Medicare A Connection

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers January 2013

In this issue

Providers welcome major improvements to the Internet-based PECOS system

Health care providers seeking to enroll in Medicare or update their information can more easily do so thanks to major improvements to Medicare's Provider Enrollment, Chain and Ownership System (PECOS).

Internet-based PECOS facilitates the Medicare provider enrollment process by giving health care providers a more efficient alternative to submitting and updating their enrollment in Medicare. Based on feedback from the medical community in 2012, the Centers for Medicare & Medicaid Services (CMS) recently expanded the types and number of transactions providers may conduct through PECOS.

PECOS advantages

Providers who move or change any of their practice information are required to update this information with Medicare. Prior to the development of Internet-based PECOS, providers would have to submit paper applications. The upgrades to PECOS have eliminated the need for paper applications for most providers.

One of the biggest benefits providers and their authorized delegate will notice from the recent enhancements to PECOS is the ability to provide an electronic signature and submit supporting documentation for provider enrollment. Providers will notice other benefits including:

- A simplified screen view called "My Enrollments" showing a provider's enrollment information;
- provider/supplier's enrollment information pertaining to their last electronic submission; and
- view new or in-progress applications that display the provider's enrollment information as its being edited in PECOS.

PECOS tools to use

On the "My Enrollments" page, providers and their delegates can generate reassignment reports displaying up to 50 records of assigned benefits. In addition, CMS has updated the tutorial videos on the PECOS homepage to illustrate how to take advantage of the system improvements.

Links to get started in PECOS

More information about provider enrollment is available on the *CMS website*. CMS has *highlighted the advantages* of using Internet-based PECOS and *established a dedicated page* for providers to register for the first time or login to the PECOS system.

Contents

Medicare A Connection subscription

Medicare A Connection is published monthly and is available online in both *English* and *Spanish*. Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published from October 2012 through September 2013.

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

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

Publication staff:
Terri Drury
Martin Smith
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

Updates to clarify inpatient rehabilitation facility (IRF) claims processing

Provider types affected

This *MLN Matters*® article is intended for physicians and providers (including inpatient rehabilitation facilities (IRFs)) submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs)) for inpatient rehabilitation services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8127, from which this article is taken, updates the "*Medicare Claims Processing Manual*," Chapter 3 (inpatient hospital billing), to clarify key components of inpatient rehabilitation facility (IRF) claims processing. These changes are intended only to clarify the existing policies and there are no system or policy changes.

Background

Medicare IRF classification requirements

A facility paid under the IRF prospective payment system (PPS) is always subject to verification that it continues to meet the criteria for exclusion from the inpatient PPS (IPPS). Your FI or MAC provides the Centers for Medicare & Medicaid Services (CMS) regional office (RO) with data for determining the classification status of each facility and the RO reviews the IRF's classification status each year. A determination that a facility either is or is not classified as an IRF takes effect only at the start of a facility's cost reporting period and applies to that entire cost reporting period. If a facility fails to meet the criteria necessary to be paid under the IRF PPS, but meets the criteria to be paid under the IPPS, it may be paid under the IPPS.

If a patient is admitted to a facility that is being paid under the IRF PPS, but is discharged from the facility when it is no longer being paid under the IRF PPS, then payment to the facility will be made from the applicable payment system that is in effect for the facility at the time the patient is discharged.

For cost reporting periods beginning on or after July 1, 2005, the IRF must have served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified in the revised manual Section 140.1.1C. See CR 8127 for a list of these criteria.

Additional criteria for inpatient rehabilitation units

Inpatient rehabilitation units must also meet additional criteria to be paid under the IRF PPS. These criteria are detailed in Section 140.1.2 of the revised manual, as attached to CR 8127. Verification process used to determine if IRF meets classification criteria

For cost reporting periods beginning on or after July

1, 2005, the compliance threshold that must be met is 60 percent. Thus, for all compliance review periods beginning on or after January 1, 2013 (except in the case of new IRFs), the compliance review period will be one continuous 12-month time period beginning four months before the start of a cost reporting period and ending four months before the beginning of the next cost reporting period. For complete details of the verification process, see the revised Section 140.1.3 of the manual, which is attached to CR 8127.

New IRFs

An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS for at least five calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.

A new IRF must provide written certification that the inpatient population it intends to serve will meet the certification requirements. The written certification is effective for the first full 12-month cost reporting period that occurs after the IRF begins being paid under the IRF PPS, and for any cost reporting period of not less than one month and not more than 11 months occurring between the date the IRF begins being paid under the IRF PPS and the start of the IRF's first full 12-month cost reporting period.

Changes in the status of an IRF unit

For purposes of payment under the IRF PPS, the status of an IRF unit may be changed from not excluded from the IPPS to excluded from the IPPS only at the start of a cost reporting period. If an IRF unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of the hospital's next cost reporting period. The status of an IRF unit may be changed from excluded from the IPPS to not excluded from the IPPS at any time during a cost reporting period, but only if the hospital notifies the FI/MAC and the RO in writing of the change at least 30 days before the date

(continued on next page)

IRF...*continued*

of the change. In addition, the hospital must maintain the information needed to accurately determine which costs are and are not attributable to the IRF unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the remainder of that cost reporting period.

New IRF Beds

Any IRF beds that are added to an existing IRF must meet all applicable State certificates of need and State licensure laws. New IRF beds may be added one time at any time during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds de-licensed or decertified.

Change of Ownership or Leasing

If an IRF hospital (or a hospital that has an IRF unit) undergoes a change of ownership or leasing, as defined in 42 CFR 489.18, the IRF (or IRF unit of a hospital) retains its excluded status and will continue to be paid under the IRF PPS before and after the change of ownership or leasing if the new owner(s) of the IRF hospital (or the hospital with an IRF unit) accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the IRF PPS.

Note: that an IRF's payment status under the IRF PPS is a Medicare classification status, which cannot be separated from its host hospital and therefore cannot be purchased outside of the purchase of its host hospital. If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to the Medicare program to operate a new IRF, under the requirements for new IRFs.

Mergers

If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the IRF PPS before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF PPS. Note that an IRF's payment status under the IRF PPS is a Medicare classification status, which cannot be separated from its host hospital and therefore cannot be merged with

another entity outside of the merger with its host hospital. If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may re-apply to the Medicare program to operate a new IRF under the requirements for new IRFs.

Full time equivalent (FTE) resident cap

Effective for cost reporting periods beginning on or after October 1, 2011, the IRF FTE resident caps may be temporarily adjusted to reflect interns and residents added because of another IRF's closure or the closure of another IRF's residency training program. An IRF is only eligible for the temporary cap adjustment if training the additional interns and residents would cause the IRF to exceed its FTE resident cap. In addition, an IRF that closes a medical residency training program must agree to temporarily reduce its FTE cap before other IRFs can receive temporary adjustments to their caps for training the IRF's interns and residents. IRFs may qualify for the temporary cap adjustment for cost reporting periods beginning on or after October 1, 2011, if they are already training interns and residents displaced by IRF closures or residency training program closures that occurred prior to October 1, 2011.

Outliers

The Social Security Act provides the Secretary of Health and Human Services with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high cost. A case qualifies for outlier payment if the estimated cost of the case exceeds the adjusted

(continued on next page)

Prompt payment interest rate revision

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

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

The new rate of 1.375 percent is in effect through June 30, 2013.

Interest is not paid on:

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

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

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

IRF*...continued*

outlier threshold. CMS calculates the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the case-mix group (CMG) payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, CMS calculates the estimated cost of the case by multiplying the IRF's overall cost-to-charge ratio (CCR) by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold. The adjusted threshold amount and upper threshold CCR are set forth annually in the IRF PPS notices published in the *Federal Register*.

Additional information

The official instruction, CR 8127 issued to your FI, carrier, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2638CP.pdf* on the CMS website.

You can find the updated "*Medicare Claims Processing Manual*," Chapter 3 (inpatient hospital billing) as an attachment to this CR. If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html* on the CMS website.

MLN Matters® Number: MM8127
Related Change Request (CR) #: CR 8127
Related CR Release Date: January 18, 2013
Effective Date: April 22, 2013
Related CR Transmittal #: R2638CP
Implementation Date: April 22, 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

Summary of policies in the 2013 Medicare physician fee schedule (MPFS) final rule and the telehealth originating site facility fee payment amount

Provider types affected

This *MLN Matters*® article is intended for physicians and non-physician practitioners submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), or A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8191 summarizes the policies in the 2013 Medicare physician fee schedule (MPFS) final rule and announces the telehealth originating site facility fee payment amount. Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians' services for the subsequent year. Make sure that your staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2012, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) who are paid under the MPFS in 2013. The final rule addresses:

- Medicare public comments on payment policies that were originally displayed on July 6, 2012, and published in the *Federal Register* on July 30, 2012;
- Medicare program; revisions to payment policies under the physician fee schedule and other revisions to Part B for 2013; and
- Interim final values established in the 2013 MPFS final rule with comment period (originally displayed on November 1, 2012, and published in the *Federal Register* on November 16, 2012)

It assigns interim final values for new and revised codes for 2013; and requests comments on these values, which it will accept until December 31, 2012. Since publication of the final rule, Congress has averted the statutorily required reduction in Medicare's physician fee schedule through the American Taxpayer Relief Act of 2012. A separate CR addresses revisions required by that legislation.

Summary of policies in the 2013 MPFS

1. Payment increases to primary care physicians

The 2013 MPFS includes a new policy to pay a physician or non-physician practitioner to coordinate a patient's care in the 30 days following a hospital or skilled nursing facility stay. CMS believes that recognizing the work of community physicians and practitioners in treating a patient following discharge from a hospital or nursing facility will ensure better continuity of care for these patients, and help reduce patient readmissions.The rule's changes in care coordination payment and other changes are expected to increase payment to family practitioners by seven percent and other primary care practitioners between three and five percent.

2. Physician value-based payment modifier

The 2013 MPFS continues the careful implementation of the physician value-based payment modifier by phasing in application of the modifier and enabling physicians in larger groups to choose how to participate. The value modifier provides differential Medicare payments to physicians based on a comparison of the quality and cost of care furnished to beneficiaries. The statute allows CMS to phase in the value modifier over three years, from 2015 to 2017. For 2015, the final rule applies the value modifier to groups of physicians with 100 or more eligible professionals, a change from the proposed rule, which would have set the group size at 25 or above. This change was adopted to gain experience with the methodology and approach before expanding to smaller groups.

The final rule also provides an option for these groups of physicians to choose how the value modifier is calculated based on whether they participate in the physician quality reporting system (PQRS). For physicians and groups of physicians who elect to participate in 2015, common sense incentives will improve the care that beneficiaries receive; physicians with higher quality and lower costs will be paid more, and those with lower quality and higher costs will be paid less. The performance period for the application of the value modifier in 2015 was previously established as 2013 in the 2012 MPFS final rule, which you can find at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html* .

3. Aligning quality reporting across programs

The 2013 MPFS continues CMS' efforts to align quality reporting across programs in order to reduce burden and complexity. It makes changes to the PQRS and the electronic prescribing incentive program (the two quality reporting programs applicable to the MPFS) and updates the Medicare electronic health records incentive pilot program. These changes will simplify reporting and align the various programs' quality reporting approaches so they support the national quality strategy.

4. Enhancing the physician compare website

The 2013 MPFS lays out the next steps to enhance the physician compare website, including posting names of practitioners who (as part of the million hearts campaign) successfully report measures to

(continued on next page)

MPFS...*continued*

prevent heart disease. Please note that these are recommended measures under PQRS as well.

5. Expanding access to services that non-physician practitioners can provide

The 2013 MPFS expands access to services that can be provided by non-physician practitioners. It allows Medicare to pay: 1) certified registered nurse anesthetists for providing all services that they are permitted to furnish under state law (i.e. to the full extent of their state scope of practice); and 2) For portable X-rays ordered by nurse practitioners, physician assistants and other non-physician practitioners.

6. Payment for molecular pathology services

The 2013 MPFS explains how Medicare will pay for molecular pathology services—the next innovation of clinical laboratory tests that will foster the development of personalized medicine. These tests will be paid under the clinical laboratory fee schedule, with the 2013 payment set by the gap filling method.

7. Face-to-face encounter as a condition of payment for certain items

The 2013 MPFS requires a face-to-face encounter as a condition of payment for certain durable medical equipment (DME) items for orders written on, or after, July 1, 2013.

8. Claims-based data collection strategy

Section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012 requires CMS to implement a claims-based data collection strategy on January 1, 2013; to gather information on: 1) beneficiary function and condition, 2) therapy services furnished, and 3) outcomes achieved. CMS will use this information to assist in reforming the Medicare payment system for outpatient therapy services. Details about this data collection can be found in CR 8005. You can find the associated *MLN Matters*® article, MM8005, "Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services — Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf* on the CMS website.

