

C Medicare A CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

March 2013



Outstanding medical records create superior patient outcomes

The medical record can be your best insurance policy in communication of quality and complexity of patient care. Use of this communication tool and the quality of the documentation can be assessed in auditing for medical necessity.

Communication tool

Physicians have been taught throughout their training that the medical record is their best insurance policy to communicate the quality of their analytical skills, problem-solving ability, and as a controlling guide for the complexity of patient care. Evidence emerging from increasing use of electronic health records confirms that, when properly applied, the medical record will:

- reduce patient care errors,
- reduce rates of missing clinical information,
- advance evidence-based clinical decision-making,
- reduce costs by preventing duplicative and contraindicated services,
- provide for care coordination across the spectrum of providers, and
- enhance the quality of patient outcomes (See references 1-13, on page three.)

In this issue

Getting prepared for ordering/referring edits	4
Coverage for aortic aneurysm screening	15
Recovery of annual wellness visit overpayments	19
Update to provider taxonomy codes	25
Mitigate risks with ICD-10 transition	27
Upcoming educational events	52

Quality of records

When the contribution of rigorously structured medical records was studied in a critical-care setting (acute coronary syndrome) in an extensive cross-section of U.S. hospitals (more than 200), the results were dramatic: **substantial incremental differences in survival and discharge health status were observed when high standards of clinical records were maintained.**¹⁴

In contrast, inferior patient records produce the opposite outcomes in all of the above categories. The American College of Medical Quality (ACMQ) has further refined concepts of quality of care and medical documentation.¹⁵

Auditing for medical necessity

Beginning with the original statute mandated by the 1965 (Medicare) provisions of the Social Security Act, and further elaborated by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), the doctrine of **medical necessity** controls coverage and payment policy by federal healthcare payers.¹⁶ Medical necessity in turn is evidenced by a variety of criteria, including criteria for effectiveness, appropriateness to the patient's presentation, relevance to a disease process, non-provision for strictly physician convenience, etc. (17-20).

(continued on page 3)



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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

General Information

Implementation of order/referring edits starts May 1	4
Steps to get ready for ordering/referring edits	10
Update to Chapter 15 of the <i>Program Integrity Manual</i>	11
Updates clarify inpatient rehabilitation facility claims processing	12
Medicare coverage of abdominal aortic aneurysms screening	15
Jurisdiction 6 implementation of new Medicare administrative contractor.....	17

General Coverage

Recovery of annual wellness visit overpayments	19
Autologous platelet-rich plasma for chronic non-healing wounds	20

Electronic Data Interchange

April 2013 integrated outpatient code editor specifications, version 14.1	24
Healthcare provider taxonomy codes update, April 2013	25
Inclusion of Veterans Administration skilled nursing claims.....	26
Valid redetermination appeal request requirements	26
Plan to mitigate risk for a smooth transition to ICD-10	27
ICD-10 checklists and timelines	27
July 2013 ASP for Medicare Part B drugs	28
Update of home health consolidated billing enforcement HCPCS codes	29
Common working file modifications when claim number mismatches occur.....	30

Claim and Inquiry Summary Data

Top inquiries	31
Top rejects	32
Top return to provider	33

Reimbursement

Mandatory Medicare budget reductions – sequestration.....	34
Federal sequestration payment reductions FAQs	34
How sequestration reductions will be applied.....	35
Multiple procedure payment reduction for selected therapy services.....	36
Requesting a comparative billing report – Part A providers	37
April 2013 update of hospital outpatient prospective payment system	38
April 2013 Medicare physician fee schedule database update	42
April update for 2013 DMEPOS fee schedule	44
Medicare adjusts travel allowance fees for collection of specimens	47

Hospitals

Inpatient prospective payment system hospital payment extensions	48
2013 Medicare Part B Participating Physician and Supplier Directory	50
Reorganization of Chapter 13 of Medicare policy manual	51
Current status of the \$3,700 therapy threshold manual medical review	51

Educational Resources

Upcoming provider outreach and educational events – April/May 2013	52
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Other Educational Resources

CMS Medicare Provider e-News	53
------------------------------------	----

Contact Information

Florida and USVI Contact Information.....	54
Puerto Rico Contact Information	55

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Records (continued from front page)

Accordingly, a nexus was established between medical necessity documentation and the vehicle of the medical record as a tool for care coordination, evidence of services, risk minimization, and outcome enhancement.

These considerations led to the medical record audits mandated by CMS, identified as comprehensive error rate testing, or CERT (21, 22). The CERT program requires (post-pay) audits of medical records to establish that services were: 1) provided and 2) of medical necessity, with the authority to recoup payments where evidence for these services is inadequate for a medically-trained reviewer. It is therefore accurate to consider the CERT audit as a tool to ascertain service provision and as a mechanism to improve overall patient quality outcomes.

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“When the contribution of rigorously structured medical records was studied in a critical-care setting (acute coronary syndrome) in an extensive cross-section of U.S. hospitals (more than 200), substantial incremental differences in survival and discharge health status were observed when high standards of clinical records were maintained.”

-Shannon M. Dunlay, MD
Archives of Internal Medicine (2008)

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Full implementation of edits on the ordering/referring providers

Note: This special edition *MLN Matters*® article is a consolidation and update of prior articles SE1011, SE1201, SE1208, and SE1221. Effective May 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will turn on the Phase 2 denial edits.

This means that Medicare will deny claims for services or supplies that require an ordering/referring provider to be identified and that provider is not identified, is not in Medicare's enrollment records, or is not of a specialty type that may order/refer the service/item being billed.

Provider types affected

This *MLN Matters*® article is intended is intended for:

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

Provider action needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using the Internet-based provider enrollment, chain, and ownership system (PECOS) or by completing the paper enrollment application (CMS-855O). Review the *Background* and *Additional information* below and make sure that your billing staff is aware of these updates.

What providers need to know

Phase 1: Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The

informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication.

Phase 2: Effective May 1, 2013, CMS will turn on the edits to deny Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. Physicians

“Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the May 1, 2013 implementation date of the ordering/referring Phase 2 provider edits.”

and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the May 1, 2013, implementation date of the ordering/referring Phase 2 provider edits.

Background

The Affordable Care Act, Section 6405, “Physicians Who Order Items or Services are Required to be Medicare enrolled physicians or eligible professionals,” requires physicians or other eligible professionals to be enrolled in the Medicare program to order or refer items or services for Medicare beneficiaries.

Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral.

Effective May 23, 2008, the unique identifier was determined to be the national provider identifier (NPI). CMS has implemented edits on ordering and referring providers when they are required to be identified in Part B, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests;
- Claims from imaging centers for ordered imaging

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Ordering (continued)

procedures; and

- Claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for ordered DMEPOS.

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

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/ services and laboratory and X-Ray services payable under Medicare Part B.)
- physician assistants,
- clinical nurse specialists,
- nurse practitioners,
- clinical psychologists,
- interns, residents, and fellows,
- certified nurse midwives, and
- clinical social workers.

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so.

Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty. CMS would like to highlight the following limitations:

Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.

Home health agency (HHA) services may only be ordered or referred by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.

Optometrists may only order and refer DMEPOS

products/services, and laboratory and X-Ray services payable under Medicare Part B.



Questions and answers relating to edits

1. What are the ordering and referring edits?

The edits will determine if the ordering/referring provider (when required to be identified in Part B, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid national provider identifier (NPI) (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?

These edits were implemented in two phases:

Phase 1 - Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

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

N264 – Missing/incomplete/invalid ordering provider name

N265 – Missing/incomplete/invalid ordering provider primary identifier

For adjusted claims, the claims adjustment reason code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

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

For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:

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Ordering *(continued)*

N272 – Missing/incomplete/invalid other payer attending provider identifier

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

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.

On January 28, 2010, CMS made available to the public, via the *Downloads* section of the “Ordering Referring Report” page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer.

The file, called the *Ordering Referring Report*, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date,

CMS will replace the report on a weekly basis. At any given time, only one report (the most current) will be available for downloading. To learn more about the report and to download it, go to <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>; click on “Ordering & Referring Information” (on the left). Information about the Report will be displayed.

Phase 2: Effective May 1, 2013, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied.

This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral. Below are the denial edits for Part B providers and suppliers who submit claims to carriers and/or MACs, including DME MACs:

254D – Referring/ordering provider not allowed to refer

255D – Referring/ordering provider mismatch

289D – Referring/ordering provider NPI required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims.

The following are the denial edits for Part A HHA providers who submit claims:

37236 - This reason code will assign when:

- The statement “From” date on the claim is on or after the date the phase 2 edits are turned on

- The type of bill is ‘32’ or ‘33’
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code.

37237 - This reason code will assign when:

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

Effect of Edits on Providers

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you, the ordering/referring provider, need to ensure that:

a. You have a current Medicare enrollment record.

- If you are not sure you are enrolled in Medicare, you may:
 - i. Check the ordering referring report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
 - ii. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
 - iii. Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
 - iv. If you choose iii, please read the information on the Medicare provider/supplier enrollment page about Internet-based PECOS before you begin.

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Ordering (continued)

b. If you do not have an enrollment record in Medicare.

- You need to submit either an electronic application through the use of Internet-based PECOS or a paper enrollment application to Medicare.
 - i. For paper applications - fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
 - ii. For electronic applications – complete the online submittal process and either e-sign or mail a printed, signed, and dated certification statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.
 - iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement.
 - iv. If you will be using Internet-based PECOS, please visit the Medicare provider/ supplier enrollment Web page to learn more about the Web-based system before you attempt to use it. Go to <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>, click on “Internet-based PECOS” on the left-hand side, and read the information that has been posted there. Download and read the documents in the *Downloads* section that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that page.

v. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html>).

c. You are an opt-out physician and would like to order and refer services. What should you do?

If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

d. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.



When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

e. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the ordering/referring provider edits?

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the ordering referring report described earlier in this article.
- Ensure you are correctly spelling the ordering/referring provider’s name.
- If you furnished items or services from an order or referral from someone on the ordering/referring report, your claim should pass the ordering/referring provider edits.
- The ordering referring report will be replaced weekly to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the ordering referring report but who may be listed on the next report.
- f. Make sure your claims are properly completed.**
- Do not use “nicknames” on the claim, as their use could cause the claim to fail the edits.

