simultaneously. If these are the same, it will also be mailed to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your Medicare contractor. Contact information may be found at http://www.CMS.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf.

Note: CMS has structured the revalidation processes

to reduce the burden on the providers by implementing innovative technologies and streamlining the enrollment and revalidation processes. CMS will continue to provide updates as progress is made on these efforts.

The most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to <https://pecos.cms.hhs.gov>. PECOS allows you to review information currently on file, update and submit your revalidation via the Internet. Once submitted, **you must** print, sign, date, and mail the certification statement along with all required supporting documentation to the appropriate MAC immediately.

PECOS PI submitters will be automatically transferred to Pay.gov to pay the application fee.

Section 6401(a) of the Affordable Care Act also requires the Secretary to impose a fee on each “institutional provider of medical or other items or services and suppliers.” The application fee is \$505 for 2011.

CMS has defined “institutional provider” to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

All institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit an enrollment fee (reference 42 CFR 424.514) with their revalidation. In mid-September, CMS revised the revalidation letter that contractors sent to providers to clarify who must pay the fee. You may submit your fee by ACH debit, or credit card. Revalidations are processed only when fees have cleared. To pay your application fee, go to <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do> and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you mail this receipt to the Medicare contractor along with the Certification Statement for the enrollment application. CMS will notify the Medicare

(continued on next page)

Enrollment *(continued)*

contractor that the application fee has been paid.

Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. **Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges.**

Additional information

For more information about the application fee payment process, refer to *MLN Matters*® Article SE1130, which is available at <http://www.cms.gov/MLNProducts/articles/downloads/SE1130.pdf>

The *MLN*® fact sheet titled “The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations” is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and can be found at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf.

To access PECOS, your authorized official must register with the PECOS Identification and Authentication system. To register for the first time go to <https://pecos.cms.hhs.gov/pecos/PecosIACconfirm.do?transferReason=CreateLogin>.

A sample letter requesting providers to review, update, and certify their enrollment information is available at <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf>.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment Web page at <http://www.cms.gov/MedicareProviderSupEnroll>.

If you have questions, contact your Medicare contractor. Medicare provider enrollment contact information for each State can be found at http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf.

MLN Matters® Number: SE1126 Revised
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 Effective Date: N/A
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CMS announces redesign of the Medicare summary notice (MSN)

Provider types affected

Physicians, providers, and suppliers who bill Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B/ MACs), regional home health intermediaries (RHHIs), or durable medical equipment Medicare administrative contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

The content and format of the Medicare summary notice (MSN) are redesigned, effective January 3, 2013.

In CR 7676, the Centers for Medicare & Medicaid Services (CMS) announces that (effective January 3, 2013) the content and format of the MSN has been redesigned. It also announces relevant manual changes that Medicare contractors will use to implement the newly designed document. Note that MACs will begin phasing the new MSN beginning on January 3, 2013. You should make sure that your billing staffs are aware of these MSN changes.

Background

Section 1806(a) of the Social Security Act (the Act)

requires CMS to provide a Part A, Part B, and/or durable medical equipment (DME) Medicare summary notice (MSN) to each Medicare beneficiary. The MSN content and format are impacted by statute, legislation, and court decisions including:

- The Plain Writing Act of 2010, which requires all government communications to be written in plain language that is easily understood by the target audience;
- Sections 1806(b), 1816(j), 1842(h)(7), 1848(g), 1869(a)(4), and 1869(a)(4)(C) of the Act;
- 42 C.F.R. Section 405.921;
- Section 925 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173); and
- Court decisions *Gray Panthers v. Schweiker*, 652 F.2d 146, 168 (D.C. Cir. 1980); *David v. Heckler*, 591 F.Supp. 1033 (E.D.N.Y 1984); *Vorster v. Bowen*, 709 F.Supp 934 (C.D. Cal. 1989); and *Connecticut Department of Social Services v. Leavitt*

CR 7676, from which this article is taken, announces

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Summary (continued)

that CMS has undertaken a redesign of the MSN, in order to make the document current and consistent with all applicable statutes and laws, and to render it more easily and widely understood by the beneficiary population that it serves. , 428 F.3d 138 (2d Cir. 2005).

In addition, CR 7676 announces that of the “Medicare Claims Processing Manual” Chapter 21 (Medicare summary notices), Sections 10.3-31 (MSN Redesign) has been updated to reflect the new MSN designs. This update is effective with the final implementation of the new designs on January 3, 2013, and will be used to provide guidance on the implementation of these new MSN designs.

Additional information

You can find the official instruction, CR 7676, issued to your carrier, FI, A/B MAC, RHHI, or DME MAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2522CP.pdf> on the CMS website. You will find the updated “Medicare Claims Processing Manual” Chapter 21 (Medicare Summary Notices), Sections

10.3-31 (MSN Redesign), and including all of the new (and final) MSN designs as attachments to that CR.

If you have any questions, please contact your carrier 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> on the CMS website.

MLN Matters® Number: MM7676
 Related Change Request (CR) #: CR 7676
 Related CR Release Date: August 21, 2012
 Effective Date: January 3, 2013
 Related CR Transmittal #: R2522CP
 Implementation Date: January 3, 2013

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Medicare Summary Notice for Part A (Hospital Insurance)
 The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

FACILITY NAME: JENNIFER WASHINGTON
 STREET ADDRESS: CITY, ST. 12345-6789

THIS IS NOT A BILL

Notice for Jennifer Washington
 Medicare Number: XXX-XX-1234A
 Date of This Notice: September 16, 2011
 Claims Processed Between: June 15 - September 15, 2011

Your Claims & Costs This Period
 Did Medicare Approve All Claims? YES
 See page 2 for how to double-check this notice.
 Total You May Be Billed: \$2,062.50

Your Deductible Status
 Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.
Part A Deductible: You have now met your \$1,068 deductible for inpatient hospital services for the benefit period that began May 27, 2011.

Facilities with Claims This Period
 June 18 - June 21, 2011
 Dr Otero Hospital
 June 29, 2011
 Dr Otero Hospital
 July 1 - July 18, 2011
 Lexington Health Center

Be Informed!
 Register at www.MyMedicare.gov for direct access to your Original Medicare claims, track your preventive services and print an "On the Go" report to share with your provider. Visit the Web site to sign up and access your personal Medicare information.

¿Sabe qué puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español. 如果您能看懂這份通知，請撥電和我們聯絡查詢，請先打 "agent"，再打 "Mandarin"。 1-800-MEDICARE (1-800-633-4227)

Medicare Summary Notice for Part A (Hospital Insurance)
 The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

FACILITY NAME: JENNIFER WASHINGTON
 STREET ADDRESS: CITY, ST. 12345-6789

THIS IS NOT A BILL

Notice for Jennifer Washington
 Medicare Number: XXX-XX-1234A
 Date of This Notice: September 16, 2011
 Claims Processed Between: June 15 - September 15, 2011

Your Claims & Costs This Period
 Did Medicare Approve All Claims? YES
 See page 2 for how to double-check this notice.
 Total You May Be Billed: \$2,062.50

Your Deductible Status
 Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.
Part A Deductible: You have now met your \$1,068 deductible for inpatient hospital services for the benefit period that began May 27, 2011.

Facilities with Claims This Period
 June 18 - June 21, 2011
 Dr Otero Hospital
 June 29, 2011
 Dr Otero Hospital
 July 1 - July 18, 2011
 Lexington Health Center

Be Informed!
 Register at www.MyMedicare.gov for direct access to your Original Medicare claims, track your preventive services and print an "On the Go" report to share with your provider. Visit the Web site to sign up and access your personal Medicare information.

¿Sabe qué puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español. 如果您能看懂這份通知，請撥電和我們聯絡查詢，請先打 "agent"，再打 "Mandarin"。 1-800-MEDICARE (1-800-633-4227)

A sample of the new Medicare summary notices provided by CMS

Implementation of provider enrollment provisions in CMS-6028-FC

Note: This article was revised on December 3, 2012, to provide the application fee amount of \$532.00 for calendar year 2013. It was previously published in the November 2011 edition on Pages 8-10. All other information remains the same

Provider types affected

All providers and suppliers submitting enrollment applications to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse (NSC) are affected by this article.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the *Federal Register*.

This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories;
- Submission of application fees as part of the provider enrollment process;
- Suspensions of payment based on credible allegations of fraud; and
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

This article is based on change request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria. (Payment suspensions will be addressed via separate CMS guidance.). Please ensure that your staffs are aware of these new provisions.

Background

CR 7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new sections 19 through 19.4 of Chapter 15 in the *Medicare Program Integrity Manual*. Those manual sections are attached to CR 7350 and are summarized as follows:

Beginning on March 25, 2011, Medicare will place newly-enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the *Program Integrity Manual* (PIM) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new section of the PIM is attached to CR 7350.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the "high" category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

Application fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011.

Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee.

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011, through December 31, 2011, is \$505.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the

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CMS 6028 (continued)

public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved;
- An application that was rejected prior to the Medicare contractor's initiation of the screening process; or
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR 424.570.

The provider or supplier must pay the application fee electronically by going to <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do> and paying their fee via credit card, debit card, or check. Providers and suppliers are strongly encouraged to submit with their application a copy of their receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

Hardship exception

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter must accompany the application. If the application is submitted via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the hardship exception letter must accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. During this review period, the contractor will not begin processing the provider's application. CMS will communicate its decision to the institutional provider and the contractor via letter.

Important: In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the

application will be processed in the order in which it was received.

Review of hardship exception request

As already stated, the application fee for 2011 is \$505. This generally should not represent a significant burden for an adequately capitalized provider or supplier. It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.). Other factors that may suggest that a hardship exception is appropriate include the following:

- a) Considerable bad debt expenses,
- b) Significant amount of charity care/financial assistance furnished to patients,
- c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;
- d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or
- e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note that if the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

Appeal of the denial of hardship exception decision

If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration

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CMS 6028 (continued)

request, providers and suppliers should follow the procedures outlined in Chapter 15, Section 19 of the *Program Integrity Manual* (PIM), which is attached to CR 7350.

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area. The announcement of a moratorium will be made via the *Federal Register*. For initial and new location applications involving the affected provider and supplier type, the moratorium:

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.
- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the "high" level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within six months after the applicable moratorium was lifted, the

contractor will process the application using the "high" level of categorical screening.

Additional information

The official instruction, CR 7350, issued to your FI, RHHI, carrier, and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/transmittals/downloads/R371PI.pdf>. Complete details regarding this issue, as defined in the PIM revisions, are attached to CR 7350.

MLN Matters® article SE1126, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/SE1126.pdf>, has further details on the Affordable Care Act-required revalidation of provider enrollment information for all providers and suppliers who enrolled in the Medicare program prior to March 25, 2011.

For more information about the application fee payment process, refer to *MLN Matters*® article SE1130, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/SE1130.pdf>. A sample letter requesting providers to review, update, and certify their enrollment information is available at <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf>.

If you have any questions, please contact your FI, RHHI, carrier, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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Try our E/M interactive worksheet

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

Implementing the claims-based data collection requirement for outpatient therapy services

Provider types affected

This *MLN Matters*[®] article for change request (CR) 8005 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 outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8005, which implements a new claims-based data collection requirement for outpatient therapy services by requiring reporting with 42 new non-payable functional G-codes and seven new modifiers on claims for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. Be sure your billing staff knows of these new requirements.

Background

The Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA; Section 3005(g); see <http://www.gpo.gov/fdsys/pkg/CRPT-112hrpt399/pdf/CRPT-112hrpt399.pdf>) states that “The Secretary of Health and Human Services shall implement, beginning on January 1, 2013, a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)). Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes.”

This claims-based data collection system is being implemented to include both 1) the reporting of data by therapy providers and practitioners furnishing therapy services, and 2) the collection of data by the contractors. This reporting and collection system requires claims for therapy services to include nonpayable G-codes and related modifiers. These non-payable G-codes and severity/complexity modifiers provide information about the beneficiary's functional status at:

- The outset of the therapy episode of care
- Specified points during treatment, and
- The time of discharge.

These G-codes and related modifiers are required on specified claims for outpatient therapy services – not just those over the therapy caps.

Application of new coding requirements

This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013. However, a testing period will be in effect from January 1, 2013, through June 30, 2013, to allow providers to use the new coding requirements in order to assure that their systems work. During this time period claims without G-codes and modifiers will be processed.

Note: A separate CR (and related *MLN Matters*[®] article) will be issued regarding the editing required for claims with therapy services on and after July 1, 2013, at which time Medicare will begin returning and rejecting claims, as applicable, that do not contain the required functional G-code/modifier information.