9. Multiple Procedure Payment Reduction (MPPR)

Also for 2013, a multiple procedure payment reduction (MPPR) will apply a 25 percent reduction to the technical component (TC) of the second and subsequent diagnostic cardiovascular service, and a 20 percent reduction to the TC of the second and subsequent diagnostic ophthalmology service; furnished by the same physician (or physicians in the same group practice) to the same beneficiary, on the same day. CR 7848 discusses this 2013 MPPR in full detail, and you can find the associated *MLN Matters*® article: MM7848, "Multiple Procedure Payment Reduction on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7848.pdf*.

10. Telehealth originating site facility fee payment

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20. For telehealth services provided on or after January 1 of each subsequent year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in Section 1842(i)(3) of the Act.

The MEI increase for 2013 is 0.8 percent. Therefore, for 2013, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser, of the actual charge, or $24.43 as described by HCPCS code Q3014. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance). More information on 2013 changes in telehealth can be found in CR 7900. You can review the associated *MLN Matters*® article: MM7900, "Expansion of Medicare Telehealth Services for Calendar Year 2013," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7900.pdf* .

Additional information

For more information and access to the 2013 final rule, go to the "Physician Fee Schedule" available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html* .

The official instruction, CR 8191, issued to your FI, carrier, or A/B MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2631CP.pdf* on the CMS website. If you have any questions, please contact your FI, carrier, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html* .

MLN Matters® Number: MM8191
Related Change Request (CR) #: CR 8191
Related CR Release Date: January 9, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2631CP
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

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

Note: This article was revised on December 26, 2012, to reflect a revised CR 8005 issued on December 21. In the article, *CPT*® code *96125* was added to the list of evaluation codes and information was added to provide direction for one-time therapy visits. Also, the transmittal numbers and the Web addresses for accessing the CR 8005 transmittals is updated. It was previously published in the December 2012 edition, Pages 27-32. All other information remains the same.

Provider types affected

This *MLN Matters*® article for change request (CR) This *MLN Matters*® article for 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 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 are aware 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 non-payable 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-*

(continued on next page)

Outpatient *(continued)*

and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8126.pdf) was issued to alert providers/suppliers and contractors that these non-payable 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).

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

(continued on next page)

Outpatient *(continued)*

from therapy or to end reporting
Short descriptor: Other PT/OT D/C status

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

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

(continued on next page)

Outpatient *(continued)*

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

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:

- 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,

(continued on next page)

Outpatient *(continued)*

- 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*	*96125*	*97001*
97002	*97003*	*97004*			

When functional reporting is required on a claim for therapy services, two G-codes will generally be

required. Two exceptions exist:

1. Therapy services under more than one therapy POC. Claims may contain more than two non-payable functional G-codes when in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.

2. One-Time Therapy Visit. When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, the clinician reports on the claim for the DOS of the visit, all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.

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

(continued on next page)

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 was issued via two transmittals. The first revises the "Medicare Benefit Policy Manual" and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R165BP*.pdf on the CMS website. The second transmittal updates the "Medicare Claims Processing Manual" and it is at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R2622CP.pdf* on the CMS website.

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*.

MLN Matters® Number: MM8005 Revised
Related Change Request (CR) #: CR 8005
Related CR Release Date: December 21, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R165BP and R2622CP
Implementation Date: January 7, 2013

Clinical laboratory fee schedule reasonable charge update

Note: This article was revised on January 10, 2013, to reflect a revised CR 8132 issued on January 9. In the article, the CR release date, transmittal number, and Web address for accessing the CR were revised. It was previously published in the December 2012 edition on Pages 41-44. 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 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
GO143	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.

(continued on next page)

Lab *(continued)*

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 CY 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 or homebound patient. If there is a revision to the standard mileage rate for CY 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 *86386*QW is priced at the same rate as code *86386*, effective January 1, 2012.
New code *83861*QW is priced at the same rate as code *83861*, effective July 1, 2012.
New code *86803*QW 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*.

(continued on next page)

Lab *(continued)*

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.

Manual instructions for determining the reasonable charge payment can be found in the "Medicare Claims Processing Manual," Chapter 23, Sections 80 through 80.8. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. Note: The Medicare manuals noted in this article are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html*

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, "*Medicare Claims Processing Manual*," Chapter 8, Section 60.3, instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

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*

(continued on next page)

Lab *(continued)*

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/R2630CP.pdf*.

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

MLN Matters® Number: MM8132 Revised
Related Change Request (CR) #: CR 8132
Related CR Release Date: January 9, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2630CP
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

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

Note: This article was revised on January 14, 2013, to reflect the revised CR 8133 issued on January 11. The CR release date, transmittal number, and Web address were revised. It was previously published in the December 2012 edition on Pages 45-47. All other information remains the same.

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 (CY) 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*.

(continued on next page)

DMEPOS *(continued)*

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).

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

1. 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 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.

2. 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.

(continued on next page)

DMEPOS *(continued)*

CY 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
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
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).

(continued on next page)

DMEPOS *(continued)*

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 Section1834(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/R2632CP.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*.

MLN Matters® Number: MM8133 Revised
Related Change Request (CR) #: CR 8133
Related CR Release Date: January 11, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2632CP
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.

CMS adds new HCPCS code for ventricular assist devices and accessories for which payment was not made under Medicare Part A

Provider types affected

This *MLN Matters*® Article is intended for hospitals and suppliers of external ventricular assist devices (VADs) or any VAD for which payment was not made under Medicare Part A. Such claims are billed to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

This article, based on change request (CR) 7888, instructs fiscal intermediaries (FI), carriers, and A/B MACs to implement a new Healthcare Common Procedure Coding System (HCPCS) codes in order to process claims for accessories and supplies for external VADs or any VAD for which payment was not made under Medicare Part A. Make sure that your billing staffs are aware of this change.

Background

The Centers for Medicare & Medicaid Services (CMS) provided instructions to its contractors on processing claims for replacement accessory and supplies for external VADs and for VADs for which payment was not made under Medicare Part A.

CR 3931, issued on July 22, 2005, instructed that claims for replacement accessories and supplies for VADs implanted in patients who were not eligible for coverage under Medicare Part A or had other insurance that paid for the device and hospital stay at the time that the device was implanted should be billed using HCPCS code L9900. (See the related *MLN Matters*® article, MM3931, at *http://www.cms.gov/Outreach-andEducation/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm3931.pdf* on the CMS website.)

Additionally, in rare instances, replacement accessory and supply claims for external VADs used by patients who are discharged from the hospital or an emergency backup controller for an external VAD were also to be billed using HCPCS code L9900.

Since the implementation of CR 3931, CMS finds that the use of HCPCS code L9900 in the above circumstances presents claims processing issues. CR 7888 enables FIs, carriers, and A/B MACs to make the necessary changes in order to process replacement accessory and supply claims for external VADs or VADs for which payment was not made under Medicare Part A using new HCPCS codes.

New HCPCS code

Payment on a fee schedule basis is required for prosthetic devices by the Social Security Act, Section 1834(h). The following codes are being added to the December 2012 HCPCS code set and are, effective for services on or after April 1, 2013:

- Q0507 - Miscellaneous supply or accessory for use with an external ventricular assist device
- Q0509 - Miscellaneous supply or accessory for use with any implanted ventricular assist device for which payment was not made under Medicare Part A

Effective April 1, 2013, claims for replacement of accessories and supplies for VADs implanted in

patients who were not eligible for coverage under Medicare Part A or had other insurance that paid for the device and hospital stay at the time that the device was implanted, but are now eligible for coverage of the replacement supplies and accessories under Medicare Part B, should be submitted using HCPCS code Q0509. Such claims will be manually reviewed.

In rare instances, it may be appropriate to pay for replacement of supplies and accessories for external VADs used by patients who are discharged from the hospital. In addition, in some rare instances, it may be necessary for a patient to have an emergency backup controller for an external VAD. Coverage of these items is at the discretion of your Medicare contractor.

Replacement supplies

Claims for replacement of supplies and accessories used with an external VAD that are furnished by suppliers should be billed to the local carriers. Claims for replacement of supplies and accessories used with an external VAD that are furnished by hospitals

(continued on next page)

VAD *(continued)*

and other providers should be billed to the FIs or A/B MACs. Effective April 1, 2013, these items should be billed using code Q0507 so that the claims can be manually reviewed.

In order to clarify the descriptor of miscellaneous VAD accessory and supply code Q0505, the following new code is being added December 2012 to the HCPCS quarterly update with an effective date of April 1, 2013:

- Q0508 - Miscellaneous Supply or Accessory For Use With An Implanted Ventricular Assist Device

Code Q0508 clarifies that the miscellaneous supplies and accessories billed under this code are for use with implanted VADs. Code Q0508 replaces code Q0505 that is discontinued March 31, 2013.

Please note that when determined to be medically necessary, dressings used with VADs are covered under the prosthetic device benefit as a supply necessary for the effective use of the VAD/prosthetic device. Claims for dressings necessary for the effective use of a VAD should be billed using the appropriate miscellaneous VAD supply code, depending upon whether the patient was eligible for coverage under Medicare Part A at the time that the VAD was implanted. The claims processing jurisdiction for dressings used with VADs is identical to that of other VAD replacement supplies and accessories and does not fall under DME MAC jurisdiction.

Additional Information

The official instruction, CR 7888, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R1159OTN.pdf* on the CMS website.

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

MLN Matters® Number: MM7888
Related Change Request (CR) #: CR 7888
Related CR Release Date: December 21, 2012
Effective Date: April 1, 2013
Implementation Date: April 1, 2013
Related CR Transmittal #: R1159OTN

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

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

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

Effective and notice dates

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

Contents

Revisions to LCDs

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.**

Revisions to LCDs

A92132: Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the LCD

LCD ID number: L28982 (Florida)

LCD ID number: L29015 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) was most recently revised October 1, 2011. Since that time, the LCD has been revised based on an external reconsideration request. The "*ICD-9 Codes that Support Medical Necessity*" section of the LCD was revised to add ICD-9-CM codes V58.69 and V67.51 with an asterisk as these diagnosis codes apply to *CPT®* code *92134* only. The "*Indications and Limitations of Coverage and/or Medical Necessity*" section of the LCD was revised to add the following indication: "Monitoring patients for the development of chloroquine (CQ) and/or hydroxychloroquine (HCQ) retinopathy. Patients being treated with CQ and/or HCQ should receive a baseline examination within the first year of treatment and an annual follow-up after five years of treatment. For higher-risk patients, annual testing may begin immediately (without a five-year delay)." 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 February 20, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database *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*.

A77055: Screening and diagnostic mammography – revision to the LCD

LCD ID number: L29048 (Florida)

LCD ID number: L29049 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for screening and diagnostic mammography was most recently revised January 1, 2013. Since that time, a revision was made under the "*CPT®*/HCPCS Codes" and "Documentation Requirements" sections of the LCD to remove instructions related to modifier-GH and include instructions for modifier-GG based on the *Medicare Claims Processing Manual,* Chapter 18, Section 20.2-20.6. In addition, the "Coding Guidelines" attachment was revised to update the instructions for modifier-GH and add instructions for modifier-GG.

Effective date

This LCD revision is effective for claims processed **on or after March 11, 2013**, for services rendered **on or after January 1, 2002**. First Coast Service Options, Inc. LCD's 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 LCD's for jurisdiction 9 (J9), please click *here*.

First Coast Service Options Inc provides current and draft local coverage determinations (LCDs), when they exist, for Medicare-covered procedure codes. Not every procedure code is covered by an LCD. Click here to look up current LCDs

A93312: Transesophageal echocardiogram – revision to the LCD

LCD ID number: L28996 (Florida)

LCD ID number: L29028 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for transesophageal echocardiogram was most recently revised October 1, 2011. Since that time, the LCD has been revised based on an external reconsideration request. The "*ICD-9 Codes that Support Medical Necessity*" section of the LCD was revised to add ICD-9-CM codes 427.31 and 427.32. The "*Indications and Limitations of Coverage and/or Medical Necessity*" section of the LCD was revised to add the following indication: "Arrhythmias – assessment of patients with certain cardiac arrhythmias [atrial fibrillation, atrial flutter] for which the results of the test will influence treatment decisions. Transesophageal echocardiogram (TEE) may complement transthoracic echocardiography particularly to assess for left atrial thrombus." 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 February 20, 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*.

AJ0897: Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the LCD

LCD ID number: L32110 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was most recently revised May 9, 2012. Since that time, a revision was made under the "*Indications and Limitations of Coverage and/or Medical Necessity*" section of the LCD to add the new Food and Drug Administration (FDA) approved indication "Treatment to increase bone mass in men with osteoporosis at high risk for fracture" for Prolia®. In addition, the "Document Requirements," "Utilization Guidelines," and "Sources of Information and Basis for Decision" sections of the LCD were updated.