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Ordering *(continued)*

- Do not enter a credential (e.g., “Dr.”) in a name field.
- On paper claims (CMS-1500), in item 17, enter the ordering/referring provider’s first name first, and last name second (e.g., John Smith).
- Ensure that the name and the NPI you enter for the ordering/referring provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral.
- Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.
- If there are additional questions about the informational messages, billing providers should contact their local carrier, A/B MAC, or DME MAC.
- Billing providers should be aware that claims that are denied because they failed the ordering/referring provider would not expose the Medicare beneficiary to liability. Therefore, an advance beneficiary notice is not appropriate.

g. What if my claim is denied inappropriately?

If your claim did not initially pass the ordering/referring provider edits, you may file an appeal through the standard claims appeals process.

Additional guidance

1. Terminology: Part B claims use the term “ordering/referring provider” to denote the person who ordered, referred, or certified an item or service reported in that claim.

The final rule uses technically correct terms:

a) A provider “orders” non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and;

b) a provider “certifies” home health services to a beneficiary. The terms “ordered” “referred” and “certified” are often used interchangeably within the industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term “ordered/referred” in materials directed to a broad provider audience.

2. Orders or referrals by interns or residents: The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that state-licensed residents may enroll to order and/or refer and may be listed on claims.



Claims for covered items and services from unlicensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.

3. Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare:

These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

4. Orders or referrals by dentists: Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare.

They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional information

For more information about the Medicare enrollment process, visit <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html> or contact the designated Medicare contractor for your state.

Provider enrollment contact information can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf.

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Ordering (continued)

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

Note: You must obtain a national provider identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field on your enrollment application.

Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

For more information about NPI enumeration, visit <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html> on the CMS website.

MLN Matters® article MM7097, “Eligible physicians and non-physician practitioners who need to enroll in the Medicare program for the sole purpose of ordering and referring items and services for Medicare beneficiaries,” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf>.

MLN Matters® article MM6417, “expansion of the current scope of editing for ordering/referring providers for claims processed by Medicare carriers and Part B Medicare administrative contractors (MACs),” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf>.

MLN Matters® article MM6421, “Expansion of the current scope of editing for ordering/referring providers for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers’ claims processed by durable medical equipment Medicare administrative contractors (DME MACs),” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf>;

MLN Matters® article MM6129, “New Requirement for Ordering/Referring Information on ambulatory surgical center (ASC) claims for diagnostic services,” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf>.

MLN Matters® article MM6856, “Expansion of the current scope for attending physician providers for free-standing and provider-based home health agency (HHA) claims processed by Medicare regional home health intermediaries (RHHIs),” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/>

<downloads/MM6856.pdf>.

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

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Related CR Release Date: N/A
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Related CR Transmittal R6420TN, R6430TN, R328PI, and R7810TN
Implementation Date: May 1, 2013

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Don't get denied

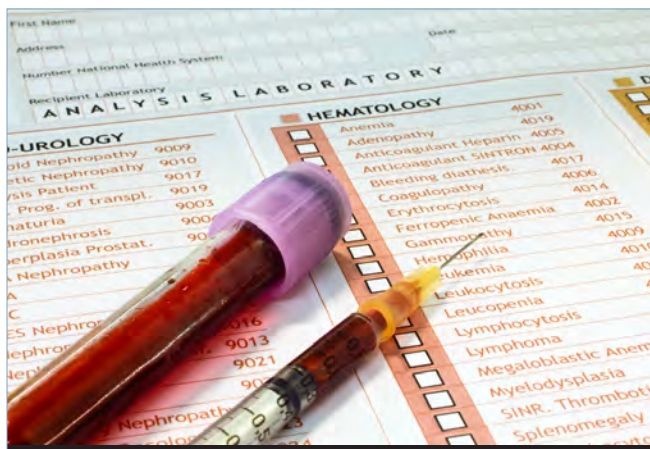
1. Check your Medicare provider enrollment record to ensure it is up to date. If you have not enrolled in the Internet-based provider enrollment, chain and ownership system (PECOS), please register as soon as possible. Providers can learn more about Internet-based PECOS on the Centers for Medicare & Medicaid Services' (CMS) Internet-based [PECOS page](#).
2. Billing providers should review recent adjustment claims notices to identify ordering or referring providers who may not be enrolled in Medicare or meet the other criteria.
3. Part B providers should [review these tips on entering ordering/referring provider information](#).

Getting prepared for ordering and referring denial edits

Effective May 1, Medicare will deny claims for all covered Medicare Part B, durable medical equipment, orthotics, and supplies (DMEPOS), and Part A home health agency (HHA) services when the ordering or referring provider is not enrolled in Medicare or the claim does not list the national provider identification (NPI) number for the ordering or referring provider.

Preventing Medicare fraud

Providers who routinely order or refer such services or supplies on behalf of Medicare beneficiaries should take proactive steps now to ensure their claims and those of billing suppliers are not denied payment once ordering and referring edits are implemented May 1. On that day, Medicare contractors and fiscal intermediaries will turn on claim edits to review each of the respective types of claims.



The purpose of the ordering and referring edits is to safeguard the Medicare trust fund as the system seeks to eliminate fraudulent Medicare claims by reviewing three important criteria:

First, the system will check to see if the physician or other provider is enrolled in Medicare, either in an approved or an opt-out status.

Second, the system will verify that the ordering or referring NPI matches that of the individual provider. Billing providers should ensure that referring or ordering provider names are spelled correctly and match the NPI database, otherwise the claim will be denied.

Finally, the system edits will check the claim to determine if the physician or provider listed on the claim is of a specialty type that is eligible to order and refer.

If any claim fails to meet any of the three criteria, payment will be denied. Providers will have the opportunity to appeal denied claims through normal processes.

Medicare Part B and DMEPOS providers will record the ordering or referring information on the line, "Name of Referring Provider or Other Source," along with the referring provider's NPI (lines 17 and 17b of Form CMS-1500).

For Medicare Part A HHAs, enter the ordering or

referring information on the line, "Attending," along with the attending provider's NPI (line 76 of Form CMS-1450). The ordering/referring provider's name must match the name found in the provider's Internet-based PECOS enrollment record.

In both instances, providers should check the spelling of provider names closely to ensure they match PECOS and NPI databases.

Ways to avoid denied claims

To avoid denied claims, CMS advises providers to check online to determine their current status with Medicare through the Internet-based PECOS and ensure their enrollment record includes their NPI. Providers uncertain of their NPI status may verify it *by visiting the NPI registry website*.

First Coast Service Options Inc. offers

providers several resources to guide them through the enrollment process, including [How to complete a CMS-855 form FAQ](#) and its [Internet-based PECOS resources page](#).

Providers may also refer to CMS' fact sheet: [The Basics of Internet-based Provider Enrollment, Chain and Ownership System \(PECOS\) for Physicians and Non-Physician Practitioners](#).

Laboratories, imaging centers, DMEPOS suppliers, and HHAs should begin immediately working with ordering and referring providers to ensure they are prepared for this change. Since 2009, Medicare contractors alerted providers when claims were missing or did not have complete provider enrollment information on referring or ordering providers. Billing providers are encouraged to review recent adjustment claims for informational alerts on ordering/referring provider documentation.

The Affordable Care Act of 2009 requires physicians or other eligible health professionals to be enrolled in the Medicare program to order or refer items or services for Medicare beneficiaries. Designed to protect the Medicare trust fund and prevent Medicare fraud, the ordering/referring edits are a result of the passage of this law.

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

Update to Chapter 15 of the *Program Integrity Manual*

Provider types affected

This *MLN Matters*[®] article is intended for providers and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), and A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8155 to alert providers of updates to Chapter 15 of the “*Medicare Program Integrity Manual (PIM)*.” Chapter 15 deals with Medicare provider enrollment and CR 8155 highlights the issues below. Make sure your staff is familiar with the key points of this *MLN Matters*[®] article.

Key points

The following are the provider enrollment issues addressed in CR 8155:

Owning and Managing Individuals: If your Medicare contractor is unsure as to whether the officers and directors/board members of the enrolling provider or supplier’s corporate owner/parent also serve as the enrolling provider or supplier’s officers and directors/board members, your contractor will contact you for clarification.

If there is a change in correspondence or special payments address/change of electronic funds transfer (EFT) Information: Your Medicare contractor may confirm the change with the contract person listed.

Rejections: Your Medicare contractor may reject an application that was signed more than 120 days prior to the date on which the contractor received the application—assuming the provider or supplier failed to furnish a new, appropriately-signed certification statement within 30 days of the contractor’s request to do so.

Timeframe: Absent a CMS instruction or directive to the contrary, your Medicare contractor will send a rejection letter no later than five business days after the contractor concludes that the provider or supplier’s application should be rejected.

Be aware: If your contractor rejects an application, it will either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.

Potential identity theft or other fraudulent activity: In conducting the verification activities described in Section 15.7.5 of Chapter 15, if the contractor believes that a case of identity theft or other fraudulent activity likely exists, the contractor will notify its provider



enrollment operations group business function lead (PEOG BFL) at CMS immediately.

Non-certified suppliers and individual practitioners: Absent a CMS instruction or directive to the contrary, an approval letter under Section 15.9.1 of Chapter 15 will be sent no later than five business days after the contractor concludes that the provider or supplier meets all Medicare requirements and that his/her/its application can be approved.

Unsolicited additional information: Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request; rather, it is considered to be and will be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first will be processed to completion prior to the second one being processed to completion.

Miscellaneous policies: In situations where a provider with multiple PTANs is to be deactivated for non-billing, the contractor will only deactivate the non-billing PTAN(s).

Partnerships: Only partnership interests in the enrolling provider need be disclosed in section five of the Form CMS-855. Partnership interests in the provider’s indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in section five.

Processing and approval of corrective action plans (CAP): The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request. If the contractor approves a

(continued on next page)

Updates to clarify inpatient rehabilitation facility (IRF) claims processing

Note: This article was revised on March 18, 2013, to reflect a revised change request (CR) that corrects formatting in the CR. The transmittal number, CR release date, and Web address of the CR also changed. It was previously published in the January 2013 edition of *Medicare A Connection*, Pages 3-5. All other information remains the same.

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) claim processing. These changes are intended only to clarify the existing policies and there are no system or policy changes.

Background

The changes that CR 8127 makes to the manual are clarifications of existing policy. The entire manual revision is attached to CR 8127. Key manual changes of interest to IRFs are summarized as follows:



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.

(continued on next page)

Manual *(continued)*

CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless stated otherwise in another CMS directive or instruction – the effective date is based on the date the supplier came into compliance with all Medicare requirements.