In order to implement use of these G-codes for reporting function data on January 1, 2013, a new status indicator of “Q” has been created for the Medicare physician fee schedule database (MPFSDB). This new status indicator will identify codes being used exclusively for functional reporting of therapy services. These functional G-codes will be added to the MPFSDB with the new “Q” status indicator. Because these are nonpayable G-codes, there will be no relative value units or payment amounts for these codes. The new “Q” status code indicator reads, as follows:

- Status code indicator “Q” –“Therapy functional information code, used for required reporting purposes only.”

A separate instruction/article (see *MLN Matters*[®] article MM8126 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8126.pdf>) was issued to alert providers/suppliers and contractors that these nonpayable functional G-codes will be added as “always therapy” codes to the new 2013 therapy code list.

Services affected

The reporting and collection requirements of beneficiary functional data apply to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the PT, OT, and SLP services furnished under the comprehensive outpatient rehabilitation facility (CORF) benefit. They also apply to the therapy services furnished incident to the service of a physician and certain non-physician practitioners (NPPs), including, as applicable, nurse practitioners (NPs), certified nurse specialists (CNSs), and physician assistants (PAs).

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Outpatient *(continued)***Providers and practitioners affected**

These reporting requirements apply to the therapy services furnished by the following providers: hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and home health agencies (HHAs) (when the beneficiary is not under a home health plan of care). It also applies to the following practitioners: therapists in private practice (TPPs), physicians, and NPPs as noted above.

Function-related G-codes

The following Healthcare Common Procedure Coding System (HCPCS) G-codes are used to report the status of a beneficiary's functional limitations:

Mobility G-code set

- G8978, Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals.
- Short descriptor: Mobility current status
- G8979, Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.
- Short descriptor: Mobility goal status
- G8980, Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting.
- Short descriptor: Mobility D/C status

Changing & maintaining body position G-code set

- G8981, Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals.
- Short descriptor: Body pos current status
- G8982, Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.
- Short descriptor: Body pos goal status
- G8983, Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting.
- Short descriptor: Body pos D/C status

Carrying, Moving & Handling Objects**G-code set**

- G8984, Carrying, moving & handling objects functional limitation, current status, at therapy episode outset and at reporting intervals
- Short descriptor: Carry current status
- G8985, Carrying, moving & handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
- Short descriptor: Carry goal status
- G8986, Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting
- Short descriptor: Carry D/C status

Self care G-code set

- G8987, Self care functional limitation, current status, at therapy episode outset and at reporting intervals
- Short descriptor: Self care current status
- G8988, Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
- Short descriptor: Self care goal status
- G8989, Self care functional limitation, discharge status, at discharge from therapy or to end reporting
- Short descriptor: Self care D/C status

Other PT/OT Primary G-code set

- G8990, Other physical or occupational primary functional limitation, current status, at therapy episode outset and at reporting intervals
- Short descriptor: Other PT/OT current status
- G8991, Other physical or occupational primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
- Short descriptor: Other PT/OT goal status
- G8992, Other physical or occupational primary functional limitation, discharge status, at discharge from therapy or to end reporting
- Short descriptor: Other PT/OT D/C status

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Outpatient *(continued)*

Other PT/OT subsequent G-code set

- G8993, Other physical or occupational subsequent functional limitation, current status, at therapy episode outset and at reporting intervals
 - Short descriptor: Sub PT/OT current status
- G8994, Other physical or occupational subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
 - Short descriptor: Sub PT/OT goal status
- G8995, Other physical or occupational subsequent functional limitation, discharge status, at discharge from therapy or to end reporting
 - Short descriptor: Sub PT/OT D/C status

Swallowing G-code set

- G8996, Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
 - Short descriptor: Swallow current status
- G8997, Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy
 - Short descriptor: Swallow goal status
- G8998, Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation
 - Short descriptor: Swallow D/C status

Motor Speech G-code Set: (Note: These codes are not sequentially numbered)

- G8999, Motor speech functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
 - Short descriptor Motor speech current status
- G9186, Motor speech functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
 - Short descriptor Motor speech goal status
- G9158, Motor speech functional limitation, discharge status at discharge from therapy/end of reporting on limitation
 - Short descriptor: Motor speech D/C status

Spoken language comprehension G-code set

- G9159, Spoken language comprehension

functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals

- Short descriptor: Lang comp current status
- G9160, Spoken language comprehension functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
 - Short descriptor: Lang comp goal status
- G9161, Spoken language comprehension functional limitation, discharge status at discharge from therapy/end of reporting on limitation
 - Short descriptor: Lang comp D/C status

Spoken Language Expressive G-code set

- G9162, Spoken language expression functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
 - Short descriptor: Lang express current status
- G9163, Spoken language expression functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
 - Short descriptor: Lang express goal status
- G9164, Spoken language expression functional limitation, discharge status at discharge from therapy/end of reporting on limitation
 - Short descriptor: Lang express D/C status

Attention G-code set

- G9165, Attention functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
 - Short descriptor: Atten current status
- G9166, Attention functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
 - Short descriptor Atten goal status
- G9167, Attention functional limitation, discharge status at discharge from therapy/end of reporting on limitation
 - Short descriptor: Atten D/C status

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Outpatient *(continued)*

Memory G-code set

- G9168, Memory functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
- Short descriptor: Memory current status
- G9169, Memory functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
- Short descriptor: Memory goal status
- G9170, Memory functional limitation, discharge status at discharge from therapy/end of reporting on limitation
- Short descriptor: Memory D/C status

Voice G-code set

- G9171, Voice functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
- Short descriptor Voice current status
- G9172, Voice functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
- Short descriptor Voice goal status
- G9173, Voice functional limitation, discharge status at discharge from therapy/end of reporting on limitation
- Short descriptor: Voice D/C status

Other speech-language pathology G-code set

- G9174, Other speech language pathology functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
- Short descriptor: Speech lang current status
- G9175, Other speech language pathology functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
- Short descriptor: speech lang goal status
- G9176, Other speech language pathology functional limitation, discharge status at discharge from therapy/end of reporting on limitation
- Short descriptor: speech lang D/C status

Severity/complexity modifiers

For each non-payable G-code shown above, a modifier

must be used to report the severity/complexity for that functional measure. The severity modifiers reflect the beneficiary’s percentage of functional impairment as determined by the therapist, physician, or NPP furnishing the therapy services. The beneficiary’s current status, the anticipated goal status, and the discharge status are reported via the appropriate severity modifiers. The seven modifiers are defined in the following table below:

Modifier	Impairment limitation restriction
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

Required reporting of functional G-codes and severity modifiers

The functional G-codes and corresponding severity modifiers listed above are used in the required reporting on specified therapy claims for certain dates of service (DOS). Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC).

However, functional reporting is required on claims throughout the entire episode of care; so, there will be instances where two or more functional limitations will be reported for one beneficiary’s POC, just not during the same time frame. In these situations, where reporting on the first reported functional limitation is complete and the need for treatment continues, reporting is required for a second functional limitation using another set of G-codes. Thus, reporting on more than one functional limitation may be required for some beneficiaries, but not simultaneously.

Specifically, functional reporting, using the G-codes and modifiers, is required on therapy claims for certain DOS as described below:

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Outpatient *(continued)*

- At the outset of a therapy episode of care, i.e., on the DOS for the initial therapy service;
- At least once every 10 treatment days – which is the same as the newly-revised progress reporting period – the functional reporting is required on the claim for services on same DOS that the services related to the progress report are furnished;
- The same DOS that an evaluative procedure, including a re-evaluative one, is submitted on the claim (see below for applicable HCPCS/CPT codes);
- At the time of discharge from the therapy episode of care, if data is available; and,
- On the same DOS the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary.

As noted above, this functional reporting coincides with the progress reporting frequency, which is being changed through this instruction. Previously, the progress reporting was due every 10th treatment day or 30 calendar days, whichever was less. The new requirement is for the services related to the progress reports to be furnished on or before every 10th treatment day. In the example below, the G-codes for the mobility functional limitation (G8978 - 8980) are used to illustrate the timing of the functional reporting.

At the outset of therapy – the DOS the evaluative procedure is billed or the initial therapy services are furnished:

G8978 and G8979, along with the related severity modifiers, are used to report the current status and projected goal status of the mobility functional limitation.

At the end of each progress reporting period – the DOS when the progress report services are furnished:

G8978 and G8979, along with the related severity modifiers, are used to report the current status and projected goal status of the mobility functional limitation.

This step is repeated as clinically appropriate

At the time the beneficiary is discharged from the therapy episode – the DOS the discharge progress report services are furnished:

G8979 and G8980, along with the related severity modifiers, are used to report the projected goal and discharge status of the mobility functional limitation.

In the above example, if further therapy is medically necessary once reporting for the mobility functional limitation has ended, the therapist begins reporting on another functional limitation using a different set

of G-codes. Reporting of the next functional limitation is required on the DOS of the first treatment day after the reporting was ended for the mobility functional limitation.

Evaluative procedures

The presence of an HCPCS/CPT® code on a claim for an evaluation or re-evaluation service listed below requires reporting of functional G-code(s) and corresponding modifier(s) for the same date of service: **HCPCS/CPT® codes requiring functional G-code(s) and corresponding modifier(s)**

92506	92597	92607	92608	92610	92611
92612	92614	96616	96105	97001	97002
97003	97004				

The number of functional G-codes required on a particular claim when functional reporting is required for therapy services under one POC will be two. However, it is possible for a claim to contain four or more non-payable G-codes in cases where a beneficiary receives therapy services under multiple POCs – PT, OT, and/or SLP – from the same therapy provider. Each reported functional G-code must also contain the following essential line of service information:

Functional severity modifier in the range CH - CN

Therapy modifier indicating the discipline of the POC – GP, GO or GN – for PT, OT, and SLP services, respectively

Date of the corresponding billable service

Nominal charge, e.g., a penny, for institutional claims submitted to the FIs and A/MACs. For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.

In addition, claims containing any of these functional G-codes must also contain another billable and separately payable (non-bundled) service.

Required tracking and documentation of functional G-codes and severity modifiers

The reported functional information is derived from the beneficiary’s functional limitations set forth in the therapy goals, a requirement of the POC, that are established by a therapist, including – an occupational therapist, a speech-language pathologist or a physical therapist – or a physician/NPP, as applicable. The therapist or physician/NPP furnishing the therapy services must not only report the functional information

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Outpatient *(continued)*

on the therapy claim, but, he/she must track and document the G-codes and modifiers used for this reporting in the beneficiary's medical record of therapy services.

Remittance advice messages

Medicare will return a claim adjustment reason code 246 (This non-payable code is for required reporting only.) and a group code of CO (contractual obligation) assigning financial liability to the provider. In addition, beneficiaries will be informed via Medicare summary notice 36.7 that they are not responsible for any charge amount associated with one of these G-codes.

Additional information

CR 8005 will be reissued in the future with revisions to the *Medicare Benefit Policy Manual* and the *Medicare Claims Processing Manual*.

At this point, CR 8005 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2603CP.pdf>.

If you have any questions, please contact your carriers, FIs, A/B MACs, and RHHIs 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>.

The following provides additional information and related links for therapy providers and practitioners:

- **CMS Therapy Services Web Page:** The CMS Therapy Services home page is located at <http://www.cms.gov/Medicare/Billing/TherapyServices/index.html>.
- **Therapy services transmittals:** The following CMS Web page lists transmittals that are directed

to the therapy services provider community: <http://www.cms.gov/Medicare/Billing/TherapyServices/Therapy-Services-Transmittals.html>

Note that this list may not include all instructions for which therapy service providers are responsible. For a list of all instructions, view the CMS transmittals Web page under Regulations and Guidance at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals.html>.

- **Annual therapy update:** You can find and download the Therapy Code List and Dispositions for 2009, 2010, 2011, and 2012 at <http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html>. The additions, changes, and deletions to the therapy code list reflect those made in the applicable year for the Healthcare Common Procedure Coding System and *Current Procedural Terminology*[®], *Fourth Edition* (HCPCS/CPT-4).
- **Studies and reports:** Studies and reports (report to Congress, CMS contracted, and other government) relating to utilization and policy for outpatient Part B therapy can be found at <http://www.cms.gov/Medicare/Billing/TherapyServices/Studies-and-Reports.html>.

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Update to Medicare deductible, coinsurance, and premium rates for 2013

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8052 which informs Medicare contractors about the changes needed to update the claims processing system

with the 2013 Medicare rates. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional Information* Sections of this article for further details regarding these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she

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Deductible *(continued)*

is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility services furnished during a spell of illness. Most individuals age 65 and older, and many disabled individuals under age 65, are insured for health insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the supplementary medical insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. The following deductible and coinsurance rates apply for 2013.