Effective date

This LCD revision is effective for services rendered **on or after September 1, 2012**. First Coast Service Options Inc. LCD's 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*.

ANCSVCS: Noncovered services (*0311T*) – revision to the LCD

LCD ID number: L28991 (Florida)

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

First Coast Service Options Inc. has made an additional revision to the local coverage determination (LCD) for noncovered services based on change request (CR) 7909 (2013 Healthcare Common Procedure Coding System [HCPCS] annual update). *CPT*® code *93799* (Noninvasive assessment of central blood pressure [e.g., SphygmoCor System/Device]) has been removed from the "*CPT*®/HCPC*S* Codes, Local Noncoverage Decisions-Procedures" section of the LCD and replaced with *CPT*® code *0311T*.

Effective date

This LCD revision is effective for claims processed **on or after January 29, 2013,** 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.

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

CMS issues instructions for ICD-10 conversion on national coverage determinations

Provider types affected

This *MLN Matters*® Article is intended for all Medicare providers covered under the Health Insurance Portability and Accountability Act (HIPAA), including those submitting claims electronically and those submitting paper claims, to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

Provider action needed

Beginning October 1, 2014, all providers submitting electronic and paper claims to Medicare contractors must use ICD-10-CM and ICD-10-PSC code sets in appropriate HIPAA standard transactions. This article, based on change request (CR) 8109, instructs Medicare contractors and shared system maintainers to both create and update national coverage determination (NCD) hard-coded shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes plus all associated coding infrastructure, such as procedure codes, Healthcare Common Procedure Coding System (HCPCS) and *Current Procedural Terminology* (*CPT*®) codes, denial messages, frequency edits, place of service (POS), type of bill (TOB) and provider specialties, etc. The requirements described reflect the operational changes that are necessary to implement the conversion of the Medicare system diagnosis codes specific to the Medicare national coverage database (NCD) spreadsheets attached to CR 8109.

What you need to do

Make sure that your billing staffs will be able to meet the October 1, 2014, requirement to use ICD-10 code sets in all HIPAA transactions submitted to Medicare. This requirement also applies to paper claims submitted to Medicare.

Background

On October 1, 2014, as required by CMS-40-F, 42 *Code of Federal Regulations* (CFR) 162, dated September 5, 2012, all Medicare claims submissions will convert from the ICD-9 to the ICD-10. The transition will require business and systems changes throughout the health care industry. All covered entities, as defined by the Health Insurance Portability and Accountability Act (HIPAA), must adhere to the conversion.

In accordance with HIPAA, the Secretary of the Department of Health and Human Services adopted standard medical data code sets for use in standard transactions adopted under this law. According to the ICD-10 final rule, published in the "*Federal Register*" of January 16, 2009, the Secretary adopted the ICD-10-Clinical Modification (CM) and ICD-10-procedure coding system (PCS) code sets for use in appropriate HIPAA standard transactions, including those for submitting health care claims electronically. Entities covered under HIPAA, which include Medicare and its providers submitting claims electronically, are bound by these requirements and must comply. Medicare will also require submitters of paper claims to use ICD-10 codes on their claims according to the same compliance date.

Note: CR 8109 in no way is intended to expand, restrict, or alter existing Medicare national coverage, nor is it intended to minimize the authority granted to MACs in their discretionary implementation of NCDs or local coverage determinations (LCDs). However, where hard-coded edits were not initially implemented due to time and/or resource constraints, doing so at this time will better serve the intent and integrity of national coverage and the Medicare program overall.

General information found in spreadsheets

In the attachments spreadsheets are attached to CR 8109 indicating certain affected ICD-9 codes and their corresponding ICD-10 codes as they relate to their respective NCDs, in addition to the rest of the coding infrastructure specific to each NCD. Each spreadsheet contains the following information:

- National coverage determinations (NCD) number;
- NCD title;
- Internet-Only Manual (IOM) searchable link related to the NCD; and
- Medicare Coverage Database (MCD) searchable link related to the NCD.

Within each spreadsheet, there are three tabs:

- ICD diagnosis, which includes; ICD-9 CM, ICD-9 DX description, ICD-10 CM, ICD-10 DX description, and any changes (remove, keep, add);
- ICD procedures, which includes; ICD-9, ICD 9 Px description, ICD-10 PCS, ICD-10 PCS description and any changes (remove, keep, add); and
- Rule description:

By Part A: Proposed HCPCS/*CPT*®, frequency limitations, type of bill, revenue code, modifier, provider specialty, proposed Medicare summary notice (MSN) message, proposed claim adjustment reason code (CARC) message, and proposed remittance advice remarks code (RARC) message, and

By **Part B:** Proposed HCPCS/*CPT*®, frequency limitations, place of service, modifier, provider specialty, proposed MSN message, proposed CARC message, and proposed RARC message.

(continued on next page)

Remittance advice remark and claims adjustment reason code, Medicare remit easy print, and PC print update

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) 8154 which instructs Medicare contractors and shared system maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) that have been added since the last recurring code update. It also instructs Medicare system maintainers to update PC print and Medicare remit easy print (MREP) software. 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 Health Insurance Portability and Accountability Act of 1996 (HIPAA; see *http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf*), instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or global policy information that generally applies to the adjudication process are required in remittance advice (RA) and coordination of benefits (COB) transactions.

For transaction 835 (health care claim payment/ advice) and standard paper remittance advice (RA), there are two code sets – CARC and RARC – that must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate Group Code must be reported as well. Additionally, CARC and RARC must be used for transaction 837 COB.

The CARC and RARC changes that impact Medicare

(continued on next page)

NCDs...*continued*

Spreadsheets attached to CR 8109 explain the following NCDs by number & title:

Number	Title
20.9	artificial hearts
20.20	external counterpulsation therapy severe angina
20.29	hyperbaric oxygen therapy
90.1	pharmacogenomic testing warfarin
190.11	home prothrombin time/international normalized ratio (PT/INR) monitoring
210.1	prostate cancer screening tests
210.3	colorectal cancer screening tests
260.1	adult liver transplantation
260.3.1	islet cell transplantation clinical trials
260.5	intestinal/multi-visceral transplantation
270.1	electrical stimulation (es) and electromagnetic therapy for the treatment of wounds

Additional information

The official instruction, CR 8109, issued to your FI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1165OTN.pdf* on the CMS website.

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

MLN Matters® number: MM8109
Related change request (CR) #: CR 8109
Related CR Release Date: January 18, 2013
Effective Date: October 1, 2014
Related CR Transmittal #: R1165OTN
Implementation Date: April 1, 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

CARC *(continued)*

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

Medicare contractors stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual "stop date" posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule.

Note that a deactivated code used in derivative messages must be accepted, even after the code is deactivated, if the deactivated code was used before the deactivation date by a payer or payers who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR 8154, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only 3 times a year and may not match the CMS schedule for releasing its system updates.

CR 8154 lists only the changes that have been approved since the last code update CR (CR 8029, Transmittal 2521, issued on August 17, 2012), and does not provide a complete list of codes for these two code sets.

The WPC website (see *http://www.wpc-edi.com/Reference*) has four listings available of codes by status for both CARC and RARC.

1. **Show All**: All codes including current, to be deactivated and deactivated codes are included in this listing.

2. **Current**: Only currently valid codes are included in this listing.

3. **To Be Deactivated**: Only codes to be deactivated at a future date are included in this listing.

4. **Deactivated**: Only codes with prior deactivation effective dates are included in this listing.

Note: In case of any discrepancy in the code text as posted on WPC Web site and as reported in any CR, the WPC version should be implemented. The CARC and RARC changes reflected by CR 8154 are as follows:

New Codes – CARC:

Code	Code narrative	Effective date
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.	9/30/2012
245	Provider performance program withhold.	9/30/2012
246	This non-payable code is for required reporting only.	9/30/2012
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim. Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).	9/30/2012

(continued on next page)

CARC *(continued)*

Code	Code narrative	Effective date
248	Coinsurance for professional service rendered in an institutional setting and billed on an institutional claim. Notes: For Medicare bundled payment use only, under the Patient Protection and Affordable Care Act (PPACA).	9/30/2012
249	This claim has been identified as a resubmission. (Use only with Group Code CO)	9/30/2012
250	The attachment content received is inconsistent with the expected content.	9/30/2012
251	The attachment content received did not contain the content required to process this claim or service.	9/30/2012
252	An attachment is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	9/30/2012
W3	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.	9/30/2012
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	9/30/2012
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF). To be used for P&C Auto only. Start: 09/30/2012	9/30/2012
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 insurance policy number segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF). To be used for P&C Auto only. Start: 09/30/2012	9/30/2012
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (loop 2100 Other Claim Related Information REF). If adjustment is at the line level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.	9/30/2012

Modified codes – CARC:

Code	Modified narrative	Effective date
18	Duplicate claim/service. This change effective 1/1/2013: Exact duplicate claim/service (Use only with Group Code OA)	1/1/2013
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	9/30/2012

(continued on next page)

CARC *(continued)*

Code	Modified narrative	Effective date
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	9/30/2012
133	The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. (Use only with Group Code OA)	9/30/2012
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). This change effective 7/1/2013: Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	7/1/2013
173	Service was not prescribed by a physician. This change effective 7/1/2013: Service/ equipment was not prescribed by a physician.	7/1/2013
201	Workers' compensation case settled. Patient is responsible for amount of this claim/ service through WC 'Medicare set aside arrangement' or other agreement. (Use Group Code PR). This change effective 7/1/2013: Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	7/1/2013
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group Code OA) This change effective 7/1/2013: Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group Code OA)	7/1/2013
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)	9/30/2012
220	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)	9/30/2012
221	Workers' Compensation claim is under investigation. Note: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 insurance policy number segment (loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the line level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). This change effective 7/1/2013: Claim is under investigation. Note: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the line level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)	9/30/2012
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 7/1/2013: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	9/30/2012

(continued on next page)

CARC *(continued)*

Code	Modified narrative	Effective date
229	Partial Charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR. This change effective 7/1/2013: Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	7/1/2013
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative. This change effective 7/1/2013: This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee	7/1/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	7/1/2013

Deactivated codes – CARC: None

New codes – RARC:

Code	Code narrative	Effective date
N560	The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.	11/1/2012
N561	The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this readmission.	11/1/2012
N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.	11/1/2012
N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	11/1/2012
N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.	11/1/2012
N565	Alert: This procedure code requires a modifier. Future claims containing this procedure code must include an appropriate modifier for the claim to be processed.	11/1/2012
N566	Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.	11/1/2012

Modified codes – RARC:

Code	Modified narrative	Effective date
M39	The Note: (Modified 2/1/04, 4/1/07, 11/1/09) Related to N563	11/1/2012
M137	Part B coinsurance under a demonstration project or pilot program.	11/1/2012

(continued on next page)

CARC *(continued)*

Deactivated codes – RARC:

Code	Narrative	Effective date
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	11/1/2012

Medicare contractors must report only currently valid codes in both the RA and COB claim transactions, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see the *Business Requirements* segment of CR 8154 for an explanation of conditions).

SSMs and Medicare contractors must make the necessary changes on a regular basis as per this recurring code update CR and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation has not been initiated by Medicare.

Additional information

The official instruction, CR 8154 issued to your FI, carrier, RHHI, DME/MAC, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R2618CP.pdf* on the CMS website. For more information on CARC and RARC codes go to *http://www.wpc-edi.com/Reference* on the internet.

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-andSystems/Monitoring-Programs/provider-compliance-interactive-map/index.html* on the CMS website.

MLN Matters® Number: MM8154
Related Change Request (CR) #: CR 8154
Related CR Release Date: December 21, 2012
Effective Date: April 1, 2013
Related CR Transmittal #: R2618CP
Implementation Date: April 1, 2013

National coverage determination (NCD): transcatheter aortic valve replacement (TAVR) coding update/policy clarification

Note: This article was revised on January 15, 2013, to show the correct modifier of 62. All other information remains the same.

Provider types affected

This *MLN Matters*® article is intended for physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MAC)) for transcatheter aortic valve replacement (TAVR) services to Medicare beneficiaries.

Provider action needed

Change request (CR) 7897, issued September 24, 2012, and implemented a new national coverage determination (NCD), TAVR, also known as transcatheter aortic valve implantation (TAVI), a new technology for use in treating aortic stenosis. CR 7897 provided billing/coding instructions that included codes expiring on December 31, 2012. CR 8168 is an update to CR 7897 that implements replacement codes for TAVR claims with dates of service on and after January 1, 2013. Those codes appear in the 2013 physician fee schedule. CR 8168 also clarifies several policy-related issues regarding use of modifier 62 and the documentation requirements, surgical team criteria, and managed care plan claims processing instructions. Please make sure that your billing staffs are aware of these updates.