Additional information

You can find the official instruction, CR 8155, issued to your carrier, FI, A/B MAC, or RHHI by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R450PI.pdf> on the CMS website. The entire revised Chapter 15 of the PIM is attached to that CR.

To review other changes to Chapter 15 issued in November of 2012, you may refer to MM8019 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8019.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>.

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 Related Change Request (CR) #: CR 8155
 Related CR Release Date: February 15, 2013
 Effective Date: March 18, 2013
 Related CR Transmittal #: R450PI
 Implementation Date: March 18, 2013

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Inpatient *(continued)*

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 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 delicensed 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

(continued on next page)

Inpatient *(continued)*

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 & 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 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/R2673CP.pdf>. As previously mentioned, 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>.

MLN Matters® Number: MM8127 **Revised**
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 Related CR Transmittal #: R2673CP
 Implementation Date: April 22, 2013

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Coverage for eligible Medicare beneficiaries of a one-time ultrasound screening for abdominal aortic aneurysms (AAA)

Note: This article was updated on March 8, 2013, to update statements regarding the coinsurance and deductible payments for abdominal aortic aneurysms (AAA) and the initial preventive physical examination (IPPE). There is no coinsurance or Part B deductible for AAA screening or the IPPE. For updated information regarding payment for preventive care services under the Affordable Care Act, please go to <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7012.pdf>. This information was previously published in *Medicare A Connection*, April 2007, Pages 37-38. All other information remains unchanged.

Provider types affected

All Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for the (IPPE) and the ultrasound screening for abdominal aortic aneurysms (AAA).

Provider action needed

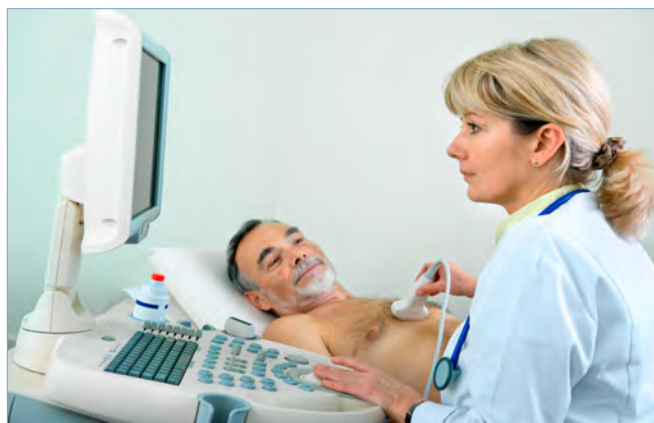
This article conveys no new policy information. This article is for informational purposes only and serves as a reminder that Medicare provides coverage of a one-time initial preventive physical examination and a one-time preventive ultrasound screening for abdominal aortic aneurysms subject to certain coverage, frequency, and payment limitations. The Centers for Medicare & Medicaid Services (CMS) needs your help to get the word out and to encourage eligible beneficiaries to take full advantage of these benefits and all preventive services and screenings covered by Medicare.

Background

In January 2005, the Medicare program expanded the number of preventive services available to Medicare beneficiaries, as a result of Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, to include coverage under Medicare Part B of a one-time IPPE, also referred to as the “Welcome to Medicare” physical exam, for all Medicare beneficiaries whose Part B effective date began on or after January 1, 2005.

On January 1, 2007, Medicare further expanded the number of preventive benefits, as provided for in Section 5112 of the Deficit Reduction Act (DRA) of 2005, to include coverage under Medicare Part B of a one-time preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at risk beneficiaries as part of the IPPE. Both benefits (the IPPE and AAA) are subject to certain eligibility and other limitations.

The information in this special edition *MLN Matters*[®] article reminds health care professionals that Medicare



now pays for these benefits as well as a broad range of other preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their “Welcome to Medicare” physical exam within the first six months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the preventive ultrasound screening as part of their “Welcome to Medicare” physical exam.

Benefit Coverage Summary - The Initial Preventive Physical Examination (“Welcome to Medicare” Physical Exam)

Effective for dates of service on or after January 1, 2005: Medicare beneficiaries whose Medicare Part B effective date is on or after January 1, 2005, are covered for a one-time IPPE visit. The IPPE must be received by the beneficiary within the first six months of their Medicare Part B effective date. The IPPE is a preventive evaluation and management (E/M) service that includes the following seven components:

- A review of an individual’s medical and social history with attention to modifiable risk factors,
- A review of an individual’s potential (risk factors) for depression,
- A review of the individual’s functional ability and level of safety,
- An examination to include an individual’s height, weight, blood pressure measurement, and visual acuity screen,
- Performance of an electrocardiogram (EKG) and interpretation of the EKG,
- Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements, and
- Education, counseling, and referral (including a brief written plan such as a checklist provided

(continued on next page)

Aneurysm *(continued)*

to the individual for obtaining the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits).

The Part B deductible and coinsurance/copayment no longer apply to the IPPE benefit. (See note below)

Note: The deductible does not apply for an IPPE provided in a federally qualified health center (FQHC). Only the coinsurance/copayment applies. Other preventive services and screenings covered under Part B include: adult immunizations (flu, pneumococcal, and hepatitis B), bone mass measurements, cardiovascular screening, diabetes screening, glaucoma screening, screening mammograms, screening Pap test and pelvic exam, colorectal and prostate cancer screenings, diabetes self-management training, medical nutrition therapy for beneficiaries diagnosed with diabetes or renal disease, and smoking and tobacco-use cessation counseling. Benefits are subject to certain eligibility and limitations.

Note: The IPPE/"Welcome to Medicare" physical exam does not include any clinical laboratory tests. The physician, qualified non-physician practitioner, or hospital may also provide and bill separately for the preventive services and screenings that are currently covered and paid for by Medicare Part B. (See the *Additional information* section for links to articles MM3771 and MM3638, which provide detailed coverage criteria and billing information about the IPPE benefit.)

Preventive ultrasound screening for abdominal aortic aneurysms (AAA)

Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time preventive ultrasound screening for AAA for beneficiaries who are at risk (has a family history of AAA or is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime). Eligible beneficiaries must receive a referral for the screening as a result of their "Welcome to Medicare" physical exam. **There is no Part B deductible or coinsurance/copayment applied to this benefit.**

Important note: Only Medicare beneficiaries who receive a referral from their physician or other qualified non-physician practitioner for the preventive ultrasound screening, as part of their "Welcome to Medicare" physical exam, will be covered for the AAA benefit. (See the *Additional information* section below for a link to *MLN Matters*[®] article MM5235, which provides detailed coverage criteria and billing information about the AAA benefit.)

Important reminders about the IPPE:

1. The IPPE is a unique benefit available only for beneficiaries new to the Medicare program and must be received within the first six months of the effective date of their Medicare Part B coverage.

2. This exam is a preventive physical exam and not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare does not provide coverage for routine physical exams.

Additional information

For more information about Medicare's coverage criteria and billing procedures for the AAA and IPPE benefits, refer to the following *MLN Matters*[®] articles:

MM5235 (2006), Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination, <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5235.pdf>

MM3771 (2005), MMA – Clarification for outpatient prospective payment system hospitals billing the initial preventive physical exam, <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3771.pdf>

MM3638 (2004), MMA – initial preventive physical examination, <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3638.pdf>.

CMS has also developed a variety of educational products and resources to help health care professionals and their staff, become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

The MLN preventive services educational products Web page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The web page is located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> on the CMS website. The CMS website provides information for preventive service covered by Medicare is at <http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/index.html> on the CMS website. For products to share with your Medicare patients, visit <http://www.medicare.gov/>.

MLN Matters[®] Number: SE0711
Related Change Request (CR) #: SE0711
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Jurisdiction 6 implementation of new Medicare administrative contractor

Effective date: July 1, 2013

Implementation date: July 1, 2013

Background

The Centers for Medicare & Medicaid Services (CMS) has awarded the J6 A/B MAC contract for the administration of the Part A and Part B Medicare fee-for-service claims in the states of Illinois, Minnesota and Wisconsin to National Government Services, Inc. (NGS).

The contractor will also be responsible for processing Medicare home health plus hospice (HH+H) billings in thirteen states and five U.S. territories: the states of Alaska, Arizona, California, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Oregon, Wisconsin and Washington, as well as the territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

The J6 A/B MAC will also administer Medicare claims for several thousand federally qualified health centers (FQHCs).

The HH+H workload was formerly known as the regional home health intermediary (RHHI) workload. NGS is the incumbent contractor for Illinois Part A, Wisconsin Part A and HH+H (RHHI) Region D workloads. NGS' address is:

National Government Services, Inc.
8115 Knue Road
Indianapolis, IN 46250

Wisconsin Physicians Services (WPS) is the outgoing contractor (OGC) for Illinois Part B, Minnesota Part B and Wisconsin Part B. WPS' address is:

Wisconsin Physicians Services
1717 W. Broadway
Madison, WI 53708

Noridian Administrative Services, LLC (NAS) is the OGC for the Minnesota Part A workload. NAS' address is:

Noridian Administrative Services
900 42nd Street South
Fargo, North Dakota 58103

CMS has determined that the J6 workloads currently processed by NGS, WPS and NAS will require new workload numbers when they are transitioned.

This change is being made because CMS needs to differentiate between the workload processed by the legacy contractors and the incoming J6 A/B MAC.

The workload numbers shall be changed and the workloads shall be transitioned to the J6 A/B MAC as follows:

Part A

Workload description: Part A Illinois J6 MAC

MAC workload number: 06101

Effective date: July 13, 2013

Current contractor workload number: 00131; OGC-NGS

Workload description: Part A Minnesota J6 MAC

MAC workload number: 06201

Effective date: August 10, 2013

Current contractor workload number: 00320; OGC-Noridian

Workload description: Part A Wisconsin J6 MAC

MAC workload number: 06301

Effective date: July 13, 2013

Current contractor workload number: 00450; OGC-NGS

Workload description: HH+H (RHHI) Region D (WI, MN, MI, NY, NJ, PR and the VI)

MAC workload number: 06004

Effective date: July 13, 2013

Current contractor workload number: 00450; OGC-NGS

Workload description: HH+H (RHHI) Region D (AK, American Samoa, AZ, CA, Guam, HI, ID, Northern Marianas, NV, OR, WA)

MAC workload number: 06004

Effective date: July 13, 2013

Current contractor workload number: 00456; OGC-NGS

Part B

Workload description: Part B Illinois J6 MAC

MAC workload number: 06102

Effective date: September 7, 2013

Current contractor workload number: 00952; OGC-WPS

Workload description: Part B Minnesota J6 MAC

MAC workload number: 06202

Effective date: September 7, 2013

Current contractor workload number: 00954; OGC-WPS

Workload description: Part B Wisconsin J6 MAC

MAC workload number: 06302

Effective date: September 7, 2013

Current contractor workload number: 00951; OGC-WPS

The following applications or business owners shall accept the new J6 A/B workload number once the above cited workload is transitioned to the J6 A/B MAC.