2013 Part A - hospital insurance (HI)

Deductible - \$1,184

Coinsurance: - \$296 a day for 61st-90th day

\$592 a day for 91st-150th day (lifetime reserve days)

\$148 a day for 21st-100th day (skilled nursing facility coinsurance)

Base Premium (BP) - \$441 per month

BP with 10 percent surcharge - \$485.10 a month

BP with 45 percent reduction - \$243 a month (for those who have 30-39 quarters of coverage)

BP with 45 percent reduction and 10 percent surcharge - \$267.30 a month

Premium rates for 2013

Part B - supplementary medical insurance (SMI)

Standard Premium - \$104.90 a month

Deductible - \$147 a year

Coinsurance - 20 percent

Additional information

The official instruction, CR 8052 issued to your FI, carrier, RHHI, DME/MAC, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R81GI.pdf> on the CMS website.

If you have any questions, please contact your FI, carrier, RHHI, DME/MAC, 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> on the CMS website.

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Implementation Date: January 7, 2013

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HIPAA eligibility transaction system to replace common working file for medicare beneficiary health insurance eligibility queries

Provider types affected

This *MLN Matters*[®] special edition article is intended for health care providers, suppliers and their billing agents, software vendors and clearinghouses that use Medicare's common working file (CWF) queries to obtain their patient's Medicare health insurance eligibility information from Medicare contractors (carriers, Fiscal Intermediaries (FIs), regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME MACs), and/or Part A/B Medicare administrative contractors (A/B MACs).

Provider action needed

If you currently use CWF queries to obtain Medicare health insurance eligibility information for Medicare fee-for service patients, you should immediately begin transitioning to the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS).

What you need to know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that the Centers for Medicare & Medicaid Services (CMS) will implement in the coming months. By April 2013, access to CWF eligibility query functions implemented in the multi-carrier system (MCS) and ViPS Medicare system (VMS), also referred to as PPTN and VPIQ, will be terminated. CMS intends to terminate access to the other CWF eligibility queries implemented in the fiscal intermediary standard system (FISS) direct data entry (DDE), often referred to the HIQA, HIQH, ELGA and ELGH screens and HUQA, soon thereafter. This will not affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare contractor's interactive voice response (IVR) units and/or Internet portals.

Background

In 2005, CMS began offering HETS in a real-time environment to Medicare health care providers, suppliers and their billing agents, software vendors and clearinghouses. HETS is Medicare's health care eligibility benefit inquiry and response electronic transaction, ASCX12 270/271 Version 5010, adopted under HIPAA. HETS replaces the CWF queries, and is to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

General information

In the coming months, CMS plans to discontinue access to the CWF queries through the shared systems: MCS PPTN, VMS VPIQ and FISS DDE. Medicare providers and their agents that currently access the CWF queries through the shared system screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS

HETS allows Medicare providers and their agents to submit and receive X12N 270/271 eligibility request and response files over a secure connection. Many Medicare providers and their agents are already receiving eligibility information from HETS. For more information about HETS and how to obtain access to the system, refer to the CMS HETS Help Web page at <http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html> on the CMS website.

Frequently asked questions

Are Medicare providers that currently use CWF to obtain beneficiary eligibility information required to switch to HETS?

No, but it is recommended. Providers may also choose to use a Medicare Contractor's IVR or Internet portal.

What are the minimum data elements required in order to complete an eligibility search in HETS?

HETS applies search logic that uses a combination of four data elements: Health insurance claim number (HICN), Medicare beneficiary's date of birth, Medicare beneficiary's full last name (including suffix, if applicable), and Medicare beneficiary's full first name. The date of birth and first name are optional, but at least one must be present.

Does HETS return the same eligibility information that is currently provided by the CWF eligibility queries?

HETS returns all of the information provided by the CWF eligibility queries that is needed to process Medicare claims with the exception of psychiatric information. HETS returns additional information that CWF does not return. For example, HETS returns:

- Part D plan number, address and enrollment dates; and.
- Medicare advantage organization name, address,

(continued on next page)

HIPPA *(continued)*

website and phone number.

HETS returns some information in a format that differs from the CWF format.

In addition, there is a change underway to allow HETS to return Hospice information in the same format as CWF. The HETS 270/271 companion guide provides specific details about the eligibility information that is returned in the HETS 271 response. The guide is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf> on the CMS website.

Additional information

If you use a software vendor or clearinghouse to access Medicare beneficiary health insurance eligibility

information, you should direct questions to your vendor or clearinghouse. If you have any questions about HETS, please contact the MCARE Help Desk at 1-866-324-7315.

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

Note: *This article was revised on December 18, 2012, to reflect a revised change request (CR) 7785 issued on December 14. In this article, the CR release date, transmittal number and the Web address for accessing CR 7785 have been revised. All other information remains the same. This information was previously published in the May 2012 Medicare A Connection, Pages 35-37*

Provider types affected

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

Provider action needed

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

Caution – what you need to know

The therapy cap amounts for 2012 are \$1880 for occupational therapy services, and \$1880 for the

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

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

Background

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

The Middle Class Tax Relief and Job Creation

(continued on next page)

Revisions *(continued)*

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

The therapy cap amounts for 2012 are:

- \$1880 for OT services, and
- \$1880 for the combined services for PT and SLP.
- CR 7785 instructs Medicare suppliers and providers to continue to use the KX modifier to request an exception to the therapy cap on claims that are over these amounts. Note that use of the KX modifier is an attestation from the provider or supplier that:
 1. The services are reasonable and necessary, and,
 2. There is documentation of medical necessity in the patient's medical record.

Therapy services furnished in an outpatient hospital setting have been exempt from the application of the therapy caps. However, MCTRJCA requires original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital between October 1, 2012, and December 31, 2012.

Although the therapy caps are only applicable to hospitals for services provided on or after October 1, 2012, in applying the caps after October 1, 2012, claims paid for outpatient therapy services since January 1, 2012, will be included in the caps accrual totals. In addition, MCTRJCA contains two requirements that become effective on October 1, 2012.

The first of these requires that suppliers and providers report on the beneficiary's claim for therapy services the national provider identifier (NPI) of the physician (or non-physician practitioner (NPP) where applicable) who is responsible for reviewing the therapy plan of care. For implementation purposes, the physician (or NPP as applicable) certifying the therapy plan of care is reported. NPPs who can certify the therapy plan of care include nurse practitioners, physician assistants and clinical nurse specialists.

The second requires a manual medical review process for those exceptions where the beneficiary therapy services for the year reach a threshold of \$3,700. The two separate thresholds triggering manual medical reviews build upon the separate therapy caps as follows:

- One for OT services, and
- One for PT and SLP services combined.

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

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

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

Key billing points

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

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

Other important points are as follows:

The new thresholds will accrue for claims with dates of service from January 1, 2012, through December 31, 2012. Medicare will display the total amount applied toward the therapy caps and thresholds on all applicable inquiry screens and mechanisms.

Providers should report the NPI of the physician/NPP certifying the therapy plan of care in the attending physician field on institutional claims for outpatient therapy services, for dates of service on or after October 1, 2012.

In cases where different physicians/NPPs certify the OT, PT, or SLP plan of care, report the additional NPI in the referring physician field (loop 2310F) on institutional claims for outpatient therapy services for dates of service on or after October 1, 2012.

On professional claims, providers are to report the physician/NPP certifying the therapy plan of care, including his/her NPI, for outpatient therapy services on or after October 1, 2012.

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Revisions *(continued)*

For claim processing purposes, the certifying physician/NPP is considered a referring provider and such providers must follow the instructions in Chapter 15, Section 220.1.1 of the *Medicare Benefit Policy Manual* (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>) for reporting the referring provider on a claim.

On electronic professional claims, report the referring provider, including NPI, per the instructions in the appropriate ASC X12 837 Technical Report 3 (TR3).

For paper claims, report the referring provider, including NPI, per the instructions in Chapter 26, Section 10 of the *Medicare Claims Processing Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf>.

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

Claim adjustment reason code 165 (Referral absent or exceeded).

Remittance advice remark code of N285 (Missing/incomplete/invalid referring provider name) and/or N286 (Missing/incomplete/invalid referring provider number).

Additional information

The official instruction, CR 7785, issued to your carriers, FIs, A/B MACs, and RHHs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2615CP.pdf>.

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

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 Implementation Date: October 1, 2012

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Transcutaneous electrical nerve stimulation for chronic low back pain

Note: *This article was revised on December 4, 2012, to reflect a revised CR 7836, issued on November 30, 2012, and was previously published in August 2012 on Pages 12-13. In this article, the CR transmittal numbers, release date, and the Web address for accessing CR 7836 have been revised. All other information remains the same.*

Provider types affected

This MLN Matters® article is intended for providers and suppliers that submit claims to Medicare contractors (carriers, regional home health intermediaries [RHHs], and durable medical equipment Medicare administrative contractors [DME MACs]) for transcutaneous electrical nerve stimulation (TENS) services provided to Medicare beneficiaries.

What you need to know

This article is based on CR 7836 which informs providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) is revising the coverage for TENS for chronic low back pain (CLBP) effective for claims with dates of service on or after June 8, 2012. See the *Key points* section for specific coverage rules and review the lists of ICD- 9 and ICD-10 codes attached to the official instruction CR 7836.

Background

In 2010, the Therapeutic and Technology Assessment Subcommittee of the American Academy of Neurology (AAN) published a report finding TENS ineffective for CLBP. CMS internally initiated a new national coverage determination (NCD) after the AAN published report and reviewed all the available evidence on the use of TENS for the treatment of CLBP.

Medicare has four NCDs pertaining to various uses of TENS that were developed before the CMS adoption of an evidence based and publicly transparent paradigm for coverage decisions. Those four NCDs are:

- Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (10.2)
- Assessing Patient’s Suitability for Electrical Nerve Stimulation Therapy (160.7.1)
- Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13), and
- Transcutaneous Electrical Nerve Stimulators (TENS) (280.13). Please note, section 280.13 has been removed from the *NCD Manual* and

(continued on next page)

TENS (continued)

incorporated into NCD 160.27

The evidentiary basis is unclear for historic coverage. TENS has been historically thought to relieve chronic pain but the current evidence base refutes this assertion when applied to TENS for CLBP. Since TENS falls within the durable medical equipment (DME) benefit, Medicare coverage results in purchase after a brief initial rental period, even if the patient soon develops a subsequent tolerance to the TENS effect.

Key points

Effective for claims with dates of service on or after June 8, 2012, CMS believes the evidence is inadequate to support coverage of TENS for CLBP as reasonable and necessary. Thus, effective for claims with dates of service on and after June 8, 2012, Medicare will only allow coverage of TENS for CLBP defined for this decision as pain for three months or longer and not a manifestation of a clearly defined and generally recognizable primary disease entity, when the patient is enrolled in an approved clinical study under coverage with evidence development (CED).

Note: CED coverage expires three years from the effective date of this CR, June 8, 2015.

Examples of clearly defined and recognizable primary disease entities: neurodegenerative (e.g. multiple sclerosis) disease, malignancy, or well-defined rheumatic disorders (except osteoarthritis).

Medicare contractors will accept and process line items that include an appropriate TENS HCPCS code, at least one ICD-9 diagnosis code for CLBP (see list of ICD-9 codes attached to CR 7836), and all of the following:

- Date of service on or after June 8, 2012
- Modifiers KX and Q0
- ICD-9 code V70.7 - Examination of participant in clinical trial (for institutional claims only)
- Condition code 30 - (for institutional claims only)
- An acceptable ICD-9 code, and
- An acceptable ICD-10 code upon implementation (see list of ICD-10 codes attached to CR 7836).

Medicare contractors will deny TENS line items on claims when billed with a TENS code and at least one of the ICD-9 or ICD-10 codes for CLBP (see attachments to transmittal R2511CP of CR 7836 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2511CP.pdf>), if the conditions of requirement listed above are not met. When Medicare denies such claims for not containing the requisite ICD-9 (or later ICD-10) code, your remittance advice will reflect the following messages:

- Group code CO

- Claim adjustment reason code B5 (Coverage/program guidelines were not met or were exceeded.), and
- Remittance advice remark code 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.

Medicare will pay for allowed TENS for CLBP based on the DME fee schedule. All of the following conditions must be met for coverage of TENS for CLBP. CLBP is defined as:

- An episode of low back pain that has persisted for three months or longer, and
- Is not the manifestation of a clearly defined and generally recognizable primary disease entity.