Background

TAVR, or TAVI, is a new technology for use in treating aortic stenosis. A bioprosthetic valve is inserted intravascularly using a catheter and implanted in the orifice of the native aortic valve. The procedure is performed in a cardiac catheterization lab or a hybrid operating room/cardiac catheterization lab with advanced quality imaging and with the ability to safely accommodate complicated cases that may require conversion to an open surgical procedure. The interventional cardiologist and cardiothoracic surgeon jointly participate in the intra-operative technical aspects of TAVR.

On May 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a NCD covering TAVR under coverage with evidence development (CED). When the procedure is furnished for the treatment of symptomatic aortic stenosis and according to a Food and Drug Administration (FDA) approved indication for use with an approved device, CED requires that each patient be entered into a qualified national registry. In addition, prior to receiving TAVR, face-to-face examinations of the patient are required by two cardiac surgeons to evaluate the patient's suitability for open aortic valve replacement (AVR). The NCD lists criteria for the physician operators and hospitals that must be met prior to beginning a TAVR program and after a

TAVR program is established.

According to CR 7897, issued September 24, 2012, TAVR claims with dates of service on and after May 1, 2012, through December 31, 2012, are billed with temporary category III *Current Procedural Terminology* (*CPT*®) codes *0256T* (Implantation of catheter-delivered prosthetic aortic heart valve: endovascular approach); *0257T* (Implantation of catheter-delivered prosthetic aortic heart valve: open thoracic approach (e.g., transapical, transventricular)); *0258T* (Transthoracic cardiac exposure (i.e., sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement, without cardiopulmonary bypass); and *0259T* (Transthoracic cardiac exposure (i.e., sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement, with cardiopulmonary bypass). These codes are contractor-priced.

Billing for TAVR on and after January 1, 2013

TAVR claims with dates of service on and after January 1, 2013 must be billed with five permanent *CPT*® category one codes and one temporary category three code. These six codes will replace the four temporary codes that expired on December 31, 2012. All other Medicare claims processing instructions as they relate to TAVR and these new codes have been updated accordingly. Thus, effective for dates of service on and after January 1, 2013, Medicare recognizes the following codes when billing for TAVR:

- *33361* - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach;
- *33362* - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach;
- *33363* - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach;

(continued on next page)

TAVR *(continued)*

- *33364* - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach;
- *33365* - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (e.g., median sternotomy, mediastinotomy); and
- *0318T* Replace aortic valve thoracic.

In addition to these codes, the claim must have a place of service (POS) code of 21 (inpatient hospital) or the claim lines will be denied with a claim adjustment reason code (CARC) of 58 (Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.), a remittance advice remarks code (RARC) of N428 (Not covered when performed in this place of service.) and a group code of CO (contractual obligation).

Also, the claim lines for these procedure codes on professional clinical trial claims must have the modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study) or the lines will be returned with a CARC of 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing.

Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.), a RARC of N29 (missing documentation/orders/notes/summary/report/chart.), and the group code of CO.

Similarly, professional claims with one of the above procedure codes must have modifier 62 also or the claim line will be returned with a CARC of 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing.

Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.), a RARC of N29 (missing documentation/orders/notes/summary/report/chart.), and the group code of CO.

Finally, the clinical trial claim line must contain the secondary diagnosis code of V70.7 (ICD-10 of Z00.6) or it will be returned with a CARC of 16 (Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the NCPDP reject reason Code, or remittance advice remark code that is not an ALERT.)), a RARC of M76 (missing/incomplete/invalid diagnosis or condition.), and the group code of CO. For claims processed prior to implementation of these changes, your Medicare contractor will adjust such claims but only if you bring such claims to the contractor's attention.

Clinical studies

For indications that are not approved by the FDA, patients must be enrolled in qualifying clinical studies. The clinical study must address pre-specified research questions, adhere to standards of scientific integrity, and be approved by CMS. Approved studies will be posted on the CMS website at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html* on the CMS website. The process for submitting a clinical research study to Medicare is outlined in the NCD.

The NCD requires an interventional cardiologist and a cardiothoracic surgeon to jointly participate in the intraoperative technical aspects of TAVR as specified in section 20.32 of the *NCD Manual*. All TAVR codes must be billed with modifier 62 (two surgeons) with the exception of the three new add-on codes *33367*, *33368*, and *33369*, effective January 1, 2013. For further information, see the *MLN Matters*® Article related to CR 7897. That article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7897.pdf* on the CMS website.

Note: When a Medicare Advantage (MA) plan participant receives TAVR services, the MA plans are responsible for payment. Medicare coverage for TAVR is not under section 310.1 of the NCD manual (routine costs in qualifying clinical trials) and it is in these trials that the fee-for-service (FFS) system is responsible for payment.

Additional information

The official instruction, CR 8168, issued to your FI, carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2628CP.pdf* on the CMS website.

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

MLN Matters® Number: MM8168 Revised
Related Change Request (CR) #: CR 8168
Related CR Release Date: January 7, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2628CP
Implementation Date: April 1, 2013 (except January 25, 2013 for claims sent to carriers/B MACs)

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

January 2013 integrated outpatient code editor (I/OCE) specifications version 14.0

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8137, which describes changes to the integrated outpatient code editor (I/OCE) and OPPS to be implemented in the January 2013 OPPS and I/OCE updates. Be sure your billing staff is aware of these changes.

The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

The full list of I/OCE specifications can now be found at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html* on the Centers for Medicare & Medicaid Services (CMS) website.

There is a summary of the changes for January 2013 in appendix M of attachment A of CR 8137 and that summary is captured in the following key points. Effective January 1, 2013, (except as noted below) Medicare will:

- Modify the software to maintain 28 prior quarters (7 years) of programs in each release. Remove older versions with each release. (The earliest version date included in this January 2013 release will be 4/1/06.) Edit 24 is affected.
- Modify the criteria for assignment of the electrophysiology/ablation composite ambulatory payment classification (APC) code (appK) by:
- Assigning the composite APC 8000 if there is a single code present from group C, or if there is one code from group A and one code from group B.
- If multiple codes from group C are present, assigning the APC to the code with the lowest numerical value and assign status indicator (SI) of N to additional group C codes on the same day.

- If the criteria for APC assignment are met from group C as well as groups A and B, assigning the APC to the group C code and assign the SI of N to the codes from groups A and B.
- Assigning terminated group C codes (with modifier 52 or 73) to the composite APC and have the terminated procedure discount applied.
- Apply edit 84 (claim lacks required primary code) to partial hospitalization program (PHP) claims if new psychiatric add-on codes are submitted without a code for the primary service on the same day.
- Modify the PHP logic to ignore the psychiatric add-on codes in the count of the number of services (3 or 4) required to assign the PHP APCs.
- Add four modifiers (24, 57, LM, and RI to the list of national correct coding initiative (NCCI) modifiers.
- Remove code *58611* from the inpatient separate procedure list. (Effective April 1, 2006.)
- Add occupational therapy (G0129) and activity therapy (G0176) to the list for edit 81.
- Deactivate edits 63 and 64.
- Make HCPCS/APC/SI changes as specified by CMS (data change files).
- Implement version 19.0 of the NCCI (as modified for applicable institutional providers). [All edits combined in a single file, in code1/code2 format; mutually exclusive pairs no longer differentiated]. Edits 20 and 40 are affected.
- Update procedure/device & device/procedure edit requirements. Edit 71 is affected.
- Update the PHP list A & B.

(continued on next page)

Outpatient *(continued)*

- Update composite APC requirements.
- Add new modifiers CH, CI, CJ, CK, CL, CM, and CN (% impaired, limited or restricted); LM and
- RI to the valid modifier list. Edit 22 is affected.
- Update the skin substitute list.
- Update nuclear medicine/radiolabeled products list.

Additional information

The official instruction, CR 8137 issued to your FI, A/B MAC, or RHHI regarding this change may be viewed *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R2616CP.pdf* on the CMS website. If you have any questions, please contact your carrier or FI, A/B MAC, or RHHI at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-andSystems/Monitoring-Programs/provider-compliance-interactive-map/index.html* on the CMS website.

MLN Matters® Number: MM8137
Related Change Request (CR) #: CR 8137
Related CR Release Date: December 21, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2616CP 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

Go green to get your green faster

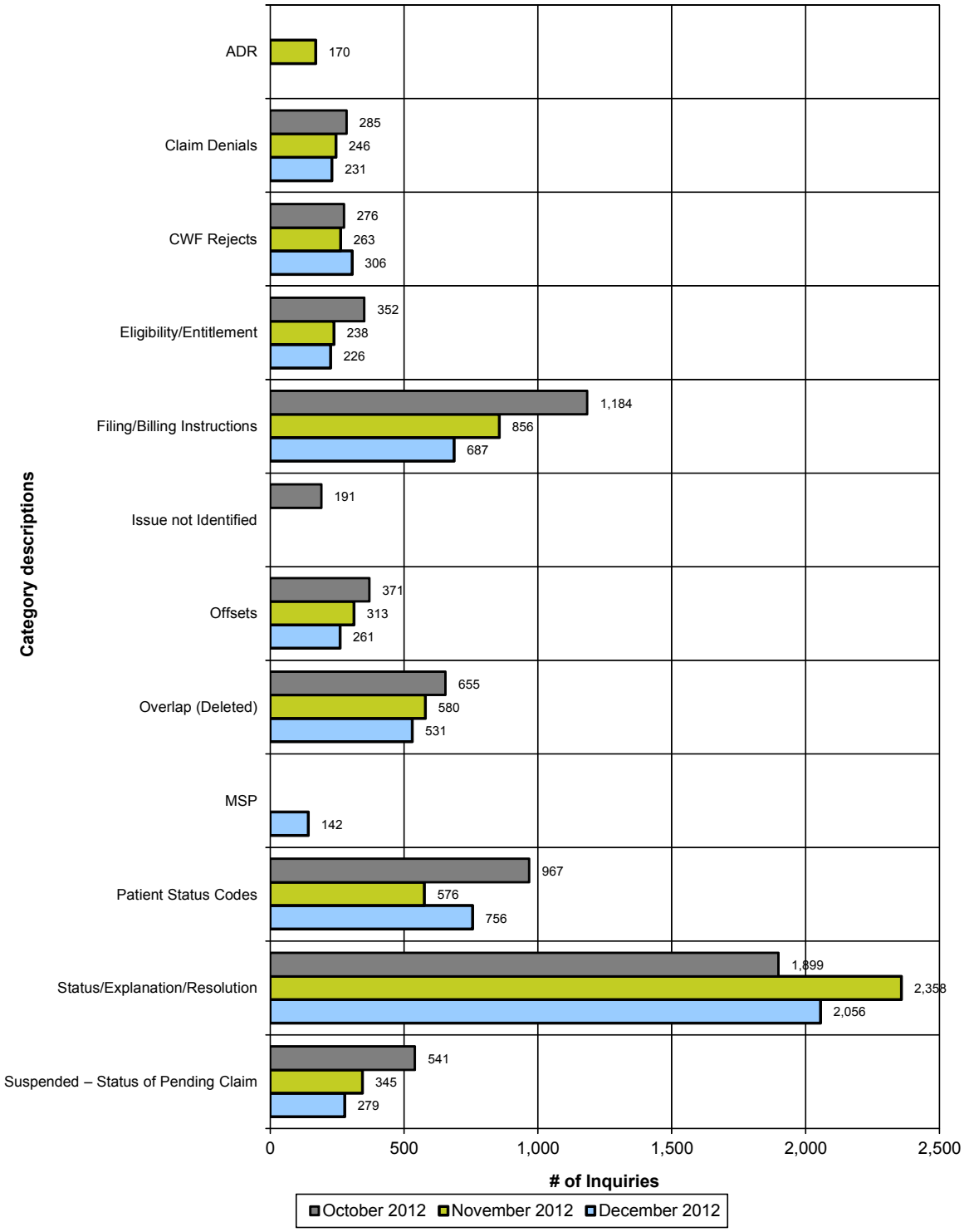
Save time, money, and the environment all at the same time by signing up for electronic funds transfer (EFT). With EFT, funds are transferred directly to your financial institution, which means quicker reimbursement for you. To start receiving EFT, simply complete and return the EFT Authorization Agreement form at *http://www.cms.gov/cmsforms/downloads/CMS588.pdf* .