- Administrative qualified independent contractor (AdQIC)

(continued on next page)

Jurisdiction ...continued

- CMS analysis, reporting and tracking system (CMS ARTS)
- Contractor administrative, budget and cost reporting system (CAFM)
- Comprehensive error rate testing system (CERT)
- Contractor management information system (CMIS)
- CMS Baltimore data center (BDC)
- Coordination of benefits agreement program (COBA)
- Coordination of benefits contractor (COBC)
- Contractor reporting of operational workload data system (CROWD)
- Common working file (CWF)
- CWF Part B eligibility and security maintenance (CWF ELGE)
- Customer service assessment and management system (CSAMS)
- Debt collection system (DCS)
- Electronic correspondence referral system (ECRS)
- Electronic health records incentive program (eRx)
- Enterprise data centers (EDCs)
- Expert claims processing system (ECPS)
- Fiscal intermediary shared system (FISS)
- Fraud prevention system (FPS)
- Health care information system (HCIS)
- Health care integrated general ledger accounting system (HIGLAS)
- Health insurance master record (HIMR)
- Integrated data repository (IDR)
- Intern and resident information system (IRIS)
- Local coverage determination database (LCD)
- Medicare appeals system (MAS)
- Medicare coverage database (MCD)
- Medicare secondary payer recovery contractor (MSPRC)
- Multi-carrier system (MCS)
- National data warehouse (NDW)
- National level repository (NLR)
- National Part B pricing files
- National provider identifier crosswalk (NPI)
- Next generation desktop (NGD)
- Part B analytics reporting system (PBAR)
- Production performance monitoring system (PULSE)
- Provider enrollment chain and ownership system (PECOS)
- Provider customer service program contractor information database (PCID)
- Provider inquiry evaluation system (PIES)
- Program integrity management reporting system (PIMR)
- Program safeguard contractor (PSC)
- Provider statistical and reimbursement system (PS and R)
- Qualified independent contractor (QIC)
- Quality improvement evaluation system (QIES)
- Recovery auditors (RA), recover management and accounting system (REMAS)
- Renal management information system (REMIS)
- System tracking for audit and reimbursement (STAR)
- Zip code file
- Zoned program integrity contractors (ZPICs)

Policy

N/A

Source: Publication 100-20, transmittal number 1197, change request 8227

MLN Matters[®] number: n/a

Related change request (CR) #: CR 8227

Related CR release date: March 15, 2013

Effective date: July 1, 2013

Related CR transmittal #: R11970TN

Implementation date: July 1, 2013

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Recovery of annual wellness visit (AWV) overpayments

Provider types affected

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

What you need to know

This article is based on change request (CR) 8153, which provides instructions to Medicare contractors for recovering annual wellness visit (AWV) overpayments that have been made.

- For claims with dates of service on and after January 1, 2011, that were processed by Medicare processed on and after April 4, 2011, through March 31, 2013, Medicare systems allowed for an AWV visit (healthcare common procedure coding system (HCPCS) G0438 or G0439) on an institutional claim and a professional claim for the same patient on the same day. In some cases, this has resulted in overpayments.
- CR 8107 has updated those business requirements in order to prevent future overpayments.
- CR 8153 instructs contractors on recovering those overpayments. Make sure that your billing staffs are aware of these changes.

Background

CR 7079 provided billing instructions for annual wellness visit (AWV) services, which informed providers that they may provide an initial AWV visit (HCPCS code G0438) to a beneficiary once in a lifetime. In addition, providers may provide a subsequent AWV (HCPCS code G0439) if the beneficiary has not received an initial preventive physical examination (IPPE) or an AWV within the past 12 months.

For claims with dates of service on and after January 1, 2011, and processed on and after April 4, 2011, through March 31, 2013, the business requirements of CR 7079 allowed an AWV visit (HCPCS G0438 and G0439) on an institutional claim and a professional claim for the same patient on the same day.

In some cases, this resulted in double billing of the same service, since institutional and professional

claims may be submitted for the same service. In other instances, both a professional and an institutional claims have been received for the same patient with different dates of service exceeding the allowed services under coverage guidelines.

As a response to double billing of AWV services, the Centers for Medicare & Medicaid Services (CMS) issued CR 8107 to provide instructions for edits to be modified to only allow payment for either the practitioner or the facility for furnishing the AWV. CR 8107 will be implemented on April 1, 2013.

In the interim period from April 4, 2011, through March 31, 2013, double billings have occurred and may continue to occur. CR 8153 provides instructions to contractors to initiate a recovery process for these overpayments of AWV services.

Section 4103(c)(3)(A) of the Affordable Care Act specifically excludes the AWV from payment under the outpatient prospective payment system (OPPS) and establishes payment for the AWV

when performed in a hospital outpatient department under the Medicare physician fee schedule (MPFS). CMS will accept claims for payment from facilities furnishing the AWV in a facility setting if no physician claim for professional services has been submitted to CMS for payment.

That is, Medicare will pay either the practitioner or the facility for furnishing the AWV providing personalized prevention plan services (PPPS) in a facility setting, and only a single payment under the MPFS will be allowed. Where an AWV payment for a beneficiary has been made, this is an overpayment that must be recovered. Where these overpayments are recovered from providers, the beneficiaries will be notified that they are not responsible for reimbursing the providers for the recovered amount.

Additional information

The official instruction, CR 8153, issued to your carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R11900TN.pdf>.

To review the initial *MLN Matters*® article, MM7079, that describes the AWV along with the particulars of the personalized prevention plan services (PPPS) go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7079.pdf> on the CMS website.

To review the *MLN Matters*® article, MM8107, that

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Wellness (continued)

describes the modified billing instructions for an AMW visit, go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8107.pdf>.

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

MLN Matters® number: MM8153
Related change request (CR) #: CR 8153

Related CR release date: February 15, 2013
Effective date: July 1, 2013
Related CR transmittal #: R11900TN
Implementation date: July 1, 2013

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Autologous platelet-rich plasma for chronic non-healing wounds

Note: This article was revised on March 13, 2013, to add the full description of HCPCS code G0460. All other information remains unchanged.

Provider types affected

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

Provider action needed

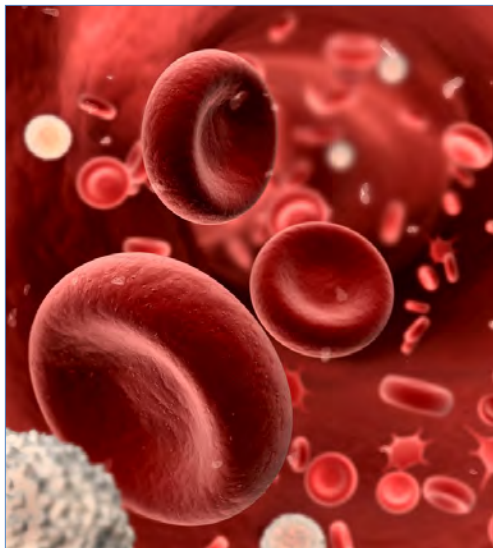
If you provide Medicare beneficiaries PRP for the treatment of chronic non-healing wounds, this national coverage determination (NCD) could impact your reimbursement.

Effective for claims with dates of service on or after August 2, 2012, the Centers for Medicare & Medicaid Services (CMS) will cover platelet-rich plasma (PRP) for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only when provided under a clinical research study that meets specific requirements to assess the health outcomes of PRP for the treatment of chronic non-healing diabetic, venous and/or pressure wounds. Please refer to the *Background* section, below for details.

Background

PRP is produced by centrifuging a patient's own blood to yield a concentrate that is high in both platelets and plasma proteins; and includes whole white and red cells, fibrinogen, stem cells, macrophages, and fibroblasts. Frequently administered as a spray, or a gel; physicians have used it in clinical or surgical settings, for a variety of purposes such as an adhesive

in plastic surgery and filler for acute wounds. In addition, it is being used, now, on chronic, non-healing cutaneous wounds that persist for 30 days or longer.



Since 1992, the CMS has issued national non-coverage determinations for platelet-derived wound healing formulas intended to treat patients with chronic, non-healing wounds.

In December 2003, CMS issued a national non-coverage determination specifically for the use of autologous PRP in treating chronic non-healing cutaneous wounds except for routine costs when used in accordance with the clinical trial policy defined in section 310.1 (Routine Costs in Clinical Trials (Effective July 9, 2007)) of the *National Coverage Determinations Manual*. Currently, as of March 2008, CMS has non-coverage determinations for the use of

autologous blood-derived products for the treatment of acute wounds where PRP is applied directly to the closed incision site, and for dehiscent wounds, as well as non-coverage for chronic, non-healing cutaneous wounds.

On October 4, 2011, CMS accepted a formal request to reopen and revise Section 270.3 of the *Medicare NCD Manual*, which addresses autologous blood-derived products for chronic non-healing wounds.

The request was for a reconsideration of the coverage of autologous PRP for the treatment of the following chronic wounds: diabetic, venous, and/or pressure ulcers. It was requested that CMS cover PRP through an NCD with data collection as a condition of coverage; and requested that this would provide a practical means by which CMS could obtain the

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Wounds *(continued)*

necessary data to evaluate the performance of PRP and to confirm the outcomes presented in their request.

Effective August 2, 2012, upon reconsideration, CMS determined that PRP is covered for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only when the following conditions are met:

1. The patient is enrolled in a randomized clinical trial that addresses the questions listed below using validated and reliable methods of evaluation. Clinical study applications for coverage pursuant to this NCD must be approved by August 2, 2014. Any clinical study approved by August 2, 2014, will adhere to the timeframe designated in the approved clinical study protocol.

If there are no approved clinical studies on or before August 2, 2014, CED for PRP only for the treatment of chronic non-healing diabetic, venous and/or pressure wounds will expire.