For example, there are cancers that, through metastatic spread to the spine or pelvis, may elicit pain in the lower back as a symptom. Certain systemic diseases, e.g. rheumatoid arthritis, multiple sclerosis etc, manifest many debilitating symptoms of which low back pain is not the primary focus. CMS believes that the appropriate management of these types of diseases is guided by a systematic strategy aimed at the underlying causes. While TENS may infrequently be used adjunctively in managing the symptoms of these diseases, it is clearly not the primary therapeutic approach.

The patient is enrolled in an approved clinical study that addresses one or more aspects of the following questions in a randomized, controlled design using validated and reliable instruments. This can include randomized crossover designs when the impact of prior TENS use is appropriately accounted for in the study protocol.

1. Does the use of TENS provide a clinically meaningful reduction in pain in Medicare beneficiaries with CLBP?
2. Does the use of TENS provide a clinically meaningful improvement of function in Medicare beneficiaries with CLBP?
3. Does the use of TENS provide a clinically meaningful reduction in other medical treatments or services used in the medical management of CLBP?

These studies must be designed so that the patients in the control and comparison groups receive the same concurrent treatments and either sham (placebo) TENS or active TENS intervention.

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TENS (continued)

The study must also adhere to standards of scientific integrity and relevance to the Medicare population and those standards are part of Section 160.27. You may read the entire set of parameters in the official instruction attached to transmittal R144NCD of CR 7836. That transmittal is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R149NCD.pdf>.

Additional information

The official instruction, CR 7836, issued to your Medicare Carrier, RHHI or DME MAC regarding this change via two transmittals. The first updates the NCD Manual and it is available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R149NCD.pdf> on the CMS website. The other transmittal updates the "Medicare Claims Processing Manual" and it is available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2605CP.pdf> on the CMS website.

If you have any questions, please contact your carrier, RHHI, or DME 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> on the CMS website.

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Therapy cap values for calendar year 2013

Provider types affected

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

What you need to know

This article is based on change request (CR) 8129, which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for calendar year 2013. The therapy caps for 2013 will be \$1900 for physical therapy and speech-language therapy combined and \$1900 for occupational therapy. Make sure that your billing staffs are aware of this update.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare patients. These limits change annually. The Deficit Reduction Act of 2005 directed the Secretary to implement a process for exceptions to therapy caps for medically necessary services. The Affordable Care Act extended the exceptions to therapy caps through December 31, 2010; the Medicare and Medicaid Extenders Act (MMEA) of 2010 extended the therapy caps exceptions through December 31, 2011; and

Section 3005 (g) of the Middle Class Tax Relief And Job Creation Act (MCTRJCA) of 2012 extended the therapy caps exceptions through December 31, 2012.

Additional information

The official instruction, CR 8129, issued to your FI, RHHI, carrier, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2600CP.pdf>.

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

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2013 annual update to the therapy code list

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8126 which updates the therapy code list for calendar year 2013 by adding two “sometimes therapy” codes. CR 8126 also adds forty two “always therapy” codes, which are non-payable and for use only in functional reporting. The additions to the therapy code list reflect those made in the 2013 Healthcare Common Procedure Coding System and *Current Procedural Terminology*®, Fourth Edition (HCPCS/CPT®-4). Please make sure your billing and coding staff are aware of these changes.

Background

The Social Security Act (Section 1834(k)(5); see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/*Current Procedural Terminology*®, 2013 Edition (HCPCS/CPT®-4) is the coding system used for the reporting of these services. CR 8126 provides the 2013 annual updates to the list of codes that sometimes or always describe therapy services. The additions to the therapy code list reflect those made in the 2013 HCPCS/CPT-4. The therapy code listing can be found at <http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html>.

CR 8126 updates the therapy code list by adding two “sometimes therapy” codes and forty two “always therapy” codes for CY 2013 as shown in the following tables

:

Always therapy codes added for CY 2013

	HCPCS code	Short descriptor		HCPCS code	Short descriptor (Cont'd)		HCPCS code	Short descriptor (Cont'd)
1	G8978	Mobility current status	15	G8992	Other PT/OT D/C status	29	G9164	Lang express D/C status
2	G8979	Mobility goal status	16	G8993	Sub PT/OT current status	30	G9165	Atten current status
3	G8980	Mobility D/C status	17	G8994	Sub PT/OT goal status	31	G9166	Atten goal status
4	G8981	Body pos current status	18	G8995	Sub PT/OT D/C status	32	G9167	Atten D/C status
5	G8982	Body pos goal status	19	G8996	Swallow current status	33	G9168	Memory current status
6	G8983	Body pos D/C status	20	G8997	Swallow goal status	34	G9169	Memory goal status
7	G8984	Carry current status	21	G8998	Swallow D/C status	35	G9170	Memory D/C status
8	G8985	Carry goal status	22	G8999	Motor speech current status	36	G9171	Voice current status
9	G8986	Carry D/C status	23	G9158	Motor speech D/C status	37	G9172	Voice goal status
10	G8987	Self care current status	24	G9159	Lang comp current status	38	G9173	Voice D/C status
11	G8988	Self care goal status	25	G9160	Lang comp goal status	39	G9174	Speech lang current status
12	G8989	Self care D/C status	26	G9161	Lang comp D/C status	40	G9175	Speech lang goal status
13	G8990	Other PT/OT current status	27	G9162	Lang express current status	41	G9176	Speech lang D/C status

(continued on next page)

Therapy (continued)

	HCPCS code	Short descriptor		HCPCS code	Short descriptor (Cont'd)		HCPCS code	Short descriptor (Cont'd)
14	G8991	Other PT/OT goal status	28	G9163	Lang express goal status	42	G9186	Motor speech goal status

Sometimes therapy codes added for CY 2013

	HCPCS code	Short descriptor
1	G0456	Neg pres wound < 50 sq cm
2	G0457	Neg pres wound > 50 sq cm

Additional information

CR 8036 alerts providers that all requests for therapy services above \$3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance. This applies to: Part B skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies (outpatient rehabilitation facilities (ORFs), private practices, home health agencies (TOB 34x), and hospital outpatient departments. You can find CR 8036 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1124OTN.pdf>. The MLN Matters® article corresponding to CR 8036 is at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8036.pdf>.

The official instruction, CR 8126 issued to your carriers, FIs, A/B MACs, and RHHs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2596CP.pdf>.

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

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Related CR Release Date: November 23, 2012

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Annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

Note: This article was revised on December 18, 2012, to reflect a revised CR 8132 issued on December 14. The CR was revised to show the correct date of November 21, 2012, under "Access to Data File" (page 3 of article). Also, the CR release date, transmittal number, and Web address for accessing the CR were revised. All other information remains the same.

Provider types affected

This MLN Matters® article is intended for clinical diagnostic laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8132 which provides instructions to Medicare contractors for the calendar year (CY) 2013 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Be sure your billing staffs are aware of these updates.

Background

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section

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3401 of the Patient Protection and Affordable Care Act (ACA) of 2010 and the Middle Class Tax Relief and Job Creation Act of 2012, the annual update to the local clinical laboratory fees for CY 2013 is -2.95 percent. The annual update to local clinical laboratory fees for 2013 reflects the consumer price index for urban areas (CPI-U) of 1.70 percent less a multi-factor productivity adjustment of 0.9 percentage points and a -1.75 percentage point reduction as described by the ACA legislation, plus a -2.0 percentage point reduction as described by the MCTRJCA. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2013 is 1.7 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA).

For a cervical or vaginal smear test (Pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key points of CR 8132

National minimum payment amounts

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The 2013 national minimum payment amount is \$14.53 (\$14.97 plus (-2.95) percent update for 2013). The affected codes for the national minimum payment amount are shown in the following table:

88142	88143	88147	88148	88150
88152	88153	88154	88164	88165
88166	88167	88174	88175	G0123
G0143	G0144	G0145	G0147	G0148
P3000				

National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

Access to data file

Internet access to the 2013 clinical laboratory fee schedule data file will be available after November 21, 2012, at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html>. Other interested parties, such as the Medicaid state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, may use the Internet to retrieve the 2013 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public comments

On July 16, 2012, CMS hosted a public meeting to solicit input on the payment relationship between 2012 codes and new 2013 CPT® codes. Notice of the meeting was published in the *Federal Register* on May 29, 2012, and on the CMS website approximately June 15, 2012.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html>. Additional written comments from the public were accepted until September 28, 2012. CMS has posted a summary of the public comments and the rationale for the final payment determinations on the CMS website.

Pricing information

The 2013 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home

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or homebound patient. If there is a revision to the standard mileage rate for 2013, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2013 clinical laboratory fee schedule also includes codes that have a “QW” modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

As in prior years, the CY 2013 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping information

New code 86386QW is priced at the same rate as code 86386, effective January 1, 2012.

New code 83861QW is priced at the same rate as code 83861, effective July 1, 2012.

New code 86803QW is priced at the same rate as code 86803.

The following are new codes to be gap filled:

81201	81202	81203	81235	81252	81253	81254	81321	81322	81323	81324	81325
81326	81200	81205	81206	81207	81208	81209	81210	81211	81212	81213	81214
81215	81216	81217	81220	81221	81222	81223	81224	81225	81226	81227	81228
81229	81240	81241	81242	81243	81244	81245	81250	81251	81255	81256	81257
81260	81261	81262	81263	81264	81265	81266	81267	81268	81270	81275	81280
81281	81282	81290	81291	81292	81293	81294	81295	81296	81297	81298	81299
81300	81301	81302	81303	81304	81310	81315	81316	81317	81318	81319	81330
81331	81332	81340	81341	81342	81350	81355	81370	81371	81372	81373	81374
81375	81376	81377	81378	81379	81380	81381	81382	81383	81400	81401	81402
81403	81404	81405	81406	81407	81408	86152					

The following are existing codes that are deleted:

83890	83891	83892	83893	83894	83896	83897	83898	83900	83901	83902
83903	83904	83905	83906	83907	83908	83909	83912	83913	83914	

New code 82777 is priced at the same rate as code 83520.

New code 86711 is priced at the same rate as code 86789.

New code 86828 is priced at the same rate as code 86807.

New code 86829 is priced at the same rate as code 86808.

New code 86830 is priced at 7 times the rate of code 83516.

New code 86831 is priced at 6 times the rate of code 83516.

New code 86832 is priced at 11 times the rate of code 83516.

New code 86833 is priced at 10 times the rate of code 83516.

New code 86834 is priced at 31 times the rate of code 83516.

New code 86835 is priced at 28 times the rate of code 83516.

New code 87631 is priced at the same rate as code 87502 plus 2 times the rate of code 87503.

New code 87632 is priced at the same rate as code 87502 plus 6 times the rate of code 87503.

New code 87633 is priced at the same rate as code 87502 plus 16 times the rate of code 87503.

New code 87910 is priced at the same rate as code 87902.

New code 87912 is priced at the same rate as code 87902.

Laboratory costs subject to reasonable charge payment in CY 2011

For outpatients, the following codes are paid under a reasonable charge basis. The reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for 2013 is 1.7 percent.

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Blood product codes

These blood codes are:

P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9044	P9050	P9051	P9052
P9053	P9054	P9055	P9056	P9057	P9058
P9059	P9060				

Also, payment for the following codes are applied to the blood deductible as instructed in the “Medicare General Information, Eligibility and Entitlement Manual”, Chapter 3, Sections 20.5 through 20.5.4:\

P9010	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine costs

These codes are:

86850	86860	86870	86880	86885	86886
86890	86891	86900	86901	86902	86904
86905	86906	86920	86921	86922	86923
86927	86930	86931	86932	86945	86950
86960	86965	86970	86971	86972	86975
86976	86977	86978	86985		

Reproductive medicine procedure codes

These codes are:

89250	89251	89253	89254	89255	89257
89258	89259	89260	89261	89264	89268
89272	89280	89281	89290	89291	89335
89342	89343	89344	89346	89352	89353
89354	89356				

Additional information

You can find the official instruction, CR 8132, issued to your FI, carrier, or A/B MAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2612CP.pdf>.

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

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2013 update for durable medical equipment, prosthetics, orthotics, and supplies fee schedule

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8133 to advise providers of the calendar year 2013 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Be sure your staffs are aware of these updates.

Background and key points of CR 8133

The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR 414.102 for parenteral and enteral nutrition (PEN) on the CMS website.

Fee schedule files

The DMEPOS fee schedule file will also be available for state Medicaid agencies, managed care organizations, and other interested parties at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html>.