Top inquiries, rejects, and return to provider claims – October-December 2012

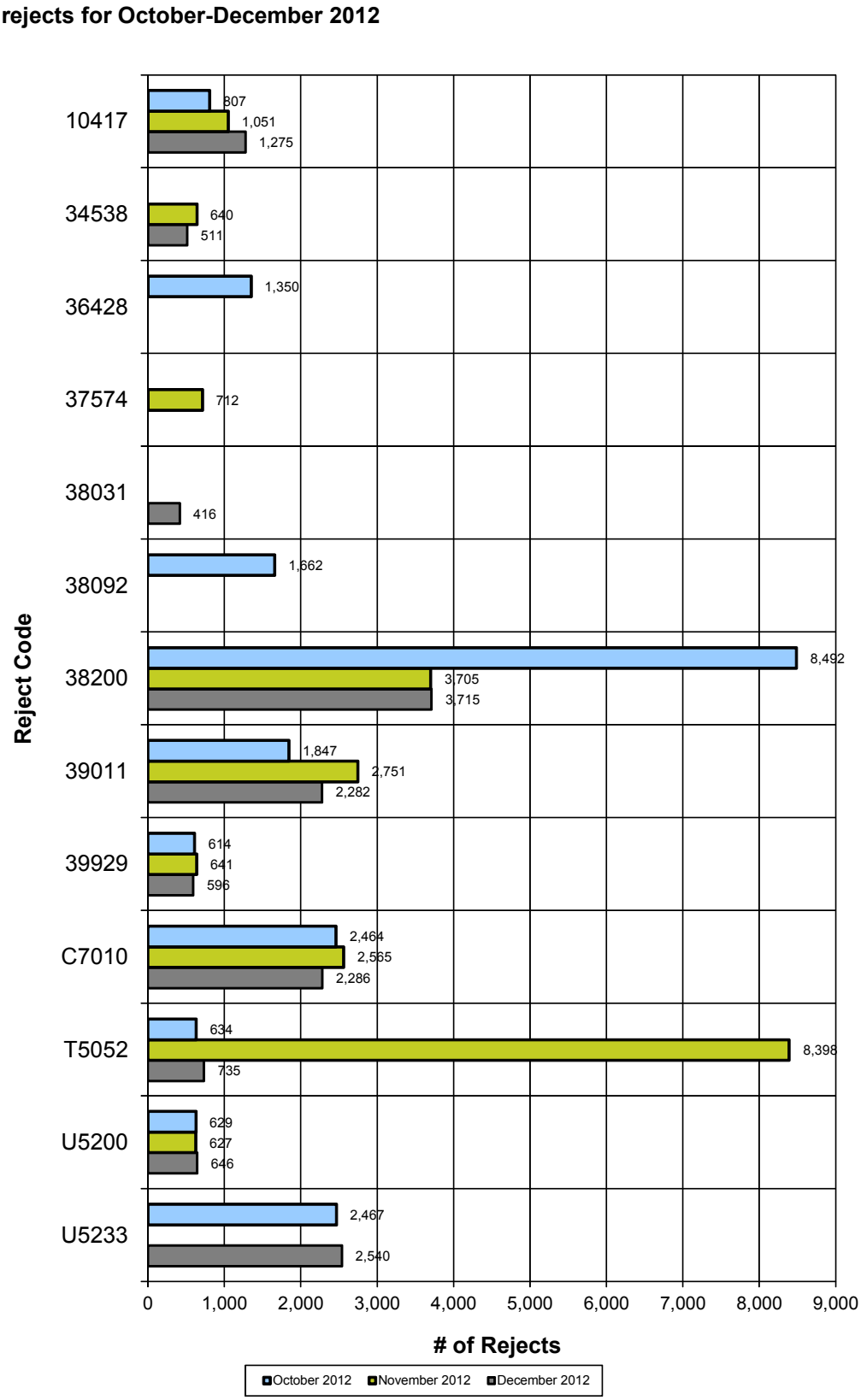
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during August through October 2012.

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 October-December 2012

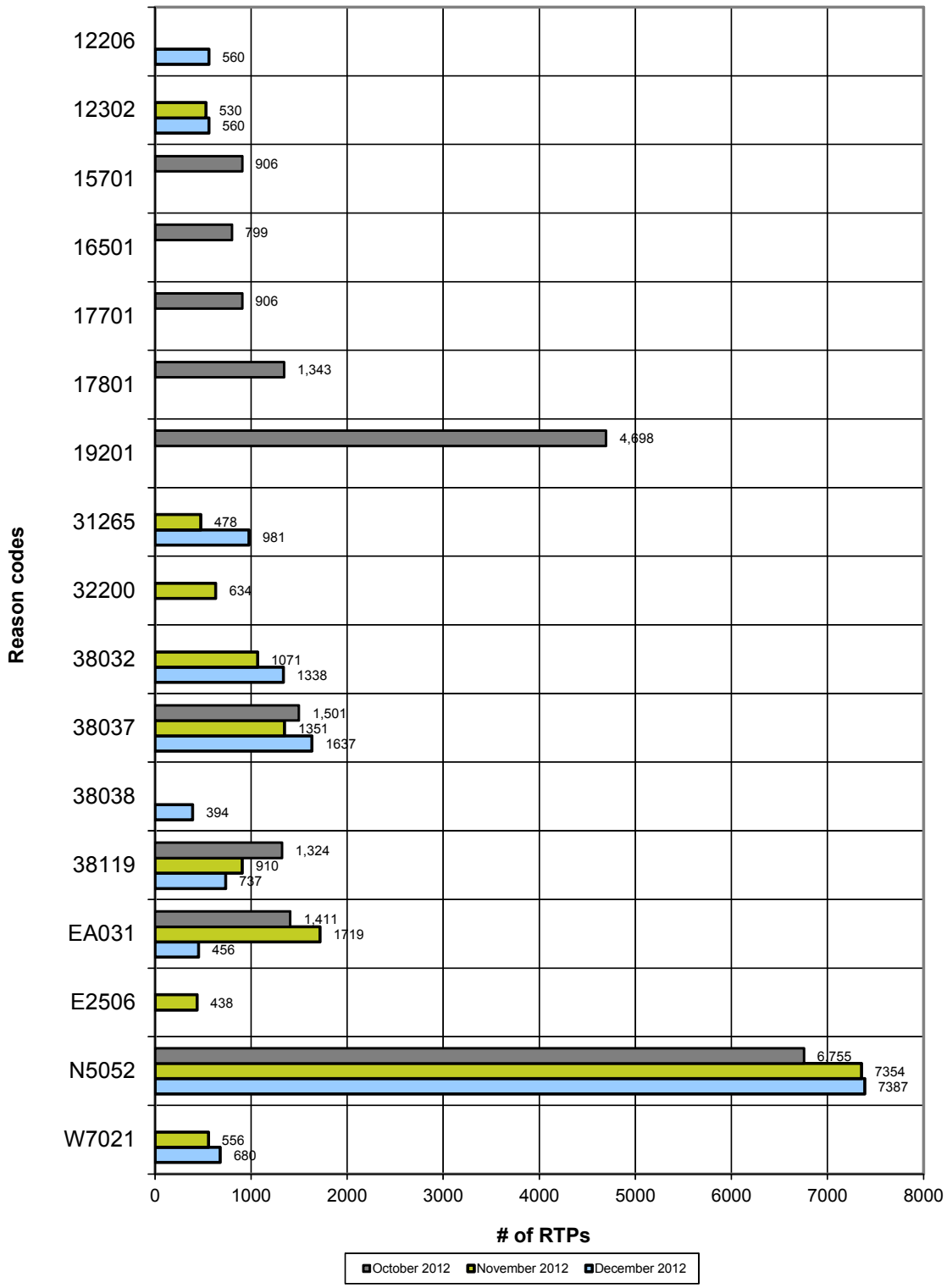


Part A top rejects for October-December 2012



Part A top return to providers (RTPs) for October-December 2012

Top RTPs for October-December 2012



Payment of global surgical split care in a method II critical access hospital submitted with modifier 54 and/or 55

Note: This article was revised on January 23, 2013, to reflect the revised CR 7872 issued on October 28, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. It was previously published in the August 2012 edition on Pages 30-31. All other information remains the same.

Provider types affected

This *MLN Matters*® article is intended for physicians, non-physician practitioners, and method II critical access hospitals (CAHs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and A/B Medicare administrative contractors [A/B MACs]) for services rendered in method II CAHs to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7872, which instructs Medicare contractors to implement the payment methodology for global surgical split care submitted on type of bill (TOB) 85x with revenue codes 96x, 97x, or 98x with a Modifier 54 (surgical care only) and/or a modifier 55 (postoperative management only) for CAH Method II providers. There are no policy changes attached to CR 7872, which simply applies the logic currently used when split global surgery services are billed on professional claims to those services when billed by a Method II CAH to an FI or MAC on type of bill 85x with revenue codes of 96x, 97x, or 98x. Please be sure your billing staffs are aware of this clarification.

Background

Physicians and non-physician practitioners billing on type of bill (TOB) 85x for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (Revenue Code [RC] 96x, 97x, or 98x) based on the Medicare Physician Fee Schedule (MPFS) supplemental file.

Occasionally, when more than one physician provides services included in the global surgical package, the physician who performs the surgical procedure may not always furnish the follow-up care. When this occurs, payment for the postoperative, post-discharge care is split between two or more physicians where the physicians agree on the transfer of care.

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services (except where stated policies result in payment that is higher than the global allowed amount, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care).

Where a transfer of care does not occur, the services of another physician may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case. CAH method II providers may review the split global surgery pricing rules in *Medicare Claims Processing Manual*, Chapter 12, Sections 40.1-40.5, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*.

CR 7872 implements the above payment logic in the fiscal intermediary shared system (FISS) for CAH method II providers to mirror the logic historically applied to physicians and non-physician practitioners that bill their own services to the Medicare Multi-Carrier System (MCS).

When payments are reduced as a result of applying this global surgery payment logic, Medicare will reflect that on the remittance advice using claim adjustment reason code 59 (Processed based on the multiple or concurrent procedure rules.) and Group Code CO to denote contractual obligation.

Section 1834(g)(2)(B) of the Social Security Act (the Act) states that professional services included within outpatient CAH services must be paid at 115 percent of such amounts as would otherwise be paid under this part if such services were not included in the outpatient CAH services.

(continued on next page)

Split care *(continued)*

Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule (MPFS) to determine the surgical care only and postoperative percentages for a specific Healthcare Common Procedure Coding System (HCPCS)/*Current Procedural Terminology* (*CPT*®) code. The MPFS is located at *http://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx*.

Additional information

The official instruction, CR 7872, issued to your FI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2574CP.pdf*.

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

MLN Matters® Number: MM7872 Revised
Related Change Request (CR) #: CR 7872
Related CR Release Date: October 26, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2574CP
Implementation Date: January 7, 2013

2013 reasonable charge fees

The Centers for Medicare & Medicaid Services (CMS) change request (CR) 8051 provides instructions for the calendar year (CY) 2013 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment.

Code	Allowance
A4565	8.26
Q4001	47.00
Q4002	177.62
Q4003	33.75
Q4004	116.86
Q4005	12.45
Q4006	28.05
Q4007	6.23
Q4008	14.02
Q4009	8.31
Q4010	18.70
Q4011	4.15
Q4012	9.36
Q4013	15.13
Q4014	25.51
Q4015	7.57
Q4016	12.75

Cost	Allowance
Q4017	8.75
Q4018	13.94
Q4019	4.38
Q4020	6.98
Q4021	6.47
Q4022	11.68
Q4023	3.25
Q4024	5.84
Q4025	36.29
Q4026	113.30
Q4027	18.15
Q4028	56.67
Q4029	27.75
Q4030	73.05
Q4031	13.87
Q4032	36.52
Q4033	25.88

Cost	Allowance
Q4034	64.38
Q4035	12.94
Q4036	32.20
Q4037	15.79
Q4038	39.56
Q4039	7.91
Q4040	19.77
Q4041	19.20
Q4042	32.78
Q4043	9.61
Q4044	16.39
Q4045	11.15
Q4046	17.93
Q4047	5.56
Q4048	8.97
Q4049	2.03

Source: Change request 8051

Ambulance inflation factor for 2013 and productivity adjustment

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8156 to alert providers of the updates to the ambulance inflation factor (AIF) for 2013 so that Medicare carriers, FIs, and A/B MACs can accurately determine the payment amounts for ambulance services. The AIF for 2013 is 0.8 percent. Please ensure that your billing staffs are aware of this 2013 AIF.

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating the payment limits that carriers, FIs, and A/B MACs use to pay for the claims that you submit for ambulance services. Specifically, this section of the Act provides for a yearly payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the prior year.

On March 23, 2010, Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to require that specific prospective payment system and fee schedule update factors be adjusted by changes in economy-wide productivity.

The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period). The MFP for 2013 is 0.90 percent and the CPI-U for 2013 is 1.70 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2013 is 0.80 percent.

Note: Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Additional information

You can find the official instruction, CR 8156, issued to your carrier, FI, or A/B MAC by visiting

http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R2620CP.pdf on the CMS website.