2. The clinical research study must meet the requirements specified below to assess PRP's effect on the treatment of chronic non-healing diabetic, venous and/or pressure wounds. The clinical study must address:

- Prospectively, do Medicare beneficiaries, with chronic non-healing diabetic, venous and/or pressure wounds, who receive well-defined optimal usual care along with PRP therapy, experience clinically significant health outcomes compared to patients who receive only well-defined optimal usual care for such wounds; as indicated by addressing at least one of the following:
 - a) Complete wound healing?
 - b) Ability to return to previous function and resumption of normal activities?
 - c) Reduction of wound size or healing trajectory which results in the patient's ability to return to previous function and resumption of normal activities?

3. The required PRP clinical trial must adhere to the following standards of scientific integrity and relevance to the Medicare population:

- Its principal purpose is to test whether PRP improves the participants' health outcomes;
- It is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;
- It does not unjustifiably duplicate existing studies;



- Its design is appropriate to answer the research question being asked in the study;
- It is sponsored by an organization or individual capable of executing the proposed study successfully;
- It is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 45 CFR Part 46;
- All of its aspects are conducted according to appropriate standards of scientific integrity set by the International Committee of Medical Journal Editors (<http://www.icmje.org>);
- It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with evidence development (CED);
- It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR §312.81(a) and the patient has no other viable treatment options;
- It is registered on the ClinicalTrials.gov website (<http://www.clinicaltrials.gov/>) by the principal sponsor/investigator prior to the enrollment of the first study subject;
- Its study protocol:
 - a) Specifies the method and timing of public release of all pre-specified outcomes to be measured, including the release of outcomes that are negative or that the study is terminated early; The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that

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Wounds *(continued)*

meets the requirements of the International Committee of Medical Journal Editors (<http://www.icmje.org>). However a full report of the outcomes must be made public no later than three (3) years after the end of data collection;

- b) Must explicitly discuss: 1) Subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies; 2) How the inclusion and exclusion criteria effect enrollment of these populations, and 3) A plan for the retention and reporting of said populations on the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.
- c) Explicitly discusses how the results are, or are not, expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability or Medicaid eligibility.

Note: Consistent with Section 1142 of the Social Security Act (the Act), the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that CMS determines meet the above-listed standards and address the above-listed research questions.

Coding and payment details

Healthcare common procedure coding system (HCPCS) codes

Effective for claims with dates of service on or after August 2, 2012, contractors will accept and pay PRP claims, HCPCS code G0460 – Autologous platelet rich plasma for chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment,” for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only in the context of an approved clinical study, when all of the following are present:

- ICD-9/ICD-10 CM Diagnosis code from the list of diagnosis codes to be maintained by the contractors
- Diagnosis code V70.7 (secondary dx) (ICD-10 Z00.6)
- Condition code 30 (institutional claims only)
- Clinical trial modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved research study)
- Value code D4 with an 8-digit clinical trial number (optional, institutional claims only)



Medicare contractors will return to provider/return as unprocessable your PRP claims that do not include ALL these diagnosis coding and additional billing requirements:

Should they return your PRP claims for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only in the context of an approved clinical study, they will use the following messages:

- CARC 16 – “Claim/service lacks information which is needed for adjudication.”
- RARC M16 – “Alert: See our Website, mailings, or bulletins for more details concerning this policy/procedure/decision.” and
- RARC MA130 – “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.”

Type of bill

Your contractor will pay claims for PRP services in the following settings:

- Hospital outpatient departments type of bills (TOB) 12x and 13x based on OPPS;
- Skilled nursing facilities (SNF) TOBs 22x and 23x based on MPFS;
- Rural health clinics (RHC) TOB 71x based on all inclusive;
- Comprehensive outpatient rehabilitation facilities (CORF) TOB 75x based on MPFS;
- Federally qualified health centers (FQHC) TOB 77x based on all-inclusive, critical access hospitals (CAH) TOB 85x based on reasonable cost, and
- CAHs TOB 85x and revenue codes 096x, 097x, or 098x based on MPFS. They will pay for PRP services in Maryland hospitals under the jurisdiction of the Health Services Cost Review Commission (HSCRC) on an outpatient basis,

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Wounds *(continued)*

TOB 13x, in accordance with the terms of the Maryland waiver. Contractors will deny claims for PRP services (HCPCS code G0460) when provided on other than TOBs 12x, 13x, 22x, 23x, 71x, 75x, 77x, and 85x using:

- CARC 58 – “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 832 healthcare policy identification segment (loop 2110 service payment information REF), if present”;
- RARC N428 – “Service/procedure not covered when performed in this place of service”; and
- Group code: CO

Place of service (POS) professional claims

Effective for claims with dates of service on or after August 2, 2012, you should use place of service (POS) codes 11 (office), 22 (outpatient hospital), and 49 (independent clinic) for PRP services. Your contractor will deny all other POS codes using the following messages:

- CARC 58 – “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service”;
- RARC N428 – “Service/procedure not covered when performed in this place of service”; and
- Group code: CO.

Note: Contractors will not retroactively adjust claims from August 2, 2012, through the implementation of this CR. However, contractors may adjust claims that are brought to their attention.

Additional information

CR 8213 is being released in two transmittals which may be found at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R152NCD.pdf> and <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2666CP.pdf> on the CMS website.

Both transmittals (R152NCD and R2666CP) contain a listing of relevant ICD-9 and ICD-10 diagnostic codes. You can find information regarding clinical trials in the *Medicare Claims Processing Manual*, Chapter 32, Section 69 (Qualifying Clinical Trails), for information regarding clinical trials, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.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: MM8213 **Revised**
 Related Change Request (CR) #: CR 8213
 Related CR Release Date: March 8, 2013
 Effective Date: August 2, 2012
 Related CR Transmittal #: R152NCD, R2666CP
 Implementation Date: July 1, 2013

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Learn the secrets to billing Medicare correctly

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

April 2013 integrated outpatient code editor specifications version 14.1

Provider types affected

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

What you need to know

This article is based on change request (CR) 8242, which describes changes to the I/OCE and OPPS to be implemented in the April 2013 OPPS and integrated outpatient code editor (I/OCE) updates. Be sure your billing staff is aware of these changes.

Background

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>.

There is a summary of the changes for April 2013 in Appendix M of attachment A of CR 8242 and that summary is captured in the following key points.

Effective April 1, 2013, (except as noted below) Medicare will:

- Clarify the criteria for assignment of the electrophysiology/ablation composite ambulatory payment classification (APC): If there is one or more codes from group C present with one or more codes from either group A or group B; assign the composite APC to the group C code and assign the standard APC and related SI to any separate group A or group B codes present. Effective January 1, 2013.
- Correct the logic to apply edit 84 to psychiatric add-on codes only on partial hospitalization program (PHP) claims (type of bill (TOB) 13x w/ CC41 or 76x): Ignore psychiatric add-on codes on non-PHP claims; do not apply edit 84; do not check for related primary codes. Effective January 1, 2013.
- Implement mid-quarter national coverage determination non-coverage for code L0430. Edit 83 is affected. Effective November 17, 2012.
- Implement mid-quarter Food and Drug Administration (FDA) approval date for code 90661. Edit 67 is affected. Effective November 20, 2012.
- Make HCPCS/APC/status indicator (SI) changes as specified by CMS (data change files). Effective January 1, 2013.
- Implement version 19.1 of the national correct coding initiative (NCCI) (as modified for applicable institutional providers). [All edits combined in a single file, in code 1/code 2 format; mutually exclusive pairs no longer differentiated]. Edits 20 and 40 are affected.
- Update procedure/device & device/procedure edit requirements. Edits 71 and 77 are affected. Effective January 1, 2013.
- Delete all genetic testing modifiers from the valid modifier list, retroactive to January 1, 2013. Edit 22 is affected.
- Update the skin substitute list; delete C9367 retroactive to January 1, 2013.
- Correct table 4 to display the correct initial versions for deactivated edits 63 and 64 (v1.0 – v13.3).
- Update the skin substitute list to delete Q4129 and to add Q4127.

Additional information

The official instruction, CR 8242 issued to your FI, RHHI, and A/B MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2667CP.pdf>.

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

MLN Matters[®] Number: MM8242
 Related Change Request (CR) #: CR 8242
 Related CR Release Date: March 8, 2013
 Effective Date: April 1, 2013
 Related CR Transmittal #: R2667CP
 Implementation Date: April 1, 2013

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Healthcare provider taxonomy codes update, April 2013

Provider types affected

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

What you need to know

This article is based on change request (CR) 8211 which instructs carriers and Part B MACs to obtain the most recent healthcare provider taxonomy codes (HPTC) set and use it to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, among them health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used.

Health care claims are among the health care transactions for which standards were adopted under HIPAA. Among the current versions of the standard implementation guides for health care claim transactions are the 5010 versions of the ASC X12 837 institutional technical report 3 (TR3) for institutional claims and the ASC X12 837 professional TR3 for professional (and some supplier) claims. (There are other standards for other types of claims).

Both the current ASC X12 837 institutional and professional TR3s require that the National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Code (HPTC) set be used to identify provider specialty information on a health care claim. However, the standards do not mandate the reporting of provider specialty information via a HPTC be on every claim, nor for every provider to be identified by specialty. The standards implementation guides state that this information is:

- “Required when the payer’s adjudication is known to be impacted by the provider taxonomy code.”; and
- “If not required by this implementation guide, do not send.”

Medicare does not use HPTCs to adjudicate its claims. It would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC code set.



The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers, and the NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view from the Washington Publishing Company (WPC) at <http://www.wpc-edi.com/codes>.

CR 8211 implements the NUCC HPTC code set that is effective on April 1, 2013. When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

Additional information

The official instruction, CR 8211, issued to your carriers and B MACs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2660CP.pdf> on the CMS website.

If you have any questions, please contact your carriers or Part 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: MM8211
 Related Change Request (CR) #: CR 8211
 Related CR Release Date: February 15, 2013
 Effective Date: April 1, 2013
 Related CR Transmittal #: R2660CP
 Implementation Date: July 1, 2013 (Contractors who have the capability may implement April 1, 2013 or after)

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Changes made to submitting VA skilled nursing claims and VA Medicare remittance advice processes

Provider types affected

This *MLN Matters*[®] article is intended for providers submitting Veterans Administration (VA) skilled nursing facility (SNF) claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for SNF services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8089 which informs Medicare contractors about changes to the VA Medicare remittance advice (VA eMRA) process. Note that you must ensure a valid qualifying stay is present on any VA SNF claims.