Healthcare Common Procedure Coding System (HCPCS) codes added/deleted

The following new codes are effective as of January 1, 2013:

- A4435 in the ostomy, tracheostomy, and urological supplies (OS) payment category
- E0670 and E2378 in the inexpensive/routinely purchased (IN) payment category
- L5859, L7902 and L8605 in the prosthetics and orthotics (PO) payment category, and
- V5281 – V5290 (67).

The fee schedule amounts for codes E2378, L5859, L7902 will be established as part of the July 2013 DMEPOS fee schedule update, when applicable. Also when applicable, DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2013, through June 30, 2013. The new codes are not to be used for billing purposes until they are effective on January 1, 2013. For gap-filling purposes, the 2012 deflation factors by payment category are listed in the following table:

Factor	Category
0.477	Oxygen
0.480	Capped Rental
0.482	Prosthetics and Orthotics
0.611	Surgical Dressings
0.665	Parenteral and Enteral Nutrition

Specific coding and pricing issues

The fee schedule amounts for shoe modification codes A5503 through A5507 are adjusted to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year

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DMEPOS *(continued)*

2004. For 2013, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 are weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2011. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2013.

Effective January 1, 2013, new code L8605 Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ML is being added to the HCPCS code set. This code falls under the claim processing jurisdiction of local carriers rather than the DME MACs. Fee schedule amounts for this code are added as part of this update.

2013 fee schedule update factor

For 2013, the update factor of 0.8 percent is applied to the applicable 2012 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2013 by the percentage increase in the consumer price index (CPI) for all urban (U) consumers (United States city average), CPI-U, for the 12-month period ending with June of 2012, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP).

The MFP adjustment is 0.9 percent and the CPI-U percentage increase is 1.7 percent. Thus, the 1.7 percentage increase in the CPI-U is reduced by the 0.9 percent MFP adjustment resulting in a net increase of 0.8 percent for the 2013 MFP-adjusted update factor.

2013 update to labor payment rates

2013 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.7 percent effective for dates of service on or after January 1, 2013, through December 31, 2013, and those rates are as follows:

State	K0739	L4205	L7520	State	K0739	L4205	L7520
AK	\$26.92	\$30.67	\$36.08	NJ	\$19.28	\$21.28	\$28.91
AL	\$14.29	\$21.30	\$28.91	NM	\$14.29	\$21.30	\$28.91
AR	\$14.29	\$21.30	\$28.91	NV	\$22.77	\$21.28	\$39.41
AZ	\$17.67	\$21.28	\$35.57	NY	\$26.32	\$21.30	\$28.91
CA	\$21.93	\$34.96	\$40.75	OH	\$14.29	\$21.28	\$28.91
CO	\$14.29	\$21.30	\$28.91	OK	\$14.29	\$21.30	\$28.91
CT	\$23.87	\$21.77	\$28.91	OR	\$14.29	\$21.28	\$41.57
DC	\$14.29	\$21.28	\$28.91	PA	\$15.34	\$21.91	\$28.91
DE	\$26.32	\$21.28	\$28.91	PR	\$14.29	\$21.30	\$28.91
FL	\$14.29	\$21.30	\$28.91	RI	\$17.03	\$21.93	\$28.91
GA	\$14.29	\$21.30	\$28.91	SC	\$14.29	\$21.30	\$28.91
HI	\$17.67	\$30.67	\$36.08	SD	\$15.97	\$21.28	\$38.65
IA	\$14.29	\$21.28	\$34.61	TN	\$14.29	\$21.30	\$28.91
ID	\$14.29	\$21.28	\$28.91	TX	\$14.29	\$21.30	\$28.91
IL	\$14.29	\$21.28	\$28.91	UT	\$14.33	\$21.28	\$45.02
IN	\$14.29	\$21.28	\$28.91	VA	\$14.29	\$21.28	\$28.91
KS	\$14.29	\$21.28	\$36.08	VI	\$14.29	\$21.30	\$28.91
KY	\$14.29	\$27.27	\$36.97	VT	\$15.34	\$21.28	\$28.91
LA	\$14.29	\$21.30	\$28.91	WA	\$22.77	\$31.21	\$37.07
MA	\$23.87	\$21.28	\$28.91	WI	\$14.29	\$21.28	\$28.91
State	K0739	L4205	L7520	State	K0739	L4205	L7520
MD	\$14.29	\$21.28	\$28.91	WV	\$14.29	\$21.28	\$28.91
ME	\$23.87	\$21.28	\$28.91	WY	\$19.92	\$28.38	\$40.31
MI	\$14.29	\$21.28	\$28.91	MN	\$14.29	\$21.28	\$28.91
MO	\$14.29	\$21.28	\$28.91	MS	\$14.29	\$21.30	\$28.91

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DMEPOS (continued)

State	K0739	L4205	L7520	State	K0739	L4205	L7520
MT	\$14.29	\$21.28	\$36.08	NC	\$14.29	\$21.30	\$28.91
ND	\$17.81	\$30.61	\$36.08	NE	\$14.29	\$21.28	\$40.31
NH	\$15.34	\$21.28	\$28.91				

2013 national monthly payment amounts for stationary oxygen equipment

CR 8133 implements the 2013 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2013. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the payment class for oxygen generating portable equipment (OGPE).

The updated 2013 monthly payment amount of \$177.36 includes the 0.8 percent update factor for the 2013 DMEPOS fee schedule.

Please note that when the stationary oxygen equipment fees are updated, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2013 maintenance and servicing payment for certain oxygen equipment

CR 8133 also updates the 2013 payment amount for maintenance and servicing for certain oxygen equipment.

You can read more about payment for claims for maintenance and servicing of oxygen equipment in *MLN Matters*® articles, MM6792, which is at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf> and MM6990, which is at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf>.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR Section 414.210(5) (iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2012 maintenance and servicing fee is adjusted by the 0.8 percent MFP-adjusted covered item update factor to yield CY 2013 maintenance and servicing fee of \$68.05 for oxygen concentrators and transfilling equipment.

Additional information

You can find the official instruction, CR 8133, issued to your FI, carrier, RHHI, or A/B MAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2608CP.pdf>.

If you have any questions, please contact your FI, carrier, 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>.

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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**.

TESTOPEL: Testosterone pellets (Testopel®) – new LCD

LCD ID number: L33004 (Florida/Puerto Rico/U.S. Virgin Islands)

Testosterone pellets (Testopel®) have been approved by the Food and Drug Administration (FDA) for the treatment of primary hypogonadism (congenital or acquired) and hypogonadotropic hypogonadism (congenital or acquired). Primary hypogonadism includes such conditions as testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome, or orchidectomy. Hypogonadotropic hypogonadism (secondary hypogonadism) includes conditions such as idiopathic or gonadotropic luteinizing hormone releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors.

This new local coverage determination (LCD) was developed to outline indications and limitations of coverage and/or medical necessity, ICD-9-CM codes that support medical necessity, documentation requirements and utilization guidelines for testosterone pellets (Testopel®). A “coding guidelines” LCD attachment was also developed which provides instructions to bill Testopel® with the Centers for

Medicare & Medicaid Services (CMS) Healthcare common procedure coding system (HCPCS) code J3490 (Unclassified drugs) and the *Current Procedural Terminology (CPT®)* code 11980 (*Subcutaneous hormone pellet implantation [implantation of estradiol and/or testosterone pellets beneath the skin]*) on the same claim. If HCPCS code J3490 and CPT® code 11980 are not billed on the same claim, the claim will be subject to prepayment review.

Effective date

This new LCD is effective for services rendered **on or after January 29, 2013**. First Coast Service Options, Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. 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](#).

A36516: Low density lipoprotein (LDL) apheresis – new LCD

LCD ID number: L33000 (Florida/Puerto Rico/U.S. Virgin Islands)

Low density lipoprotein (LDL) apheresis describes the process of acutely removing LDL-cholesterol (LDL-C) from the plasma of high risk patient populations. LDL-apheresis (LDL-A) is not routinely used for the treatment of hypercholesterolemia, as hypercholesterolemia usually responds to medical management. LDL-A is indicated for the treatment of hypercholesterolemia for patients with selected inherited conditions who have failed to respond to maximum medical management and diet therapy.

Currently, there is a Medicare national coverage determination (NCD) for apheresis (Therapeutic Pheresis) NCD 110.14. However, it does not specifically address coverage requirements for LDL apheresis.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage and/or medical necessity, type of bill

codes, revenue code(s), CPT® code 36516, ICD-9-CM diagnosis code 272.0, documentation guidelines, and utilization guidelines for low density lipoprotein (LDL) apheresis.

Effective date

This new LCD is effective for services rendered **on or after February 4, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. 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](#).

Additions to LCDs

A43644: Surgical management of morbid obesity – new LCD

LCD ID number L33019 (Florida/Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for surgical management of morbid obesity was developed based on the revised Part B LCD and on the Centers for Medicare and Medicaid Services change request (CR) 8028 effective for claims processed on or after December 10, 2012, for dates of service on or after June 27, 2012. According to CR 8028 Medicare administrative contractors acting within their respective jurisdictions may determine coverage of stand-alone laparoscopic sleeve gastrectomy (LSG), CPT® code 43775, for the treatment of comorbid conditions related to obesity.

This LCD was developed to clarify which bariatric procedures are currently covered and non-covered per national coverage determination (NCD) 100.1, as well as at the local level for LSG. The criteria are clarified for the covered bariatric procedures in the LCD section titled “Indications and Limitations of Coverage and/or Medical Necessity.” The “Documentation Requirements” section of the LCD applies to all of the covered indications and clarifies what should be included in the medical record in support of the allowed procedures. Criteria that must be met in order to meet the covered indications include:

- The patient has a BMI \geq 35 and comorbid conditions exist (e.g., hypertensive cardiovascular disease, pulmonary/respiratory disease, diabetes, sleep apnea or degenerative arthritis of weight-bearing joints) related to obesity. Documentation of the level of severity of the comorbid existing condition must be included in the patient’s medical record; **AND**
- The patient has been previously unsuccessful with

medical treatment for obesity; **AND**

- Treatable metabolic causes for obesity (e.g., adrenal or thyroid disorders) have been ruled out or have been clinically treated if present; **AND**
- When performed at facilities that are (1) certified by the American College of Surgeons as a Level I Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (program standards and requirements in effect on February 15, 2006).

A list of approved facilities and their approval dates will be listed and maintained on the CMS coverage website at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> and will be published in the *Federal Register*.

A triple diagnosis combination will need to be submitted on claims for bariatric procedures. The primary diagnosis (ICD-9-CM code 278.01) and then an additional secondary diagnosis for body mass index (BMI) followed by the comorbidity diagnosis as appropriate will need to be submitted.

Effective date

This new LCD is effective for services rendered **on or after January 29, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section” drop-down menu at the top of the LCD page.

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

A86352: Transplantation immune cell function assay (ImmuKnow®) – new LCD

LCD ID number: L33017 (Florida/Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) was developed as a non-coverage LCD based on review of the current published available literature for transplantation immune cell function assay (ImmuKnow®) (CPT® code 86352). This assay addresses recipient cell-mediated immunity in the course of evaluation of possible immunologic graft

rejection. It was determined that this service does not meet the reasonable and necessary criteria as defined in Section 1862 (a)(1)(A) of the Social Security Act and is therefore a non-covered service.

Effective date

This new LCD is effective for services rendered **on or after January 29, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare

(continued on next page)

Revision to LCD

AJ9263: Oxaliplatin (Eloxatin®) – revision to the LCD

LCD ID number: L28942 (Florida)

LCD ID number: L28963 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for oxaliplatin (Eloxatin®) was most recently revised January 25, 2012. Since that time, a revision was made under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD to include the off-labeled indications of hepatobiliary cancers and multiple specific non-Hodgkin Lymphomas based on the Centers for Medicare & Medicaid Services (CMS)-approved compendia. Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, diagnosis codes 155.1, 156.0, 156.1, 156.2, 156.8, 156.9, 200.30-200.38, 200.40-200.48, 200.60-200.68, 200.70-200.78, 202.00-202.08, and 202.10-

202.18 were added. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after December 19, 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](#).

ANCSVCS: Noncovered services (0191T) – revision to the LCD

LCD ID number: L28991 (Florida)

LCD ID number: L29023 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised October 9, 2012. Since that time, the LCD was revised to remove Category III CPT® code 0191T from the “CPT/HCPCS Codes, Local Noncoverage Decisions-Procedures” section of the LCD. When a service or procedure is removed from the Noncovered Services LCD, this does not imply a positive coverage statement, since there is no coverage statement in any LCD. Therefore, claims billed for Category III CPT® code 0191T (assuming all other requirements of the program are met) would always need to meet the medically reasonable and necessary threshold for coverage in a prepayment or post payment audit of

the official record. Therefore, at this time CPT® code 0191T will be medically reviewed on an individual consideration basis.