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

MLN Matters® Number: MM8156
Related Change Request (CR) #: CR 8156
Related CR Release Date: December 21, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2620CP
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

EHR incentive deadline is February 28

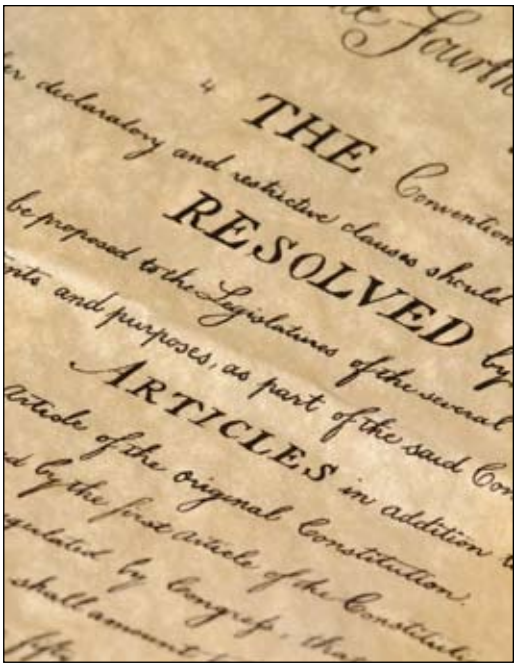
February 28, 2013 is the last day for Medicare eligible professionals (EPs) to register and attest to receive an incentive payment for calendar year 2012. Click here to register and attest.

EPs could earn incentive payments up to $44,000 in incentive payments.

President Obama signs the American Taxpayer Relief Act of 2012

New law includes physician update fix through December 2013

On Wednesday, January 2, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012. This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect January 1, 2013. The new law provides for a zero percent update for such services through December 31, 2013. This provision guarantees seniors have continued access to their doctors by fixing the sustainable growth rate (SGR) through the end of 2013. President Obama remains committed to a permanent solution to eliminating the SGR reductions that result from the existing statutory methodology. The Administration will continue to work with Congress to achieve this goal.



The new law extends several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act) as well as provisions of the Affordable Care Act. Specifically, the following Medicare fee-for-service policies (with January 1, 2013, or October 1, 2012, effective dates) have been extended. Also included is Medicare billing and claim processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, and more information about other provisions will be forthcoming.

Section 601 – Medicare Physician Payment Update: As previously indicated, the new law provides for a zero percent update for claims with dates of service on or after January 1, 2013, through December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is currently revising the 2013 Medicare physician fee schedule (MPFS) to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2013 conversion factor is $34.0230.

In order to allow sufficient time to develop, test, and implement the revised MPFS, Medicare claims administration contractors may hold MPFS claims with January 2013 dates of service for up to 10 business days (i.e., through January 15, 2013). CMS expects these claims to be released into processing no later than January 16, 2013. The claim hold should have minimal impact on physician/practitioner cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 for paper claims) after the date of receipt. Claims with dates of service prior to January 1, 2013, are unaffected. Medicare claims administration contractors will be posting the MPFS payment rates on their websites no later than January 23, 2013.

The 2013 Annual Participation Enrollment Program allowed eligible physicians, practitioners, and suppliers an opportunity to change their participation status by December 31, 2012. Given the new legislation, CMS is extending the 2013 annual participation enrollment period through February 15, 2013. Therefore, participation elections and withdrawals must be post-marked on and before February 15, 2013. The effective date for any participation status changes elected by providers during the extension remains January 1, 2013.

Section 602 – Extension of Medicare Physician Work Geographic Adjustment Floor: The 2012 1.0 floor on the physician work geographic practice cost index is extended through December 31, 2013. As with the physician payment update, this extension will be reflected in the revised 2013 MPFS.

Section 603 – Extension Related to Payments for Medicare Outpatient Therapy Services: Section 603 extends the exceptions process for outpatient therapy caps through December 31, 2013. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through December 31, 2013. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD), and counts outpatient therapy services furnished in a critical access hospital towards the cap and threshold. Additional information about the exception process for therapy services may be found in the *Medicare Claims Processing Manual*, Pub 100-04, Chapter 5, Section 10.3: *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf*.

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a

(continued on next page)

Relief...*continued*

new cap for outpatient therapy services received on January 1, 2013. For physical therapy and speech language pathology services combined, the 2013 limit for a beneficiary on incurred expenses is $1,900. There is a separate cap for occupational therapy services which is $1,900 for 2013. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 603 also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2013, through December 31, 2013, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services, including OPD therapy services, for a year. There are two separate $3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

Section 604 – Extension of Ambulance Add-On Payments: Section 604 extends the following three Job Creation Act ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas is extended through December 31, 2013; (2) the provision relating to air ambulance services that continues to treat as rural any area that was designated as rural December 31, 2006, for purposes of payment under the ambulance fee schedule, is extended through June 30, 2013; and (3) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the “super rural” bonus) is extended through December 31, 2013.

CMS is currently revising the 2013 Medicare ambulance fee schedule (MAFS) to reflect the new law’s requirements. In order to allow sufficient time to develop, test, and implement the revised MAFS, Medicare claims administration contractors may hold MAFS claims with January 2013 dates of service for up to 10 business days (i.e., through January 15, 2013). CMS expects these claims to be released into processing no later than January 16, 2013. The claim hold should have minimal impact on supplier cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 for paper claims) after the date of receipt. Claims with dates of service prior to January 1, 2013, are unaffected.

Suppliers of ambulance services affected by these provisions may continue billing as usual.

Section 605 – Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals: The Affordable Care Act allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment through September 30, 2013, retroactive to October 1, 2012. Be on the alert for further information about implementation of this provision.

Section 606 – Extension of the Medicare-Dependent Hospital (MDH) Program: The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until October 1, 2013, and is retroactive to October 1, 2012. Be on the alert for further information about implementation of this provision.

Be on the alert for more information about the American Taxpayer Relief Act of 2012.

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

Source: CMS PERL 201301-01

FY 2013 inpatient prospective payment system and long term care hospital PPS changes

Note: This article was revised on January 8, 2013, to reflect the revised CR 8041 issued on January 4, 2013. In the article, the CR release date, transmittal number, and the Web address for accessing CR 8041 have been revised. It was previously published in the September 2012 edition on Pages 45-53. All other information remains the same.

Provider types affected

This *MLN Matters*® article is intended for hospitals that submit claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for acute care hospital services and long-term care hospital services.

Provider action needed

This article is based on change request (CR) 8041 which provides:

- Fiscal year (FY) 2013 updates to the acute care hospital inpatient prospective payment system (IPPS) and the long-term care hospital (LTCHs) prospective payment system (PPS), and
- FY 2013 changes to the Medicare severity diagnosis related groups (MS-DRGs) grouper and Medicare code editor (MCE).

All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2012, unless otherwise noted. Be sure your billing staffs are aware of these changes.

Background

CR 8041 outlines changes to the inpatient prospective payment system (IPPS) for acute care hospitals and the prospective payment system (PPS) for long-term care hospitals (LTCHs) for FY 2013. Updates to the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 3 (inpatient hospital billing) are also incorporated within CR 8041. The policy changes for FY 2013 were displayed in the *Federal Register* on August 01, 2012, with a publication date of August 31, 2012. The FY 2013 hospital IPPS final rule can be found at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html*. The IPPS home page centralizes file(s) related to the IPPS final rule, and it contains links to:

- The final rule (display version or published *Federal Register* version) with 1) changes to the acute care hospital IPPS and FY 2013 rates and 2) changes to the LTCH PPS and FY 2013 rates, and all subsequent published correction notices (if applicable);
- All tables
- Additional data and analysis files, and
- The impact file.

Files related to the long-term care PPS can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html*.

All items covered in CR 8041 are effective for hospital discharges occurring on or after October 1, 2012, unless otherwise noted. The grouper contractor, 3M Health Information Systems (3M-HIS), developed new MS-DRG grouper software package (version 30.0), effective for discharges on or after October 1, 2012. The grouper assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The MCE version 30.0, which is also developed by 3M-HIS, uses the ICD-9-CM codes to validate coding for discharges on or after October 1, 2012.

MS-DRG grouper and Medicare code editor changes

Users of the Medicare code editor (MCE) should be aware that there is a new edit effective October 1, 2012 (Edit 19 – Procedure inconsistent with length of stay). ICD-9-CM procedure code 9672 should only be coded on claims

(continued on next page)

IPPS *(continued)*

with a length of stay of four days or greater. The length of stay will be determined by counting the days between the "from" and "through" dates of the claim (minus any days in occurrence span code 74). Claims will be returned to provider indicating a length of stay conflict if less than four consecutive days. Systems changes were made to pass this information to the MCE.

IPPS FY 2013 update

The FY 2013 IPPS Pricer is released to the FISS for discharges occurring on or after October 1, 2012. Refer to Table 1 for the FY 2013 IPPS rates and factors.

Attachment Table 1 – FY 2013 IPPS rates and factors

Description	Rates and factors
Standardized amount applicable percentage increase	1.018 if IQR = '1' in PSF or 0.998 if IQR = '0' or Blank in PSF
Hospital specific applicable percentage increase	1.018 if IQR = '1' in PSF or 0.998 if IQR = '0' or Blank in PSF
Common fixed loss cost outlier threshold	$21,821
Federal capital rate	$425.49
Puerto Rico capital rate	$207.25
Outlier offset-operating national	0.948999
Outlier offset-operating Puerto Rico	0.94476
SCH budget neutrality factor	0.998431
SCH documentation and coding adjustment factor	0.9480

Operating rates

Full-market basket and wage index > 1

Description	Rates
National labor share	$3,679.95
National non-labor share	$1,668.81
PR national labor share	$3,679.95
PR national non-labor share	$1,668.81
Puerto Rico specific labor share	$1,564.17
Puerto Rico specific non-labor share	$954.62

Full-market basket and wage index < or = 1

Description	Rates
National labor share	$3,316.23
National non-labor share	$2,032.53
PR national labor share	$3,316.23
PR national non-labor share	$2,032.53
Puerto Rico specific labor share	$1,561.65
Puerto Rico specific non-labor share	$957.14

Reduced market basket and wage index > 1

Description	Rates
National labor share	$3,607.65
National non-labor share	$1,636.02
PR national labor share	$3,679.95
PR national non-labor share	$1,668.81
Puerto Rico specific labor share	$1,564.17
Puerto Rico specific non-labor share	$954.62

(continued on next page)

IPPS *(continued)*

Reduced market basket and wage index < or = 1

Description	Rates
National and PR national labor share	$3,251.08
National and PR national non-labor share	$1,992.59
PR national labor share	$3,316.23
PR national non-labor share	$2,032.53
Puerto Rico specific labor share	$1,561.65
Puerto Rico specific non-labor share	$957.14

Post-acute transfer and special payment policy

There are no changes to the post-acute and special post-acute payment policy or applicable DRGs for FY 2013.

See Table 5 of the FY 2013 IPPS/LTCH PPS final rule for a listing of all post-acute and special post-acute MS-DRGs at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html*.

New technology add-on payments

The following items are eligible for new-technology add-on payments in FY 2013:

- **Continue payments for the AutoLITT™** – Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26, and 27 with an ICD-9 procedure code of 17.61 (ICD-10-PCS codes D0Y0KZZ and D0Y1KZZ) in combination with one of the following primary ICD-9 diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9 (ICD-10-CM codes C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, and C71.9). The maximum add-on payment for a case involving the AutoLITT™ is $5,300.
- **New for FY 2013- DIFICID** – Cases involving DIFICID that are eligible for the new technology add-on payment will be identified with a ICD-9-CM diagnosis code of 008.45 in combination with NDC code 52015-0080-01 in data element LIN03 of the 837I. The maximum add-on payment for a case involving DIFICID is $868.
- **New for FY 2013- Zenith Fenestrated Graft** – Cases involving the Zenith Fenestrated Graft that is eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith Fenestrated Graft is $8,171.50.
- **New for FY 2013- Voraxaze** – Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The maximum add-on payment for a case involving the Voraxaze is $45,000.

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2013. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2012, can be found in the FY 2013 IPPS/LTCH PPS final rule.

Cost of living adjustment (COLA) update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2013. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2012, can be found in the FY 2013 IPPS/LTCH PPS final rule.

Expiration of Section 508 reclassifications

Section 508 of the 2003 Medicare Modernization Act (MMA; see *http://www.gpo.gov/fdsys/pkg/BILLS-108hr1enr/pdf/BILLS-108hr1enr.pdf*) and as extended by both the Affordable Care Act (see *http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf*) and the Middle Class Tax Relief and Job Creation Act of 2012 (see *http://www.gpo.gov/fdsys/pkg/BILLS-112hr3630enr/pdf/BILLS-112hr3630enr.pdf*) is no longer in effect as of April 1, 2012.

Section 505 Hospital (out-commuting adjustment)

Attachment A of CR 8041 (Section 505) shows the IPPS providers that will be receiving a “special” wage index for FY 2013 (i.e., receive an out-commuting adjustment under section 505 of the MMA; see *http://www.gpo.gov/fdsys/pkg/BILLS-108hr1enr/pdf/BILLS-108hr1enr.pdf*).