Background

SNF claims were initially excluded from the VA eMRA project in 2003. VA bills professional services of physicians providing care to patients in skilled nursing facilities/nursing home settings via the eMRA process; however institutional charges for Medicare-eligible patients are submitted directly to the secondary payer with a request to estimate the amount due. VA currently bills third-party payers for institutional SNF claims using a 211 bill type and submits a SNF bill with revenue code 0100 covering room and board plus ancillary charges.

Medicare requires providers to submit SNF bills with occurrence code 70, revenue code 0022 and a health insurance prospective payment system (HIPPS) code. The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the "Grouper" software program followed by a

2-digit assessment indicator that specifies the type of assessment associated with the RUG code obtained from the Grouper.

CR 8089 implements the technical requirements needed to include SNF claims into the VA eMRA process. The VA SNF bill types to be included are as follows: 21x, 22x, and 23x. The default HIPPS code to be used should be AAA00. (TOB 18x is not used)

Additional information

The official instruction, CR 8089 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/R11920TN.pdf> on the CMS website. If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.

MLN Matters[®] Number: MM8089
 Related Change Request (CR) #: CR 8089
 Related CR Release Date: February 15, 2013
 Effective Date: July 1, 2013
 Related CR Transmittal #: R11920TN
 Implementation Date: July 1, 2013

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Valid redetermination appeal request requirements

A redetermination is an independent review of an initial claim determination performed by the same contractor that processed the original claim. This independent review is performed by staff not involved with making the original claim determination.

A request for a redetermination must be submitted in writing and should be made on the standard Centers for Medicare & Medicaid (CMS) [Form 20027](#). If the standard form is not used, the request must include the same elements required on the form:

The beneficiary's name,

The beneficiary's Medicare health insurance claim (HIC) number,

The specific service(s) and item(s) for which the redetermination is being requested,

The specific date(s) of service, and

The name and written signature.

If any of these five elements are missing, the redetermination will be dismissed as invalid. The appellant may resubmit the appeal if still within the original appeal timeframe. Resubmission of the appeal to include originally missing requirements does not extend the original timeframe or in any way constitute good cause for late filing.

Source: CMS Internet-only manuals [Publication 100-4, Chapter 29, Section 310.1.B.3](#)

Plan ahead to mitigate risk for a smooth ICD-10 transition

To make your transition to ICD-10 smooth, consider following these steps:

- **Establish a transition plan.** Outline the steps your practice intends to follow to comply with ICD-10 requirements. Establish milestones to keep your practice on track. Share your transition plan with your EHR and practice management system vendors and billing services. Talk to them about how you can set up testing before the deadline.
- **Communicate with your vendors regularly.** encourage vendors to take action now to avoid reimbursement delays. Talk to your vendors about making sure your practice management systems will be able to handle ICD-10 transactions. Ask them about their schedule for training your practice's staff on the system changes. Make sure you and your vendors allow ample time for testing ICD-10 systems.
- **Identify everywhere that your practice uses ICD-9.** Any function where you currently use ICD-9 will be affected by the transition to ICD-10. By taking a look at where you use ICD-9, you will see where you need to be prepared to use ICD-10 codes.
- **Plan for staff training.** Decide who needs training, what type of training they need, and when they need it. Anyone who will test ICD-10 systems before the transition will need training in advance so they can perform meaningful testing. Others

who use ICD codes can be trained six to nine months before the October 1, 2014, transition.

- **Network with peers.** Talking with your peers in other practices can help you to identify best practices and opportunities for sharing resources.
- **Set up an emergency fund to cover potential cash-flow disruptions from claim processing.** If you think you might have a serious disruption in getting claims processed after the transition, having a cash reserve on hand could be helpful.
- **Process ICD-9 transactions before the deadline.** Get claims with ICD-9 transactions processed before the deadline to avoid facing a major backlog after the October 1, 2014, ICD-10 transition.

Keep up to date on ICD-10

Visit the [CMS ICD-10 website](#) for the latest news and resources to help you prepare for the October 1, 2014, deadline.

Practical transition tips

Read [recent ICD-10 email update messages](#)

Access the [ICD-10 continuing medical education modules](#) developed by CMS in partnership with Medscape

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

ICD-10 checklists and timelines

To assist with preparation for ICD-10, the Centers for Medicare & Medicaid Services (CMS) has released new [checklists and timelines](#) for small and medium provider practices, large provider practices, small hospitals, and payers. These resources are designed to provide a high-level understanding of what the ICD-10 transition requires and how your ICD-10 preparations compare with recommended timeframes.

Checklists

The checklists offer easy-to-understand lists of tasks that CMS recommends completing before the October 1, 2014, ICD-10 deadline. Each task also includes an estimated timeframe, allowing you to plan based on your current progress. Depending on your organization, you may be able to perform some of the tasks on a compressed timeline or at the same time as other tasks.

Timelines

The timelines are an at-a-glance resource for getting

a sense of how your transition is moving forward. The timelines provide a visual guide to key transition activities by phase.

Use these resources to identify where you need to focus your efforts. Then you can consult the more in-depth ICD-10 resources available on the CMS website.

Keep up to date on ICD-10

Visit the [CMS ICD-10 website](#) for the latest news and resources to help you prepare for the October 1, 2014, deadline.

Practical transition tips

Read [recent ICD-10 email update messages](#) .

Access the [ICD-10 continuing medical education modules](#) developed by CMS in partnership with Medscape

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

July 2013 quarterly average sales price Medicare Part B drug pricing files and revisions to prior quarterly pricing files

Provider types affected

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

Provider Action Needed

Medicare will use the July 2013 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 1, 2013, with dates of service July 1, 2013, through September 30, 2013.

Also, change request (CR) 8247, from which this article is taken, instructs your Medicare contractors to download and implement the July 2013 ASP Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised April 2013, January 2013, October 2012, and July 2012 files. Make sure that your billing staffs are aware of the release of these July 2013 ASP Medicare Part B drug files.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B hospital (Including inpatient hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf> on the CMS website.

The following table shows how the quarterly payment files will be applied:

Files	Effective for Dates of Service
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012

Additional information

The official instruction, CR 8247 issued to your FI, carrier, A/B MAC, RHHI or DME/MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2676CP.pdf> on the CMS website.

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

MLN Matters[®] Number: MM8247

Related Change Request (CR) #: CR 8247

Related CR Release Date: March 15, 2013

Effective Date: July 1, 2013

Related CR Transmittal #: R2676CP

Implementation Date: July 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.

Update of home health consolidated billing enforcement HCPCS codes

Provider types affected

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

What you need to know

This article is based on change request (CR) 8246 which provides the annual update to home health (HH) consolidated billing effective July 1, 2013. CR 8246 adds the following HCPCS codes to the HH consolidated billing therapy code list:

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

G0457 (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm).

Background

The Social Security Act (Section 1842(b)(6); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA).

This requirement is found in Medicare regulations at 42 CFR 409.100 (see <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=e49c86165ce00a5c3e044053adf4c2d0&rgn=div5&view=text&node=42:2.0.1.2.9&idno=42>) and in the *Medicare Claims Processing Manual* (Chapter 10, Section 20; see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf>).

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of healthcare common procedure coding system (HCPCS) codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS).

Services appearing on this list (that are submitted on claims to Medicare contractors) will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA), with the exception of the following:

- Therapies performed by physicians;
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. The following are not subject to HH consolidated billing:

- Therapies performed by physicians,
- Supplies incidental to physician services, and
- Supplies used in institutional settings.

The HH consolidated billing code lists are updated annually to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year.

These new codes were effective January 1, 2013, but were overlooked in the annual HH consolidated billing update published in CR 8043 (see the related article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8043.pdf>).

The following HCPCS codes are added to the HH consolidated billing therapy code list effective for claims with dates of service on or after July 1, 2013:

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



(continued on next page)

Modification to CWF when there is a provider number mismatch

Note: This article was revised on March 15, 2013, to reflect a revised change request (CR). The revised CR restores the common working file (CWF) entitlement validation criterion (in bold below) used prior to the implementation of CR 7260 (October 1, 2012). It was previously published on Page 15 in the May 2012 edition of *Medicare A Connection*.

The implementation date for CR 7260 was changed to April 1, 2013. The transmittal number, CR release date, and Web address also changed. All other information remains the same.

Provider types affected

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

Provider action needed

If Medicare systems reject a claim when there is a mismatch of the health insurance claim number (HICN) with the beneficiary's personal characteristics (such as name, sex or date of birth), your Medicare contractor will return the claim to you as unprocessable with the identifying beneficiary information from the submitted claim as follows:

- Your contractor will return to provider (RTP) Part A claims.
- Your contractor will return as unprocessable Part B claims. Your contractor will use reason code 140

(Patient/Insured health identification number and name do not match).

If an adjustment claim is received where the beneficiary's name does not match the submitted HICN, your contractor will suspend the claim and, upon their review, either correct, develop, or delete the adjustment, as appropriate. All providers should ensure that their staffs are aware of these changes.

Additional information

The official instruction, CR 7260 issued to your FI, A/B MAC, and DME/MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2670CP.pdf>.