Effective date

This LCD revision is effective for services rendered **on or after December 19, 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](#).

ImmuKnow® (continued)

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](#).

A90862: Pharmacologic medication management for psychiatry services – retired LCD

LCD ID number: L30345 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pharmacologic medication management for psychiatry services was most recently revised October 1, 2011. Since that time, a decision was made to retire the LCD based on the annual 2013 HCPCS updates and data analysis.

Effective date

This LCD retirement is effective for services rendered

on or after January 1, 2013. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. 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](#).

ANCSVCS: Noncovered services – revision to the LCD

LCD ID number: L28991 (Florida) LCD ID number: L29023 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised on January 1, 2013. Since that time a revision was made to the LCD. The following codes were evaluated and determined not to be medically reasonable and necessary at this time based on the current published evidence (e.g., peer-reviewed medical literature, published studies): CPT® code 84999 (CancerType ID) was added to the “CPT/HCPCS Codes, Local Noncoverage Decisions-Laboratory Procedures” section of the LCD. CPT® codes 78999 (Intraoperative nuclear mapping during parathyroidectomy [Gamma probe]), 92700 (Vestibular evoked myogenic potentials [VEMP]), 97039 (Cold laser therapy [low level laser therapy]) and Category III CPT® codes 0302T, 0303T, 0304T, 0305T, 0306T, and 0307T were added to the

“CPT/HCPCS Codes, Local Noncoverage Decisions “Procedures” section of the LCD. In addition, under the “Related Documents” section of the LCD a reference page is included.

Effective date

This LCD revision is effective for services rendered **on or after January 29, 2013.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. 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](#).

Self-administered drug (SAD) list – Part A: J1744/J2212

The self-administered drug (SAD) list was most recently revised August 6, 2012. Since that time, based on the 2013 Healthcare Common Procedure Coding System (HCPCS) Annual Update, self-administered drugs icatibant (Firazyr®) and methylsantrexone bromide (Relistor®) (HCPCS codes J3490/C9399) have received new HCPCS codes.

Effective date

Effective for services rendered **on or after January 1, 2013**, the following new HCPCS codes have been

added to the Medicare administrative contractor (MAC) for jurisdiction 9 (J9) Part A SAD list to replace the unclassified codes for icatibant (Firazyr®) and methylsantrexone bromide (Relistor®).

J1744 Injection, icatibant, 1 mg

J2212 Injection, methylsantrexone, 0.1 mg

The First Coast Service Options Inc. SAD lists are available through the CMS Medicare coverage database at: http://medicare.fcso.com/Self-administered_drugs/.

Revision to LCD

2013 HCPCS local coverage determination changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2013 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

LCD Title	Changes
ABOTULINUM TOXINS Botulinum Toxins (Coding Guidelines only)	Descriptor change for CPT® codes 64612 and 64614 Added CPT® code 64615 and 52287
AC1300 Hyperbaric Oxygen Therapy (HBO Therapy)	Descriptor change for CPT® code 99183
AJ0881 Erythropoiesis Stimulating Agents	Deleted HCPCS code Q2047 Added HCPCS code J0890
AJ1459 Intravenous Immune Globulin	Descriptor change for HCPCS codes J1561 and J1569
AJ9280 Mitomycin (Mutamycin®, Mitomycin-C)	Descriptor change for HCPCS code J9280
ANCSVCS Noncovered Services	Descriptor change for CPT® codes 0195T, 0196T, and 0206T Deleted CPT® codes 0242T (replaced with CPT® code 91112), 0276T (replaced with CPT® code 31660), 0277T (replaced with CPT® code 31661), and 90664 Removed CPT® code 99199 (Snap wound care system) and replaced with HCPCS codes G0456 and G0457 Added CPT® codes 0309T, 22586, 90653, 90685, 90686, 90687, 90688, and 90739
APHPROG Psychiatric Partial Hospitalization Program	Descriptor change for CPT® codes 90875, 90876, 97532, and 97533 Deleted CPT® codes 90801, 90802, 90816-90819, 90821-90824, and 90826-90829 Added CPT® codes 90785, 90791, 90792, and 90832-90838
AQ2048 Doxorubicin, Liposomal (Doxil/Lipodox)	Deleted HCPCS code Q2048 Added HCPCS code J9002 Changed "Contractor's Determination Number" to AJ9002
ASKINSUB Skin Substitutes	Descriptor change for HCPCS codes Q4119, Q4126, and Q4128 Deleted HCPCS code C9366, C9368, and C9369 Added HCPCS codes Q4131, Q4132, Q4133, Q4134, Q4135, and Q4136 to "The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products" section of the LCD
ATHERSVCS Therapy and Rehabilitation Services	Descriptor change for CPT® codes 97530, 97532, 97533, 97535, 97537, and 97755 Changed CPT® code range 29000-29590 to CPT® code range 29000-29584 in the "Coding Guidelines" attachment
A01991 Monitored Anesthesia Care (MAC) for Certain Interventional Pain Management Services	Descriptor change for CPT® codes 01991 and 01992

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HCPCS (continued)

LCD Title	Changes
A0279T Circulating Tumor Cell Testing	Delete CPT® codes 0279T and 0280T Added CPT® codes 86152 and 86153 Changed "Contractor's Determination Number" to A86152
A22533 Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions	Added CPT® codes 0309T and 22586
A33224 Biventricular Pacing/Cardiac Resynchronization Therapy	Descriptor change for CPT® code 33225
A43201 Noncovered Procedures-Endoscopic Treatment of Gastroesophageal Reflux Disease (GERD)	Descriptor change for HCPCS code C9724
A76376 3D Interpretation and Reporting of Imaging Studies	Descriptor change for CPT® codes 76376 and 76377
A77055 Screening and Diagnostic Mammography	Descriptor change for CPT® codes 77051 and 77052
A77371 Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (Coding Guidelines only)	Added CPT® code 32701
A86003 Allergy Testing	Descriptor change for CPT® codes 95004, 95024, and 95027 Deleted CPT® codes 95010 and 95015 Added CPT® codes 95017 and 95018
A90802 Interactive Psychiatric Services	Deleted CPT® codes 90802, 90804, 90810, 90811, 90812, 90813, 90814, 90815, 90823, 90824, 90826, 90827, 90828, 90829, and 90857 Added CPT® codes 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, and 90838 Changed "Contractor's Determination Number" to A90785 Changed "LCD Title" from "Interactive Psychiatric Services" to "Interactive Complexity Services"
A90804 Individual Psychotherapy	Deleted CPT® codes 90804, 90805, 90806, 90807, 90808, 90809, 90816, 90817, 90818, 90819, 90821, and 90822 Added CPT® codes 90832, 90833, 90834, 90836, 90837, and 90838 Changed "Contractor's Determination Number" to A90832 Changed "LCD Title" from "Individual Psychotherapy" to "Psychotherapy"
A90901 Biofeedback	Descriptor change for CPT® codes 90875 and 90876
A91110 Wireless Capsule Endoscopy	Descriptor change for CPT® codes 91110 and 91111

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HCPCS (continued)

LCD Title	Changes
A93015 Cardiovascular Stress Testing	Descriptor change for CPT® codes 93015 and 93016
A93224 Long-Term Wearable Electrocardiographic Monitoring (WEM)	Descriptor change for CPT® codes 93224, 93227, 93228, 93229, 93268, and 93272
A93350 Stress Echocardiography	Descriptor change for CPT® codes 93351
A95805 Polysomnography and Sleep Testing	Descriptor change for CPT® codes 95808, 95810, and 95811 Added CPT® codes 95782 and 95783 Changed "Contractor's Determination Number" to A95782
A95860 Electromyography and Nerve Conduction Studies	Deleted CPT® codes 95900, 95903, 95904, 95934, and 95936 Added CPT® codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913
A95920 Intraoperative Neurophysiology Testing	Deleted CPT® code 95920 Added CPT®/HCPCS codes 95940 and G0453 Changed "Contractor's Determination Number" to A95940 Changed "LCD Title" from "Intraoperative Neurophysiology Testing" to "Intraoperative Neurophysiology Monitoring"
A95921 Autonomic Function Tests	Added CPT® codes 95924 and 95943
A95990 Implantable Infusion Pump for the Treatment of Chronic Intractable Pain	Descriptor change for CPT® codes 62370 and 95991

Source: Pub 100-04, transmittal 2529, change request 7909

Implementation of the PWK segment for X12N version 5010

Note: This article was updated on December 7, 2012, to reflect current Web addresses. This article was previously revised on April 21, 2011, to reflect a revised change request (CR) 7041 issued on April 20, 2011. In the previous revision, the CR release date, transmittal number, and the Web address for accessing CR 7041 were revised. Also, a reference to *MLN Matters*[®] article SE1106 was added in the *Additional information* section to give important reminders about the implementation of HIPAA 5010 and D.O., including fee-for-service implementation schedule and readiness assessments. All other information remains unchanged. This information was previously published in the April 2011 *Medicare A Connection*, Pages 28-29.

Provider types affected

This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare administrative contractors (MACs), durable medical equipment (DME) MACs, and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs)).

Provider action needed

This article is based on CR 7041 which announces the implementation of the PWK (paperwork) segment for X12N version 5010. Be sure your billing staff is aware of these changes.

Background

Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides the “linkage” between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

Key points for Medicare billers

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html>.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar “waiting” days (from the date of receipt) for additional information to be faxed or ten calendar “waiting” days for additional information to be mailed.
- Submitters must send **all** relevant PWK data at the same time for the same claim.

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PWK (continued)

- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the coordination of benefits contractor.

Additional information

If you have questions, please contact your MAC and/or FI/carrier 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>.

The official instruction (CR 7041) issued to your MAC and/or FI/carrier is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R874OTN.pdf>.

You may also want to review *MLN Matters*[®] article MM7306 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7306.pdf>.

You may also want to review *MLN Matters*[®] article SE1106 available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1106.pdf> for important reminders about the implementation of HIPAA 5010 and D.O., including fee-for-service implementation schedule and readiness assessments.

MLN Matters[®] Number: MM7041 *Revised*
Related Change Request (CR) #: 7041
Related CR Release Date: April 20, 2011
Effective Date for Providers: July 1, 2011
Related CR Transmittal #: R874OTN
Implementation Date: July 5, 2011

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



Calculate the possibilities ...

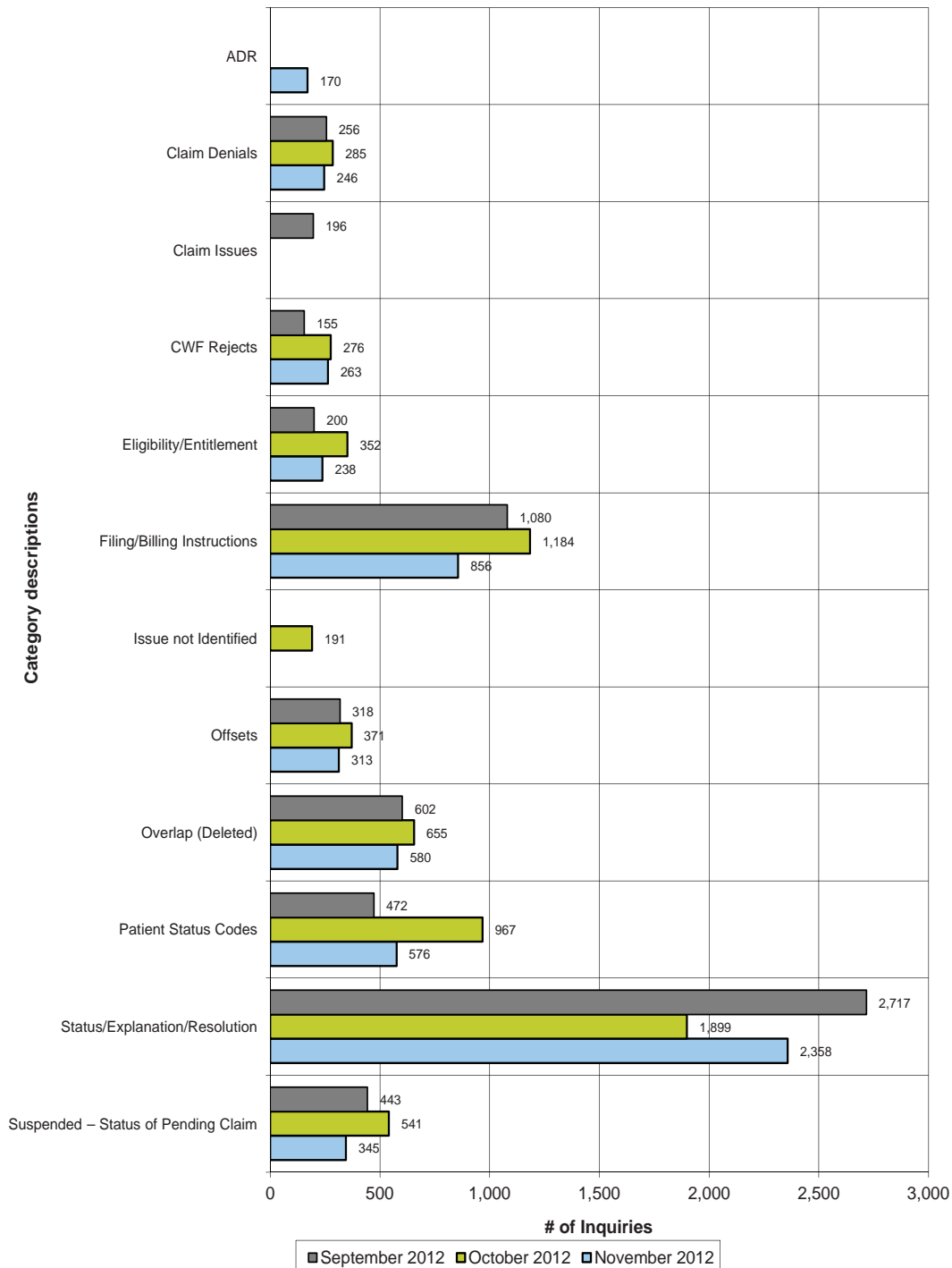
Whether you're estimating the amount of a Medicare payment, the length of an ESRD coordinating period, or the deadlines for sending an appeals request or responding to an additional development request, try the easy way to calculate the possibilities. Find everything you need to "do it yourself" in our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

Top inquiries, rejects, and return to provider claims – September-November 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 August through October 2012.