(continued on next page)

IPPS *(continued)*

Treatment of certain providers re-designated under Section 1886(d)(8)(B) of the Social Security Act

The *Code of Federal Regulations* (42 CFR 412.64(b)(3)(ii); see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr412_main_02.tpl*) implements the Social Security Act (Section 1886(d)(8)(B); see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*), which re-designates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. These counties are commonly referred to as "lugar counties."

Accordingly, hospitals located in "lugar counties" are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are re-designated.

A hospital that waives its "lugar" status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes.

Treatment of certain urban hospitals reclassified as rural hospitals under 42 CFR 412.103

An urban hospital that reclassifies as a rural hospital is considered rural for all IPPS purposes.

Note: Hospitals that are reclassified as rural under 42 CRF 412.103 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&rgn=div5&view=text&node=42:2.0.1.2.12&idno=42*) are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see 42 CFR 412.320(a)(1)).

Medicare-dependent, small rural hospital (MDH) program expiration

The special payment protections provided to a Medicare dependent small rural hospital (MDH) are not authorized by statute beyond FY 2012. Therefore, beginning in FY 2013, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based solely on the federal rate. (CMS notes that they have revised their SCH policy to allow MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program, as explained further in this instruction.)

Sole community hospital (SCH) clarification and changes to effective dates for SCH classification

The *Code of Federal Regulations* (42 CFR 412.92 (b)(2) and (b)(3); see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=82260cc9a5cc08c88a1c188780937d5a&rgn=div8&view=text&node=42:2.0.1.2.12.7.47.2&idno=42*) address the effective dates of a classification as an SCH and the duration of this classification. Currently, a hospital's SCH classification status remains in effect without the need for re-approval unless there is a change in the circumstances under which the classification was approved. The *Code of Federal Regulations* (42 CRF 412.92(b)(3)) requires a hospital to notify the FI or MAC within 30 days of a change that could affect its classification as an SCH. The existing language at 42 CFR 412.92(b)(3) only refers to a hospital becoming aware of a "change," because it deals specifically with a situation where a hospital was appropriately classified as an SCH because it had previously met the requirements to become an SCH. However, the regulations did not explicitly address the situation where a hospital never met the requirements to be classified as an SCH, but was incorrectly classified as an SCH.

In light of the fact that CMS found a number of providers who may have been classified as SCHs incorrectly, in the FY 2013 rule, CMS discusses the current authority to recoup any overpayments associated with the incorrect SCH status, consistent with the cost report reopening rules at 42 CFR 405.1885 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=04bc29d77e11df84ab4b97b2649fb8cc&rgn=div8&view=text&node=42:2.0.1.2.5.11.33.48&idno=42*), and to cancel the hospital's classification retroactively. As a result, CMS has the discretion to reopen cost reports within the three-year reopening period and cancel a hospital's SCH status.

Additionally, effective October 1, 2012, if a hospital reports any factors or information to CMS that could have affected its initial classification as an SCH and CMS then determines that, based on the additional information, the hospital should not have qualified for SCH status, and CMS will cancel SCH status effective beginning with 30 days from the CMS' date of determination.

Current regulations state that if a hospital qualifies for SCH status, that status is generally effective beginning 30 days after CMS' written notification of approval. Due to the expiration of the MDH provision on September 30, 2012, there may be a number of hospitals currently classified as MDHs under 42 CFR 412.108 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=82260cc9a5cc08c88a1c188780937d5a&rgn=div8&view=text&node=42:2.0.1.2.12.7.47.13&idno=42*) that believe they qualify for classification as SCHs under 42 CFR 412.92. In the FY 2013 IPPS/LTCH PPS final rule, CMS revised the regulations to provide for an exception to the effective date of SCH classification for any MDH that:

- Applies for SCH status at least 30 days prior to the expiration of the MDH provision (that is, by August 31, 2012), and

(continued on next page)

IPPS *(continued)*

- Requests that SCH status be effective with the expiration of the MDH provision and the hospital is approved for SCH status.

The effective date of SCH status for those MDHs that comply with the application requirements and qualify for SCH status is the day following the expiration date of the MDH provision, that is, October 1, 2012.

Low-volume hospitals – criteria and payment adjustments for FY 2013

For FYs 2011 and 2012, the Affordable Care Act expanded the definition of a low volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Beginning with FY 2013, the low volume hospital definition and payment adjustment will revert to the policies that were in effect prior to the amendments made by the Affordable Care Act. Therefore, as specified under the regulations at 42 CRF 412.101 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=82260cc9a5cc08c88a1c188780937d5a&rgn=div8&view=text&node=42:2.0.1.2.12.7.47.6&idno=42*), effective for FY 2013 and subsequent years, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another "Subsection (d) Hospital" and have less than 200 total discharges (including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2013 and subsequent years, the low-volume hospital adjustment for all qualifying hospitals is 25 percent.

The FI/MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment for the FY. The FI/MAC and CMS may review available data, in addition to the data the hospital submits with its request for low-volume hospital status, in order to determine whether or not the hospital meets the qualifying criteria. For FY 2013 (and subsequent years), the FI/MAC makes the discharge determination based on the hospital's number of total discharges, that is, Medicare and non-Medicare discharges. The hospital's most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low-volume hospital payment adjustment for the current year (see 42 CFR 412.101(b)(2)(i)). To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2013 (and subsequent years), a hospital must be located more than 25 road miles (as defined at 42 CFR 412.101(a)) from the nearest "Subsection (d) hospital" (that is, in general, an IPPS hospital).

A hospital must notify and provide documentation to its FI/ MAC that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The FI/ MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the FI/MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion. In order to receive the low-volume hospital payment adjustment for FY 2013, a hospital must meet both the discharge and mileage criteria (set forth at 42 CFR 412.101(b)(2)(i)).

For FY 2013, a hospital should make its request for low-volume hospital status in writing to its FI/MAC and provide documentation that it meets the mileage criterion by September 1, 2012, so that the 25 percent low-volume hospital adjustment can be applied to payments for its discharges occurring on or after October 1, 2012 (through September 30, 2013). For requests for low-volume hospital status for FY 2013 received after September 1, 2012, if the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the 25 percent low-volume hospital adjustment in determining payments to the hospital's FY 2013 discharges prospectively within 30 days of the date of the FI's/MAC's low-volume hospital status determination.

The 25 percent low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH, IME and outliers. For SCHs, the low-volume hospital payment is based on and in addition to either payment based on the federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at *https://www.qualitynet.org*. This website is expected to be updated in September 2012. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website, and FIs and A/B MACs shall update the provider file as needed. A list of hospitals that will receive the 2.0 percent reduction to the annual payment update for FY 2013 under the Hospital Inpatient Quality Reporting (IQR) Program will be available in September 2012.

(continued on next page)

IPPS *(continued)*

Hospital readmissions reduction program

Section 3025 of the Affordable Care Act added Section 1886(q) to the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*) establishing the hospital readmissions reduction program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in **subpart I** of 42 CFR 412 (§412.150 through §412.154) as established in the FY 2013 IPPS/LTCH PPS final rule.

In the FY 2012 IPPS/LTCH PPS final rule, CMS finalized the readmission measures for acute myocardial infarction, (AMI), heart failure (HF) and pneumonia (PN) and the calculation of the excess readmission ratio, which is used, in part, to calculate the readmission payment adjustment under the hospital readmissions reduction program. CMS defined readmission as an admission to a subsection (d) hospital within 30 days of a discharge from the same or another subsection (d) hospital. CMS finalized the calculation of a hospital's excess readmission ratio for AMI, HF and PN, which is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition. CMS established a policy of using the risk adjustment methodology endorsed by the national quality forum (NQF) for the readmissions measures for AMI, HF and PN to calculate the excess readmission ratios. The excess readmission ratio includes adjustment for factors that are clinically relevant including patient demographic characteristics, comorbidities, and patient frailty. Finally, CMS established a policy of using three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition. For FY 2013, the excess readmission ratio is based on discharges occurring during the three year period of July 1, 2008 to June 30, 2011.

For more information on the readmissions measures, please refer to the FY 2012 IPPS/ LTCH PPS final rule at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2012-IPPS-Final-Rule-Home-Page.html*.

In the FY 2013 IPPS/LTCH PPS final rule, CMS finalized that "Subsection (d) hospitals" are subject to the hospital readmissions reduction program, which excludes Puerto Rico hospitals. In addition, CMS has exempted Maryland hospitals from the Hospital Readmissions Reduction Program for FY 2013. In the FY 2013 IPPS/ LTCH PPS final rule, CMS established the methodology to calculate the hospital readmissions adjustment factor, what portion of the IPPS payment will be used to calculate the readmissions adjustment amount and CMS has established a process for hospitals to review their readmissions information and submit corrections to the information before the readmission rates are to be made public.

For FY 2013, the readmissions adjustment factor is the higher of a ratio or 0.99 (-1 percent). The methodology to calculate the ratio is discussed in the FY 2013 IPPS/ LTCH PPS final rule. The readmissions adjustment factor is applied to a hospital's "base operating DRG payment amount," or the wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the amount reduced from a hospital's IPPS payment due to excess readmissions. Add-on payments for IME, DSH, outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor.

Hospitals that are not subject to a reduction under the hospital readmissions reduction program in FY 2013, such as Maryland hospitals, will have a readmissions adjustment factor of 1.0000. For FY 2013, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9900. (The readmissions adjustment factors for FY 2013 are shown in Table 15 listed in the Addendum to the FY 2013 IPPS/LTCH PPS final rule.) Hospitals that are not included in the hospital readmissions reduction program, such as Puerto Rico hospitals, will not have a readmissions adjustment factor.

Hospital value-based purchasing program

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*), establishing the hospital value-based purchasing (VBP) program. This program results in adjustments to base operating DRG payment amounts for discharges from subsection (d) Hospitals, for discharges beginning in FY 2013. CMS has excluded Maryland hospitals from the hospital VBP program for the FY 2013 program year. CMS will not implement the FY 2013 payment adjustments under the hospital VBP program until January 2013.

(continued on next page)

IPPS *(continued)*

The regulations that implement this provision are in Subpart I of 42 CFR 412 (§412.160 through §412.162) as established in the FY 2013 IPPS/LTCH PPS final rule.

Under the hospital VBP program, CMS will reduce base operating DRG payment amounts for subsection (d) hospitals by the applicable percent, beginning with discharges occurring in FY 2013. The applicable percent for payment reductions for FY 2013 is 1.0 percent, and it gradually increases each fiscal year to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals' performance under the hospital VBP program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

CMS will calculate a total performance score (TPS) for each hospital eligible for the hospital VBP program. CMS will then use a linear exchange function to convert each hospital's TPS into a value-based incentive payment. Based on that linear exchange function's slope, as well as an individual hospital's TPS, the hospitals' own annual base operating DRG payment amount and the applicable percent reduction to base operating DRG payment amounts, CMS will calculate a value-based incentive payment adjustment factor that will be applied to each discharge at a hospital, for a given fiscal year.

In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPSs and submit requests for corrections to the information before it is made public. For FY 2013, as noted above, CMS will not implement the base operating DRG payment amount reductions or the value-based incentive payment adjustments until January 2013. Claims for discharges occurring in FY 2013 that are paid prior to this January 2013 implementation will be reprocessed by CMS as quickly as practicable.

Recalled devices

As a reminder, Section 2202.4 of the *Provider Reimbursement Manual*, Part I states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device. If a hospital receives a replacement medical device for free, the hospital should not be charging the patient or Medicare for that device. The hospital should not be including costs on the cost report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.

Bundled payments for care improvement initiative (BPCI) model 1

CMS is working in partnership with providers to develop models of bundling payments through the BPCI initiative. On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments. In model 1, the episode of care is defined as the acute care hospital stay only. Applicants for this model will propose a discount percentage which will be applied to payment for all participating hospitals' DRG over the lifetime of the initiative. Participating hospitals may gain share with physicians any internal hospital savings achieved from redesigning care if they can reduce hospital costs for the episode below the discount provided to CMS as part of their agreement. More information may be found at *http://www.innovations.cms.gov/initiatives/Bundled-Payments/index.html*.

For hospitals participating in model 1 of the BPCI, a standard discount will be taken from all DRG payments made to the hospital. The discount will be phased in over time, with the discount amount updated as frequently as every six months. This adjustment will be made to the base operating DRG (as defined earlier in this change request). IME, DSH, and outlier payments will be calculated based on the non-discounted base payments.

LTCH PPS FY 2013 update

The FY 2013 LTCH PPS rates and factors are as follows:

Description	Rates/Factors
Federal rate for discharges from 10/1/12 through 12/28/12	$40,915.95
Federal rate for discharges from 12/29/12 through 9/30/13	$40,397.96
High cost outlier fixed-loss amount	$15,408
Labor share	63.096 percent
Non-labor share	36.904 percent

(continued on next page)

IPPS *(continued)*

The LTCH PPS Pricer has been updated with the version 30.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2012, and on or before September 30, 2013.