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

MLN Matters[®] Number: MM7260
 Related Change Request (CR) #: CR 7260
 Related CR Release Date: March 14, 2013
 Effective Date: October 1, 2012
 Related CR Transmittal #: R2670CP
 Implementation Date: April 1, 2013

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HCPCS (continued)

Additional information

The official instruction, CR 8246 issued to DME MACs, FIs, RHHIs, and A/B MACs regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2672CP.pdf>. If you have any questions, please contact your DME MAC, FI, RHHI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

MLN Matters[®] Number: MM8246
 Related Change Request (CR) #: CR 8246
 Related CR Release Date: March 15, 2013
 Effective Date: July 1, 2013
 Related CR Transmittal #: R2672CP
 Implementation Date: July 1, 2013

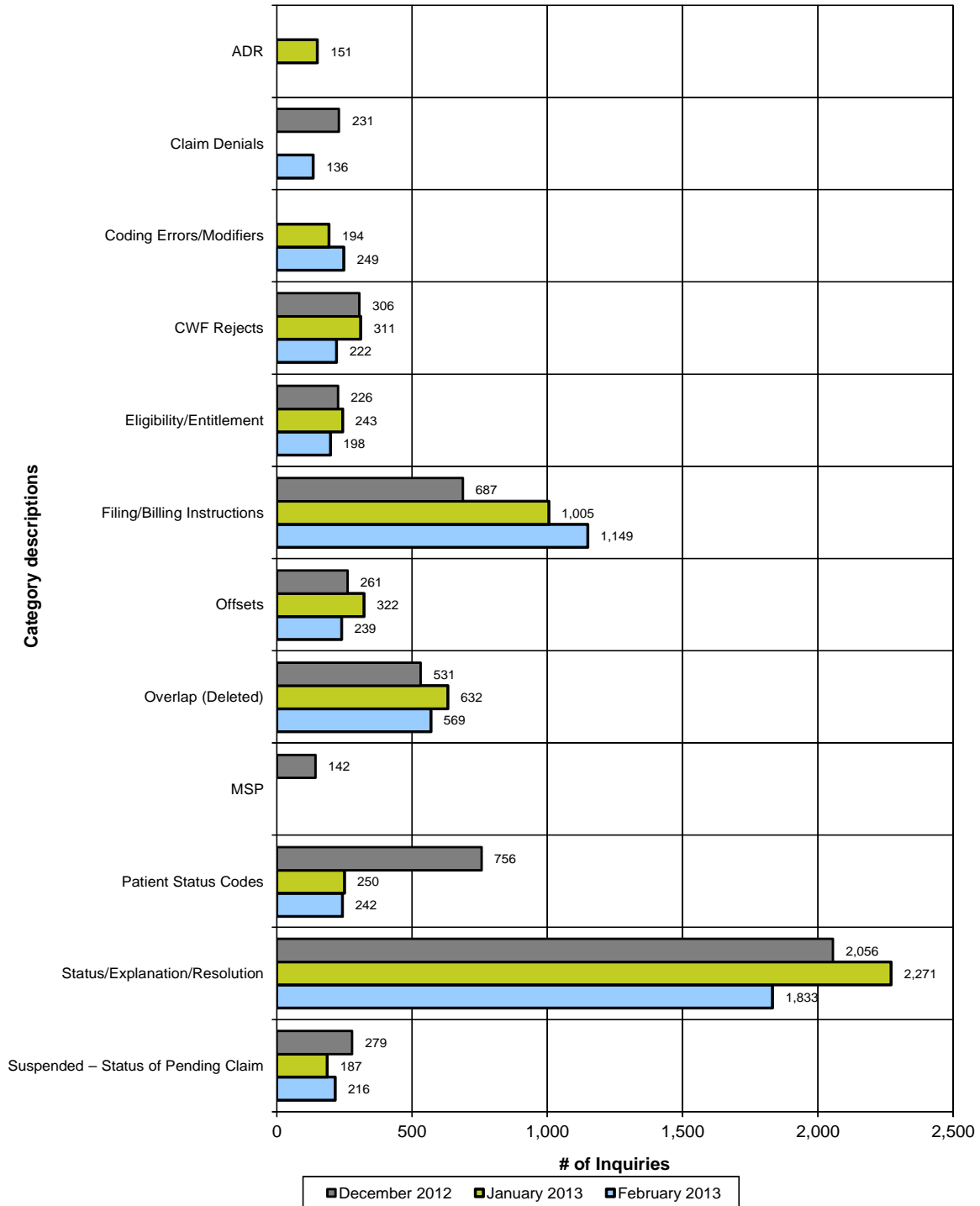
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Top inquiries, rejects, and return to provider claims December 2012 - February 2013

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 December 2012 through February 2013.

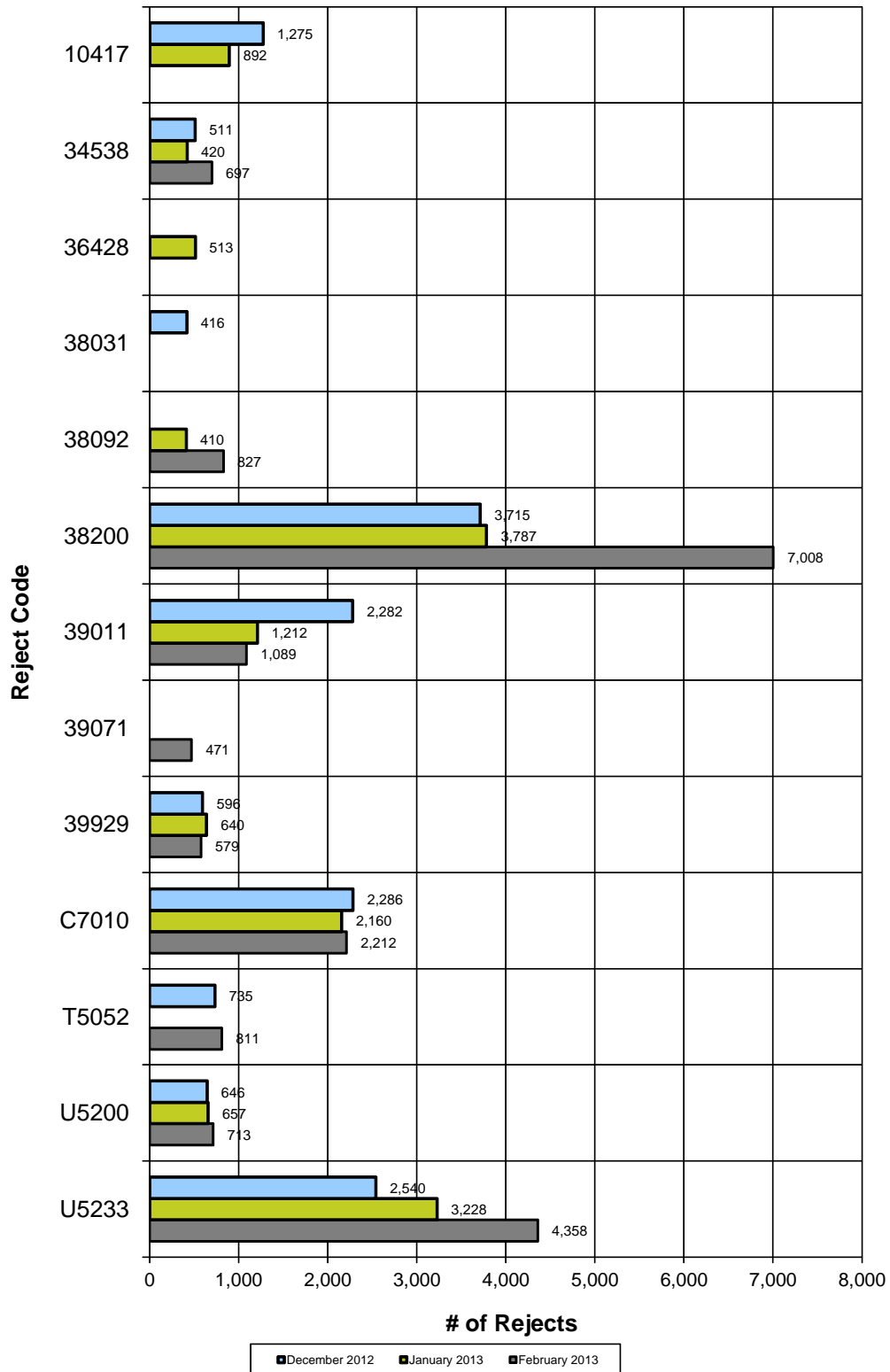
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at http://medicare.fcso.com/Inquiries_and_denials/index.asp.

Top inquiries for December 2012-February 2013



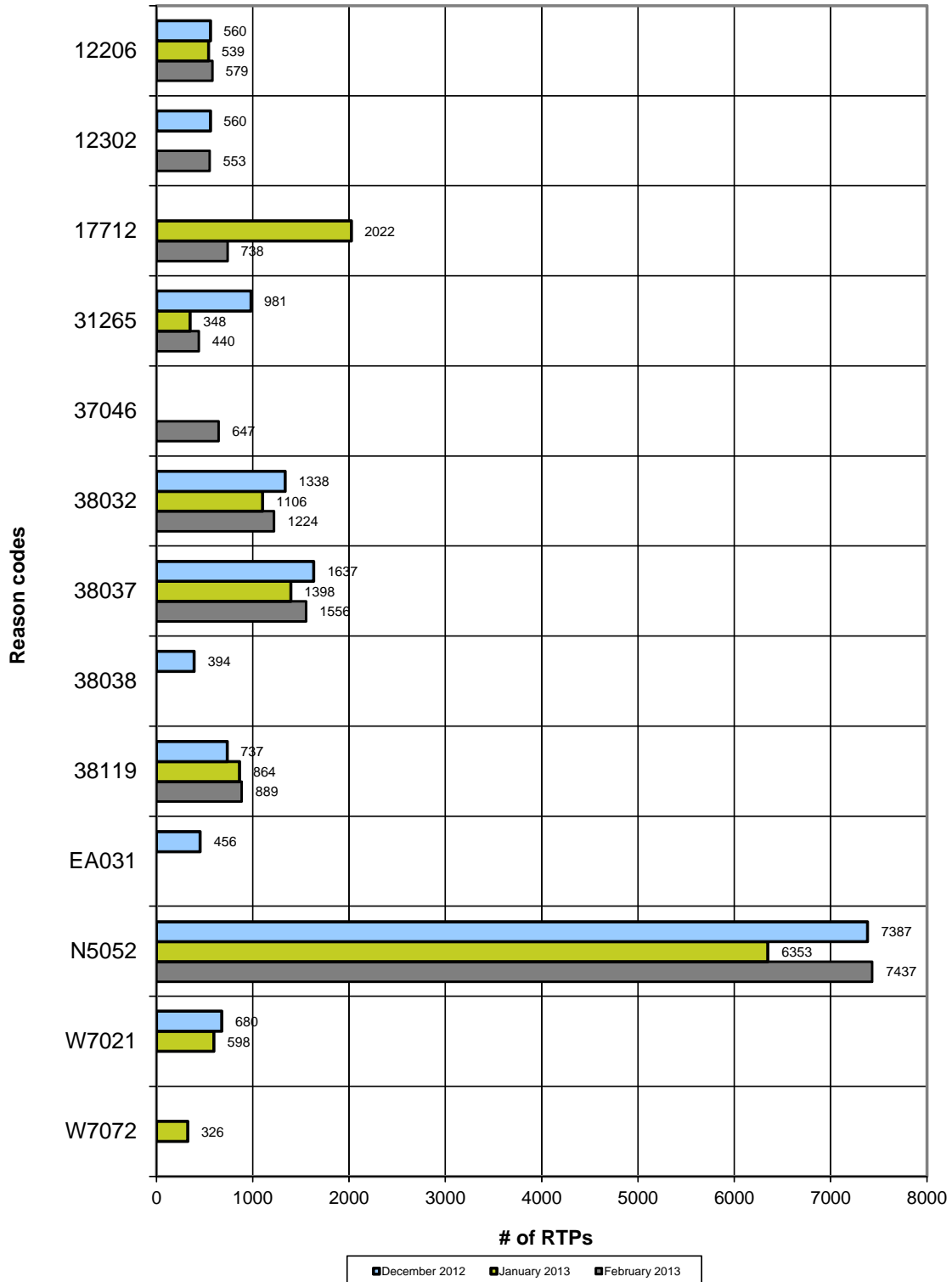
Part A top rejects for December 2012- February 2013

Top rejects for December 2012-February 2013



Part A top return to providers (RTPs) for December 2012-February 2013

Top RTPs for December 2012-February 2013



Mandatory Medicare budget reductions – sequestration

The Budget Control Act of 2011 requires, among other things, mandatory across-the-board reductions in federal spending, also known as sequestration. The American Taxpayer Relief Act of 2012 postponed sequestration for two months.