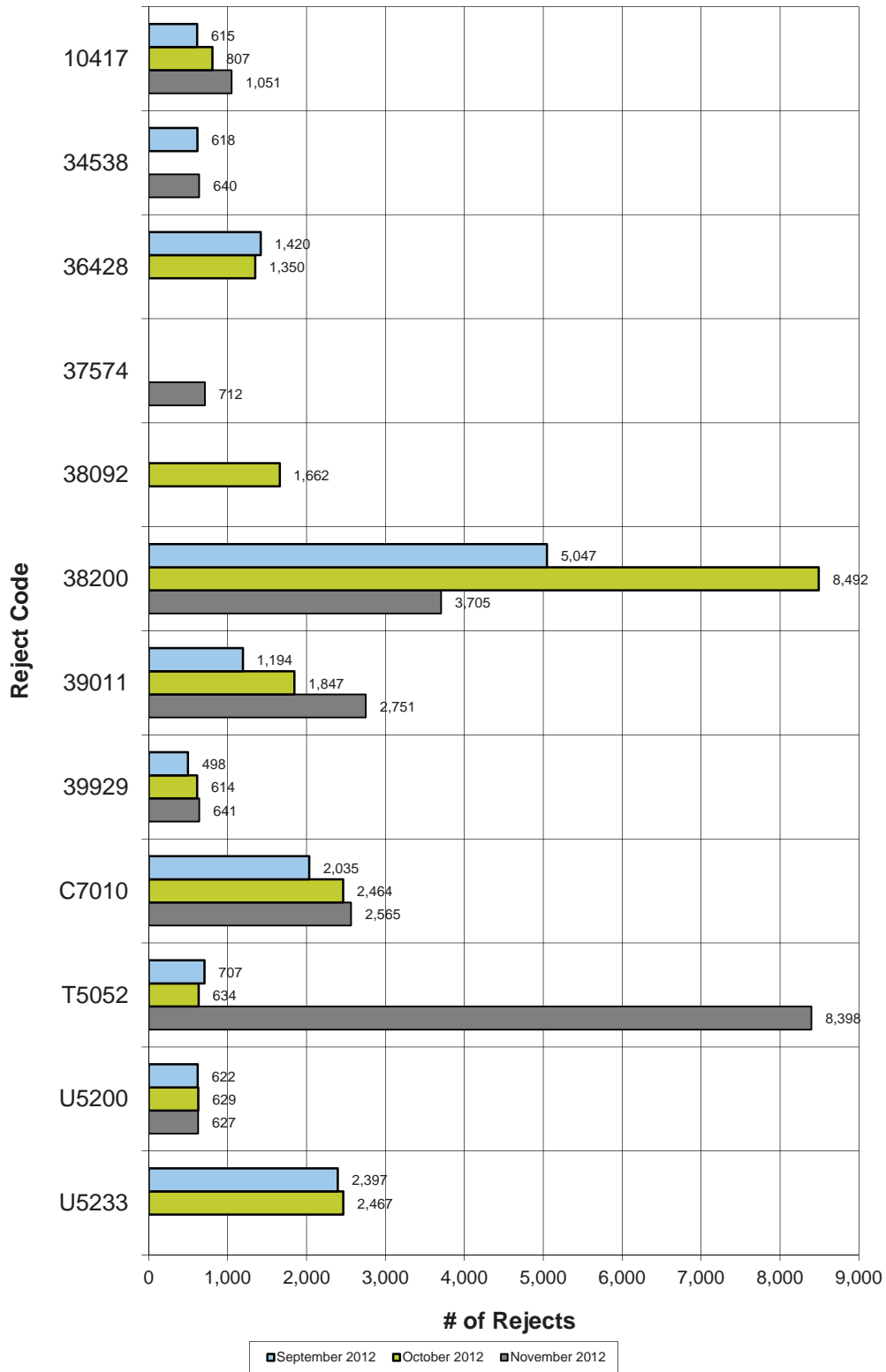
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at http://medicare.fcso.com/Inquiries_and_denials/index.asp.

Top inquiries for September-November 2012



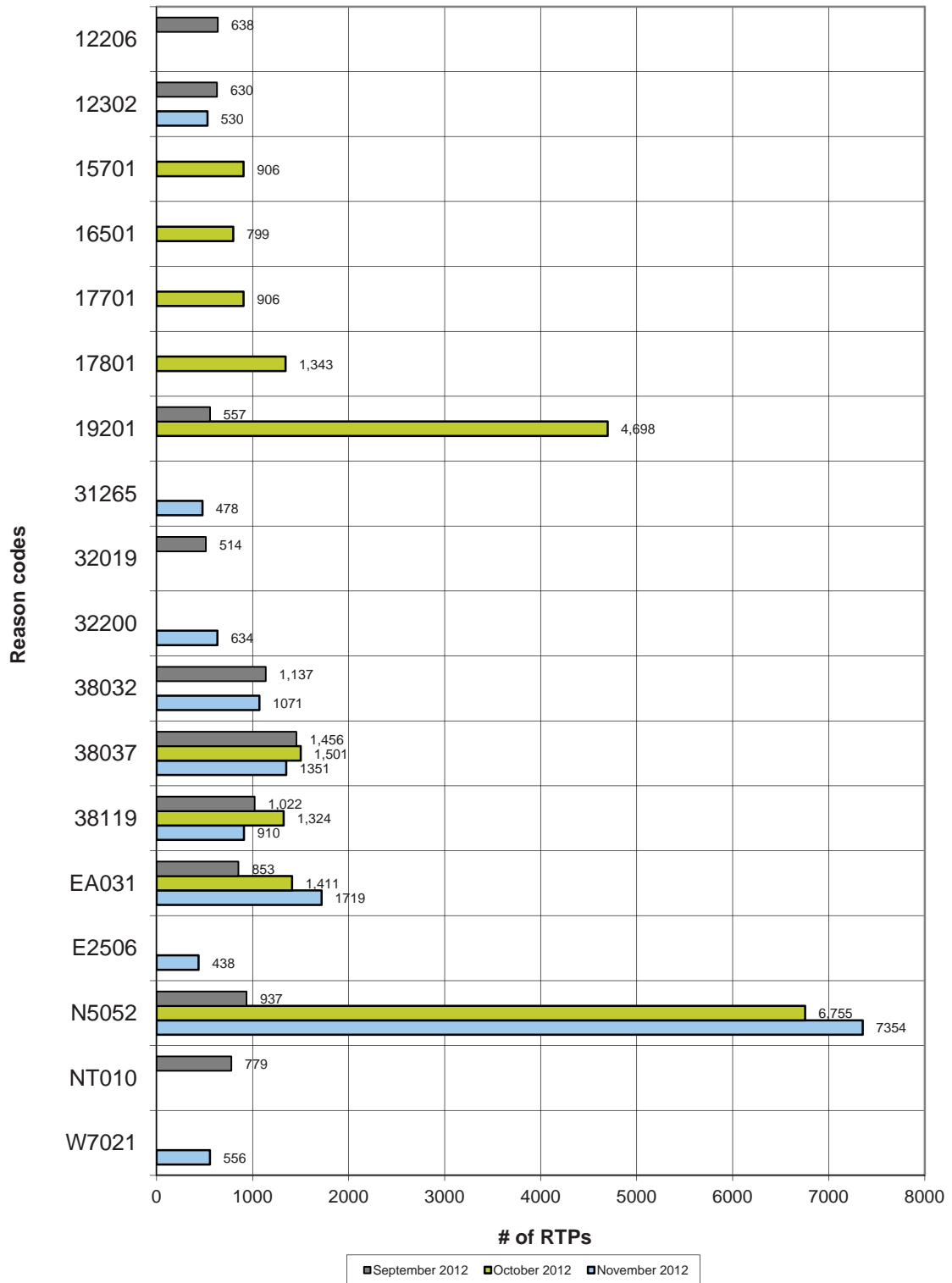
Part A top rejects for September-November 2012

Top rejects for September-November 2012



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

Top RTPs for September-November 2012



Home health prospective payment system rate update for 2013

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8122 which informs Medicare contractors about the changes and updates to the 60-day national episode rates, the national per-visit amounts, LUPA add-on amount, the non-routine medical supply payment amounts, the fixed dollar loss ratio, and the labor and non-labor percentages under the HH PPS for 2013. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

The Affordable Care Act of 2010 mandated several changes to Section 1895(b) of the Social Security Act and, therefore, the HH PPS Update for 2013.

Section 1895 (b)(3)(B)(v) of the Social Security Act (the Act) provides that Medicare home health payments be updated by the applicable market basket percentage increase for CY 2013. Section 3401(e) of the Affordable Care Act amended Section 1895(b)(3) (B) of the Act by adding a new clause (vi) which states, "After determining the home health market basket percentage increase ... the Secretary shall reduce such percentage ... for each of 2011, 2012, and 2013, by 1 percentage point." The home health market basket percentage increase for 2013 is 2.3 percent. However, after reducing it by 1 percentage point as required by the Affordable Care Act, the 2013 HH PPS payment update percentage becomes 1.3 percent. In addition, Section 1895 (b)(3)(B)(v) of the Act requires that home health agencies (HHAs) report such quality data as determined by the Secretary. HHAs that do not report the required quality data will receive a 2 percent reduction to the home health payment update percentage of 1.3 percent for a final HH PPS payment update of -0.7 percent for 2013.

In addition, Section 3131(c) of the Affordable Care Act amended Section 421(a) of the Medicare Modernization Act (MMA), which was amended by Section 5201(b) of the DRA. The amended Section 421(a) of the MMA provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The statute waives budget neutrality related to this provision, as the statute specifically states that the



Secretary shall not reduce the standard prospective payment amount (or amounts) under Section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

Policy

1. **Market Basket Update** The home health market basket update for 2013 is 2.3 percent. After reducing it by 1 percentage point as required by the Affordable Care Act, the 2013 HH PPS payment update percentage becomes 1.3 percent. HHAs that do not report the required quality data will receive a 2 percent reduction to the home health payment update percentage of 1.3 percent, for a final HH PPS payment update of -0.7 percent for 2013.

2. **Outlier payments** Section 3131(b) of the Affordable Care Act requires the following outlier policy: (1) target to pay no more than 2.5 percent of estimated total payments for outliers and (2) apply a 10 percent agency-level cap on outlier payments as a percentage of total HH PPS payments.

For 2013 and subsequent years, the total amount of the additional payments or payment adjustments made may not exceed 2.5 percent of the total payments projected or estimated to be made based on the PPS in that year as required by Section 1895(b)(5)(A) of the Act as amended by Section 3131(b)(2)(B) of the Affordable Care Act. Per Section 3131(b)(2)(C) of the Affordable Care Act, outlier payments to HHAs will be capped at 10 percent of that HHA's total HH PPS payments.