Short stay outlier (SSO) payment formula

The statutory five-year moratorium on the application of the "IPPS comparable per diem amount" option under the short-stay outlier (SSO) payment adjustment expires for discharges beginning on or after December 29, 2012. With the expiration of the moratorium, the existing SSO payment formula is revised for those cases where the patient's covered length of stay (LOS) is less than or equal to the "IPPS comparable threshold" for the MS-LTC-DRG to which the case is assigned. The "IPPS-comparable threshold" is defined as one standard deviation from the geometric average length of stay for the same MS-DRG under the IPPS (as shown in Table 11 listed in the Addendum to the FY 2013 IPPS/LTCH PPS final rule and available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/CMS-1588-F.html*). If the covered LOS of an LTCH SSO case is within the "IPPS-comparable threshold", the "IPPS comparable per diem amount" (capped at the full "IPPS comparable amount") option will replace the "blend amount" option in the current SSO payment formula.

For a SSO discharge occurring on or after December 29, 2012, the Medicare payment will be based on the least of the following:

- 100 percent of the estimated cost of the case
- 120 percent of the MS-LTC DRG specific per diem amount multiplied by the covered length of stay of the particular case;
- The full MS-LTC-DRG per diem amount
- Comparing the covered length of stay for the SSO case and the "IPPS comparable threshold," one of the following:

  a) A blend of the 120 percent of the MS-LTC-DRG specific per diem amount and an amount comparable to the IPPS per diem amount, for cases where the covered length of stay for the SSO case is greater than the "IPPS comparable threshold";

  b) An amount comparable to the IPPS comparable per diem amount, if the covered length of stay for an SSO case is equal to or less than one standard deviation from the geometric average length of stay for the same MS-DRG under the IPPS (the "IPPS comparable threshold").

The IPPS comparable per diem amount is determined by the same methodology as the IPPS comparable per diem portion of the current "blend amount" option. For SSO cases where the covered LOS exceeds the "IPPS comparable threshold," payment is made under the existing SSO policy, as specified above.

Cost of living adjustment update for LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2013. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2012, can be found in the FY 2013 IPPS/LTCH PPS final rule.

CBSA-based labor market area updates

There are no changes to the core-based statistical area (CBSA)-based labor market area definitions or CBSA codes used under the LTCH PPS for FY 2013. The CBSAs definitions and codes that will continue to be effective October 1, 2012, can be found in Table 12A listed in the Addendum of the FY 2013 IPPS/LTCH PPS final rule, which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/CMS-1588-F.html*.

Additional LTCH PPS policy changes for FY 2013

The five-year statutory moratorium on the full-implementation of the "25 percent threshold" payment adjustment for LTCH discharges admitted from individual referring hospitals expires for LTCH cost reporting periods beginning on or after July 1, 2012, or October 1, 2012, as applicable. In the FY 2013 IPPS/LTCH PPS final rule, CMS extended the moratorium on the implementation of the "25 percent threshold" payment policy effective for cost reporting periods beginning on or after October 1, 2012, and before October 1, 2013. For certain LTCHs and LTCH satellites with cost-reporting periods beginning on or after July 1, 2012, and before October 1, 2012, CMS also provided a supplemental moratorium effective for discharges occurring on or after October 1, 2012, and

(continued on next page)

IPPS *(continued)*

through the end of the cost reporting period. For additional details, refer to the discussion in the FY 2013 IPPS/LTCH PPS final rule. The five-year statutory moratorium on the development of new LTCHs and LTCH satellite facilities and an increase in number of LTCH beds initially provided in section 114(d) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA; see *http://www.gpo.gov/fdsys/pkg/PLAW-110publ173/html/PLAW-110publ173.htm*), will expire on December 29, 2012.

Additional information

The official instruction, CR 8041, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2627CP.pdf*.

You can find the home page for the FY 2013 hospital inpatient PPS (IPPS) final rule at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html*. The IPPS home page centralizes file(s) related to the IPPS proposed rule, and it contains links to: the proposed rule (display version or published *Federal Register* version) and all subsequent published correction notices (if applicable); all tables; additional data and analysis files; and the impact file.

Files related to the long term care PPS can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html*.

If you have any questions, please contact your FIs 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*.

MLN Matters® Number: MM8041
Related Change Request CR 8041
Related CR Release Date: January 4, 2013
Effective Date: October 1, 2012
Related CR Transmittal #: R2627CP
Implementation Date: October 1, 2012

Implementation of the hospital value-based purchasing program and hospital readmission reduction program for the rural community hospital demonstration for 2013

Provider types affected

This *MLN Matters*® article is intended for hospitals participating in the rural community hospital demonstration program that submit claims to Medicare contractors (fiscal intermediaries (FIs) and/or Part A Medicare administrative contractors (A MACs)) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8076 which clarifies the methodology according to which payment enhancements (possible for the hospital value-based purchasing (HVBP) program) and payment reductions (possible for both the HVBP and hospital readmission reduction programs) will be calculated and implemented for fiscal year (FY) 2013. This article is intended only for hospitals participating in the rural community hospital demonstration program, and it applies to cost report periods beginning after October 1, 2011. Make sure that your billing staffs are aware of these changes.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 410A; see *http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf*) mandated that the Centers for Medicare & Medicaid Services (CMS) establish a rural community hospital demonstration program demonstration that establishes rural community hospitals, which receive reimbursement for inpatient services according to a cost-based methodology. To be eligible to participate in the rural community hospital demonstration, a hospital needs to be:

- Located in a rural area;
- Have fewer than 51 acute care beds;
- Make available 24-hour emergency services; and
- Ineligible for critical access hospital designation.

The Affordable Care Act (Sections 3123 and 10313;

(continued on next page)

Rural hospitals *(continued)*

see *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm*) both expanded and extended the rural community hospital demonstration program for an additional five-year period.

Currently, there are 23 hospitals participating in the demonstration. Seven hospitals were selected between 2004 and 2008, while 16 are participating as result of the Affordable Care Act expansion. The period of performance will conclude December 31, 2016. Both of the following programs apply to hospitals participating in the rural community hospital demonstration:

- The hospital value-based purchasing program (HVBP) - implemented by CMS as authorized by Section 3001(a) of the Affordable Care Act under which value-based incentive payments are made in a given fiscal year to hospitals meeting performance standards specified by CMS for the fiscal year. The value-based incentive payment will be applied to discharges beginning October 1, 2012; and
- The hospital readmission reduction program, established by Sections 3025 and 10309 of the Affordable Care Act, which is effective for discharges from an applicable hospital beginning October 1, 2012.

Both the HVBP and the hospital readmission reduction program will apply to the hospitals participating in the rural community hospital demonstration. CR 8076 clarifies the methodology according to which payment enhancements (possible for the HVBP) and payment reductions (possible for both the HVBP and hospital readmission reduction program) will be calculated and implemented beginning in FY 2013, for the hospitals participating in the demonstration, applying to their cost report periods that include discharges beginning October 1, 2012, i.e., cost report periods beginning after October 1, 2011.

The methodology CMS will use to determine the hospital's payment for covered inpatient services (for each participating hospital's cost report year, and net of adjustments for the HVBP Program and the hospital readmission reductions program), is outlined in CR 7505 (as amended by CR 7898). CR 7505 (Transmittal 77 dated July 22, 2011) can be found at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R77DEMO.pdf* on the CMS website, and CR 7898 (Transmittal 84 dated August 17, 2012) can be found at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R84DEMO.pdf* on the CMS website. All provisions of CR 7505 and CR 7898 remain in effect. CR 8076 further clarifies (for hospitals participating in the rural community hospital demonstration) the methodology CMS will use to calculate their:

- Payment enhancements (possible for the HVBP program), and
- Payment reductions (possible for both 1) the HVBP and 2) the Hospital Readmission Reduction Program).

Hospital value-based purchasing program (HVBP)

The HVBP applies to subsection (d) hospitals, with certain exceptions. Because they are subsection (d) hospitals, hospitals participating in the rural community hospital demonstration will be included in the HVBP program. CMS will determine exceptions for individual hospitals on the basis of rules specific to the HVBP program – there will be no exception on the basis of participation in the demonstration.

Total performance score

CMS will calculate a total performance score (TPS) for each hospital eligible for the HVBP Program. The regulations that implement the provision for the TPS are in Subpart I of 42 CFR part 412 (412.160 through 412.162; see *http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr;sid=389f40956b40a469c130f2f21af073e7;rgn=div2;view=text;node=20120831%3A1.8;idno=42;cc=ecfr;start=1;size=25* on the Internet).

Value based incentive payment

Each eligible hospital's value-based incentive payment percentage will be based on its total performance score. In the FY 2013 IPPS/LTCH PPS final rule, CMS established:

- The methodology used to calculate the hospital value-based incentive payment adjustment factor,
- The review and corrections process, and
- The appeal process.

This enables hospitals to review information used to calculate their total performance scores and submit requests for corrections to the information before it is made public. You can find the FY 2013 IPPS/LTCH PPS final rule at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html* on the CMS website.

(continued on next page)

Rural hospitals *(continued)*

Implementing the HVBP

CR 8041 provides instructions for your MACs to implement the HVBP provision. You can review CR 8041 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2539CP.pdf* on the CMS website.

According to CR 8041, CMS will not implement the value-based incentive payment adjustments or base operating DRG amount reductions until January 2013. For each hospital participating in the rural community hospital demonstration that is eligible for the HVBP, your MAC will calculate either:

- The value-based incentive payment adjustment, or
- The base operating diagnosis related group (DRG) amount reduction.

This would apply to the hospital for FY 2013 as if the hospital were paid under the IPPS. Your MAC will 1) add this amount to (if it's a value-based incentive payment adjustment), or 2) subtract this amount from (if it is a reduction) the payment amount for inpatient services that the hospital would receive under the cost-based reimbursement methodology for the rural community hospital demonstration. For each hospital, the MAC will apply the adjustment (calculated on the basis of the HVBP methodology for FY 2013) to the reimbursement amount determined for the first cost reporting year beginning after October 1, 2012. This addition will occur at cost report settlement.

Hospital readmission reduction program

This program requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR (412.150 through 412.154 as established in the FY 2013 IPPS/LTCH PPS final rule. (See *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=389f40956b40a469c130f2f21af073e7;rgn=div2;view=text;node=20120831%3A1.8;idno=42;cc=ecfr;start=1;size=25* on the Internet)

In the FY 2013 IPPS final rule CMS finalized that subsection (d) hospitals are subject to the hospital readmissions reduction program. See *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html* on the CMS website. Hospitals participating in the rural community hospital demonstration will be subject to the hospital readmissions reduction program.

For FY 2013, the methodology to calculate excess readmissions ratios and readmissions payment adjustment factors is discussed in the FY 2013 IPPS final rule. For hospitals participating in the rural community hospital demonstration, the readmission adjustment factor is applied in accordance with CR 8041, as if the hospital were paid under the IPPS.

See CR 8041 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2539CP.pdf* on the CMS website.

The readmission adjustment factor is applied to a hospital's base operating amount to determine the amount reduced from a hospital's inpatient payment due to excess readmissions.

For hospitals participating in the rural community hospital demonstration, your MAC will calculate the amount of reduction for FY 2013, and apply it to the amount otherwise to be paid for inpatient services for the first cost reporting period beginning after October 1, 2012. This reduction will occur at cost report settlement.

Additional information

The official instruction, CR 8076 issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R86DEMO.pdf* on the CMS website.

If you have any questions, please contact your carriers, DME MACs, 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* on the CMS website.

The CMS official source of information about the hospital value-based purchasing (HVBP) program can be reviewed at *http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html* on the CMS website.

MLN Matters® number: MM 8076
Related change request (CR) #: CR 8076
Related CR release date: December 21, 2012
Effective Date: October 2, 2011
Related CR transmittal #: R86DEMO
Implementation date: January 22, 2013

Educational Events

Provider outreach and educational events – February/March 2013

E/M under review: 99215 and critical care

When: Wednesday, February 20
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

Medifest 2013 - Fort Lauderdale

When: **March 12-13**
Location: Renaisssance Fort Lauderdale-Plantation Hotel
Time: All Day **Delivery language:** English
Type of Event: Educational Seminar **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Medicare Part A: changes and regulations

When: Tuesday, March 19
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 *www.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 *www.fcsouniversity.com*.

Other 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 Medicare FFS Provider e-News': January 4, 2013, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-04-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': January 10, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-10-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': January 17, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-17-eNews.pdf*
- 'CMS Medicare FFS Provider e-News': January 24, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-24-eNews.pdf*

Source: CMS PERL 201301-02, 201301-03, 201301-04, 201301-05

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

Puerto Rico Contact Information

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 Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare
Palmetto Goverment 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