The loss-sharing ratio of 0.80 remains unchanged for 2013. However, the new fixed dollar loss ratio for 2013 is 0.45.

3. **Rural Add-on** As stipulated in Section 3131(c) of the Affordable Care Act, the 3 percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit rates, low utilization payment adjustment (LUPA) add-on payment, and non-routine medical supply (NRS) conversion factor when home health services are provided in rural (non-CBSA)

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Home (continued)

areas.

Note: All of the information provided below contains references to Tables. These tables can be found in attachment contained in CR 8122 (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2592CP.pdf> on the CMS website).

4. Payment Calculations & Rate Tables

For 2013, the labor related share is 78.535 percent and the non-labor related share is 21.465 percent when wage-adjusting all payments.

In order to calculate the 2013 national standardized 60-day episode payment rate, CMS will update the payment amount by the 2013 HH PPS payment update percentage of 1.3 percent (the 2.3 percent home health market basket update percentage minus 1 percentage point, per Section 3401(e)(2) of the Affordable Care Act).

CMS updated analysis of the change in case-mix that is not due to an underlying change in patient health status reveals an additional increase in nominal change in case-mix. Therefore, CMS will next reduce rates by 1.32 percent resulting in an updated 2013 national standardized 60-day episode payment rate. The updated 2013 national standardized 60-day episode payment rate for an HHA that submits the required quality data is shown in Table 1. These payments are further adjusted by the individual episode's case-mix weight and wage index.

The updated 2013 national standardized 60-day episode payment rate for an HHA that does not submit the required quality data is subject to a HH PPS payment update percentage of 1.3 percent reduced by 2 percentage points as shown in Table 2. These payments are further adjusted by the individual episode's case-mix weight and wage index.

In calculating the 2013 national per-visit rates used to calculate payments for LUPA episodes and to compute the imputed costs in outlier calculations, the 2012 national per-visit rates are updated by the 2013 HH PPS payment update percentage of 1.3 percent for HHAs that submit quality data, and by 1.3 percent minus 2 percentage points (-0.7 percent) for HHAs that do not submit quality data.

The 2013 national per-visit rates per discipline are shown in Table 3. The six HH disciplines are as follows:

Home Health Aide (HH aide);

Medical Social Services (MSS);

Occupational Therapy (OT);

Physical Therapy (PT);

Skilled Nursing (SN); and

Speech Language Pathology Therapy (SLP).

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The per-visit rates noted above are before that additional payment is added to the LUPA amount. The 2013 LUPA add-on payment is updated in Table 4.

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor. The NRS conversion factor for CY 2013 payments is updated in Table 5a.

The payment amounts for the various NRS severity levels based on the updated conversion factor from Table 5a are shown in Table 5b.

The NRS conversion factor for HHAs that do not submit quality data is shown in Table 6a.

The payment amounts for the various NRS severity levels based on the updated conversion factor from Table 6a are shown in Table 6b.

The three percent rural add-on, per Section 3131(c) of the Affordable Care Act, is applied to the national standardized 60-day episode rate, national per-visit rates, LUPA add-on payment, and NRS conversion factor when home health services are provided in rural (non-Core Based Statistical Areas (CBSAs)). Refer to Tables 7 through 10b for these payment rates.

These changes will be implemented through the Home Health Pricer software found in Medicare contractor standard systems.

Additional information

The official instruction, CR 8122 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/R2592CP.pdf> on the CMS website.

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> on the CMS website.

MLN Matters® Number: MM8122

Related Change Request (CR) #: CR 8122

Related CR Release Date: November 16, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R2592CP

Implementation Date: January 7, 2013

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

Medicare DMEPOS competitive bidding program: quick reference

Provider types affected

This *MLN Matters*® special edition article is informational in nature. It is intended to be a quick reference tool for all health care professionals who order or refer patients for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in a Competitive Bidding Area (CBA).

Background

The Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program was successfully implemented in nine areas on January 1, 2011. Round 2 of the bidding program is targeted to go into effect in 91 Metropolitan Statistical Areas (MSAs) on July 1, 2013. Medicare will also be implementing a national mail-order program for diabetic testing supplies at the same time as Round 2. The national mail-order program will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

When a round of the bidding program becomes effective, beneficiaries with original Medicare who obtain competitively bid items in CBAs must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. Referral agents located in CBAs who prescribe DMEPOS for Medicare beneficiaries or refer beneficiaries to specific suppliers should be aware of which suppliers in the area are contract suppliers. The Centers for Medicare & Medicaid Services (CMS) plans to announce the contract suppliers for Round 2 and the national mail order program in the spring of 2013.

About this article

This article is designed as a quick reference tool that provides referral agents with a list of important web links and phone numbers to find information on the bidding program. The information found at these sources will greatly assist referral agents in locating information that will assist them in obtaining DMEPOS items and services for Medicare beneficiaries. For purposes of the program, referral agents include such entities as Medicare enrolled providers, physicians, treating practitioners, discharge planners, social workers, disability/disease-based organizations, and pharmacists who refer beneficiaries for services in a CBA.

Referral agents play a critical role in helping beneficiaries select DMEPOS suppliers that can meet the beneficiaries' needs and meet the requirements of the bidding program. A beneficiary's first contact with the program may be at the point when he or she receives a prescription for a competitively bid item. If the beneficiary resides in a CBA or is visiting a CBA in which he or she needs to obtain a competitively bid item, he or she may need to be directed to a contract supplier.

Where do I go to learn more about the Medicare DMEPOS competitive bidding program?

The CMS webpage on The Program (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html>) provides links to the latest news, press releases, announcements and fact sheets. A link to the Round 2/national mail order timeline can also be found on this webpage.

Partnering with CMS is a key to helping people with Medicare maximize their benefits. Beyond extending the reach of these important benefits to people who need them, a partnership helps you leverage resources by fostering relationships with other CMS partners, keeps you informed, and provides you with expert training, educational materials, tools such as this toolkit at http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS_Toolkit.html, research, and a connection to CMS' 10 regional offices, where you may access personalized local assistance.

E-Mail updates for referral agents

In the coming months leading up to the start of the program, CMS will send out more information that will be helpful for referral agents and guide them through the changes that the new program brings.

In light of the important role that referral agents serve, CMS has adopted the use of a new email update to better communicate the various aspects of the program and to ensure that official information is released and received by referral agents as quickly as possible. CMS encourages all referral agents to sign up for this new email update to ensure they receive the most accurate and timely information regarding the program.

To ensure you give Medicare patients correct DMEPOS information, sign up for the email updates for referral agents.

How do I know if a Medicare beneficiary resides in a competitive bidding area?

The Competitive Bidding Implementation Contactor (CBIC) provides a tool at <http://www.dmecompetitivebid.com> to find a CBA on its website. To determine if a beneficiary resides in a CBA, click on the "Find a CBA" tab and enter the ZIP CODE of the beneficiary's permanent residence on file with the Social Security Administration (SSA).

The tool will indicate whether the zip code is within a CBA or not.

How do I find a Medicare contract supplier for a Medicare beneficiary in a CBA?

(continued on next page)

DMEPOS *(continued)*

The Medicare.gov website (<http://www.medicare.gov/default.aspx>) provides a supplier directory tool under the “resource locator” tab for finding a Medicare contract supplier to provide certain durable medical equipment in the Medicare DMEPOS competitive bidding program where the beneficiary resides. Once the contract suppliers have been announced, the supplier directory tool will indicate whether the beneficiary is affected by the Medicare competitive bidding program based on the beneficiary’s zip code and the particular DMEPOS needed.

Customer service representatives at 1-800-MEDICARE (1-800-633-4227) can also assist beneficiaries in finding a contract supplier. TTY users should call 1-877-486-2048.

How do I know what DMEPOS items and services are competitively bid items in the program?

Product categories are groupings of related items that are used to treat a similar medical condition. A list of the product categories for Round 2 can be found by visiting http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Product_Categories_and_Items.html on the CMS website.

The CBIC provides a tool to identify specific items within a product category by Healthcare Common Procedure Coding System (HCPCS) code at <http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Product%20Categories> on its website.

MLN Matters® Number: SE1244
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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Feeling confused about 5010?



We can help remove the mystery ...

Try our 5010 reject code lookup.

Announcement of Medicare rural health clinic (RHC) and federally qualified health centers (FQHC) payment rate increases

Provider types affected

This *MLN Matters*® Article is intended for rural health clinics (RHC) and federally qualified health centers (FQHC) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (A/B MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8119 which informs Medicare contractors about the calendar year 2013 Payment Rate Increases for RHC and FQHC services. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 8119 provides instructions for the 2013 Payment Rate Increases for RHC and FQHC services. The RHC upper payment limit per visit is increased from \$78.54 to \$79.17 effective January 1, 2013,

through December 31, 2013 (i.e., CY 2013). The 2013 rate reflects a 0.8 percent increase over the 2012 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI) as authorized by §1833(f) of the Social Security Act.

The FQHC upper payment limit per visit for urban FQHCs is increased from \$126.98 to \$128.00 effective January 1, 2013, through December 31, 2013 (i.e., CY 2013), and the maximum Medicare payment limit per visit for rural FQHCs is increased from \$109.90 to \$110.78 effective January 1, 2013, through December 31, 2013 (i.e. CY 2013). The 2013 FQHC rates reflect a 0.8 percent increase over the 2012 rates in accordance with the rate of increase in the MEI.

Additional information

The official instruction, CR 8119 issued to your FI and



A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2595CP.pdf> on the CMS website.

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> on the CMS website.

MLN Matters® Number: MM8119
 Related Change Request (CR) #: CR 8119
 Related CR Release Date: November 23, 2012
 Effective Date: January 1, 2013
 Related CR Transmittal #: R2595CP
 Implementation Date: January 7, 2013

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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 highlights 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.

Educational Events

Upcoming provider outreach and educational events – January 2013

Medicare Part A changes and regulations

When: Wednesday, January 16
Time: 9:00 a.m.-10:30 a.m. ET **Delivery language:** Spanish
Type of Event: **Webcast** **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Implementing the claims-based data collection requirement for outpatient therapy services

When: Thursday, January 17
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 has extended it until further notice. The following are links to the latest e-News:
- CMS e-News for Wednesday, December 13, 2012 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/eNews121312.pdf>
- 'CMS Medicare FFS Provider e-News': December 6, 2012 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-12-06-e-News.pdf>
- 'CMS Medicare FFS Provider e-News': November 29, 2012 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-29-e-News.pdf>
- 'CMS Medicare FFS Provider e-News': December 20, 2012 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/eNews-12202012.pdf>

Source: CMS PERL 201211-07, 201211-08, 201212-01, 201212-04



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.*

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

Addresses

Claims

Additional documentation

General mailing

Congressmen mailing

First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Redeterminations

Redeterminations on overpayments

First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Debt recovery (except for MSP)

First Coast Service Options Inc.
P.O. Box 45096
Jacksonville, FL 32232-5096

Post-payment medical exams

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

Freedom of Information Act (FOIA*) related requests

First Coast Service Options Inc.
Attn: FOIA PARD 16T
P.O. Box 45268
Jacksonville, FL 32232-5268

Medicare fraud and abuse

First Coast Service Options Inc.
P.O. Box 45087
Jacksonville, FL 32232-5087

Provider enrollment

First Coast Service Options Inc.
Provider Enrollment
Post Office Box 44021
Jacksonville, FL 32231-4021

Electronic Data Interchange (EDI*)

First Coast Service Options Inc.
P.O. Box 44071
Jacksonville, FL 32231-4071

MSPRC DPP debt collection – Part A

First Coast Service Options Inc.
P.O. Box 44179
Jacksonville, FL 32231-4179

Credit balance

First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

Audit and reimbursement department

Reporte de costo, auditoría,
apelación de reporte de costo,
porcentaje tentativo, rama de PS & R
First Coast Service Options Inc.
P.O. Box 45268
Jacksonville, FL 32231-0048

Overnight mail and other special handling postal services

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

Other Medicare carriers and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)

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

Regional Home Health & Hospice Intermediary

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

Railroad Medicare

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

Phone Numbers

Providers

Customer service – free of charge

Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-908-8433

For the hearing and speech impaired (TDD)

1-888-216-8261

Interactive voice response (IVR)

1-877-602-8816

Beneficiary

Customer service – free of charge

1-800-MEDICARE
1-800-633-4227

For the hearing and speech impaired (TDD)

1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number

1-904-361-0407

Audit And Reimbursement Department

Fax number
1-904-361-0407

Websites

Providers

First Coast – MAC J9

medicare.fcso.com
medicareespanol.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services

www.medicare.gov