As required by law, President Obama issued a sequestration order on March 1, 2013. The administration continues to urge Congress to take prompt action to address the current budget uncertainty and the economic hardships imposed by sequestration.

This listserv message is directed at the Medicare fee-for-service (FFS) program (i.e., Part A and Part B). In general, Medicare FFS claims with dates of service or dates of discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME competitive bidding program, will be reduced by 2 percent based upon whether the date of service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.



The claims payment adjustment shall be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare secondary payment adjustments.

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The Centers for Medicare & Medicaid Services (CMS) encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to discuss

with beneficiaries the impact of sequestration on Medicare's reimbursement.

Questions about reimbursement should be directed to your Medicare claims administration contractor. As indicated above, CMS is hopeful that Congress will take action to eliminate the mandatory payment reductions.

Source: CMS PERL 201303-02

Federal sequestration payment reductions FAQs

Question: Does the 2 percent payment reduction under sequestration apply to the payment rates reflected in Medicare fee-for-service fee schedules or does it only apply to the final payment amounts?

Answer: Payment adjustments required under sequestration are applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible, and any applicable Medicare secondary payment adjustments. All fee schedules, Pricers, etc., are unchanged by sequestration; it's only the final payment amount that is reduced.

Question: How is the 2 percent payment reduction under sequestration identified on the electronic remittance advice (ERA) and the standard paper remittance (SPR)?

Answer: Claim adjustment reason code (CARC) 223

is used to report the sequestration reduction on the ERA and SPR.

Question: What is the verbiage for CARC 223?

Answer: "Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created."

Question: Will the 2 percent reduction be reported on the remittance advice in a separate field?

Answer: For institutional Part A claims, the adjustment is reported on the remittance advice at the claim level. For Part B physician/practitioner, supplier, and institutional provider outpatient claims, the adjustment is reported at the line level.

Question: How will the payments be calculated on the claims?

Answer: The reduction is taken from the calculated
(continued on next page)

Sequestration FAQs *(continued)*

payment amount, after the approved amount is determined and the deductible and coinsurance are applied.

Example: A provider bills a service with an approved amount of \$100.00, and \$50.00 is applied to the deductible. A balance of \$50.00 remains. We normally would pay 80 percent of the approved amount after the deductible is met, which is \$40.00 (\$50.00 x 80 percent = \$40.00).

The patient is responsible for the remaining 20 percent coinsurance amount of \$10.00 (\$50.00 - \$40.00 = \$10.00). However, due to the sequestration reduction, 2 percent of the \$40.00 calculated payment amount is not paid, resulting in a payment of \$39.20 instead of \$40.00 (\$40.00 x 2 percent = \$0.80).

Question: How are unassigned claims affected by the 2 percent reduction under sequestration?

Answer: Though beneficiary payments toward deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare’s payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The non-participating physician who bills on an unassigned basis collects his/her full payment from the beneficiary, and Medicare reimburses the beneficiary the Medicare portion (e.g., 80 percent of the reduced fee schedule amount).

Note: The “reduced fee schedule” refers to the fact that Medicare’s approved amount for claims from non-participating physicians/practitioners is 95 percent of the full fee schedule amount).

This reimbursed amount to the beneficiary would be subject to the 2 percent sequester reduction just like payments to physicians on assigned claims. Both are

claims payments, but to different parties. If the limiting charge applies to the service rendered, providers cannot collect more than the limiting charge amount from the beneficiary.

Example: A non-participating provider bills an unassigned claim for a service with a limiting charge of \$109.25. The beneficiary remains responsible to the provider for this full amount. However, sequestration affects how much Medicare reimburses the beneficiary. The non-participating fee schedule approved amount is \$95.00, and \$50.00 is applied to the deductible. A balance of \$45.00 remains.

Medicare normally would reimburse the beneficiary for 80 percent of the approved amount after the deductible is met, which is \$36.00 (\$45.00 x 80 percent = \$36.00). However, due to the sequestration reduction, 2 percent of the \$36.00 calculated payment amount is not paid to the beneficiary, resulting in a payment of \$35.28 instead of \$36.00 (\$36.00 x 2 percent = \$0.72).

We encourage physicians, practitioners, and suppliers who bill unassigned claims to discuss with their Medicare patients the impact of the sequestration reductions to Medicare payments.

Question: Is this reduction based on the date of service or date of receipt?

Answer: In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME competitive bidding program, will be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.



How sequestration reductions will be applied

Payment adjustments required under sequestration shall be applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible, and any applicable Medicare secondary payment adjustments.

A sequestration order was issued on March 1, 2013, that provides for a 2 percent reduction in Medicare fee-for-service (FFS) payments for dates of service or dates of discharge on or after April 1, 2013.

The Medicare Part B physician fee schedule (MPFS) allowances posted to the First Coast Service Options (First Coast) Medicare provider websites do not reflect the payment adjustment required under sequestration.

Payment adjustments required under sequestration shall be applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible, and any applicable Medicare secondary payment adjustments.

Multiple procedure payment reduction for selected therapy services

Provider types affected

This *MLN Matters*[®] article is intended for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and Part A/B Medicare administrative contractors (A/B MACs) for therapy services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS) or paid at the physician fee schedule rate.

Provider action needed

This article is based on change request (CR) 8206, which informs Medicare contractors that Section 633 of the American Taxpayer Relief Act of 2012 increased the multiple procedure payment reduction (MPPR) on selected therapy services to 50 percent for both office and institutional settings. This is effective for claims with dates of service on or after April 1, 2013. Make sure that your billing staffs are aware of this update.

Background

Effective January 1, 2011, Medicare applied an MPPR to the practice expense (PE) payment of select therapy services paid under the physician fee schedule or paid at the physician fee schedule rate.

Currently, the reduction is 20 percent for therapy services furnished in office and other non-institutional settings, and 25 percent for therapy services furnished in institutional settings. Effective for claims with dates of service April 1, 2013, and after, Section 633 of the American Taxpayer Relief Act of 2012 revised the reduction to 50 percent for all settings.

Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. Effective for claims with dates of service on or after April 1, 2013, full payment is made for work and malpractice and 50 percent payment is made for the PE for subsequent units and procedures, furnished to the same patient on the same day.

For therapy services furnished by a group practice or “incident to” a physician’s service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, e.g., physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP).

The reduction applies to the healthcare common procedure coding system (HCPCS) codes contained on the list of “always therapy” services that are paid under the physician fee schedule, regardless of the type of provider or supplier that furnishes the services (e.g., hospitals, home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs), etc.)

For professional claims, the MPPR applies to the procedures with a multiple procedure (Field 21) value of “5” on the Medicare fee schedule database (MFSD). For institutional claims, the MPPR applies to procedures with a multiple services indicator (field labeled MULTSURG) value of “5” on the therapy abstract file. Note that these services are paid with a non-facility PE. The current and revised payments are shown in the example in the following table:

Sample Payment Calculation						
	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Total Current Payment	Revised Total Payment	Revised Payment Calculation
Work	\$7.00	\$7.00	\$11.00	\$25.00	\$25.00	no reduction
PE	\$10.00	\$10.00	\$8.00	\$23.50	\$19.00	\$10 + (.50 x \$10) + (.50 x \$8)
MP	\$1.00	\$1.00	\$1.00	\$3.00	\$3.00	no reduction
Total	\$18.00	\$18.00	\$20.00	\$51.50	\$47.00	\$18 + (\$18-\$10) + (.50 x \$10) + (\$20-\$8) + (.50 x \$8)

Note: The total current payment reflects the 25 percent reduction for institutional services.

(continued on next page)

Requesting a comparative billing report – Part A providers

Provider types affected

Comparative billing report (CBR) information is available to providers by request. The purpose of the CBR is to show comparative data Medicare considers when determining how a provider's billing patterns contrast with other providers in the same specialty. A CBR may be a helpful tool for providers when conducting self-audits.



Comparative billing reports by type of bill

Medicare compares a Part A provider to its peers by type of bill using quantity billed per beneficiary per procedure code. This type of CBR contains billing information for a provider in intervals defined by the requester.

Since Medicare bases a CBR on dates of service and not processed dates, Medicare must allow two to three months to permit claims to be finalized before a report can be generated. For example, January data is not available until April or May.

How to request a comparative billing report

To request a CBR, providers must follow these steps:

- A provider must request a CBR on office or corporate letterhead and the provider/officer signature must be affixed. A request from a

corporate entity must be submitted by a corporate officer, or in the case of a hospital, the hospital administrator. If the requesting provider wants the information sent to another party, it must be noted in the letter.

- The mailing address must be stated clearly and legibly in the letter, since these reports will only be sent via the U.S. mail, and not electronically.
- The CBR request must include the Medicare provider number, the dates of service preferred, and the applicable type of bill. Due to the volume of data, Medicare cannot generate a report for types of bill 11x or 12x.
- The request must be faxed to Statistical and Medical Data Analysis at 904-361-0543 or mailed to:

First Coast Service Options
 Statistical and Medical Data Analysis
 P.O. Box 44288
 Jacksonville, FL 32231-4288.

There is no fee for providing these reports. Once Medicare receives a CBR request, the report and a CBR explanation document will be mailed to the requesting provider (or authorized party) within 10 business days.

Therapy (continued)

Additional information

The official instruction, CR 8206, issued to your carrier, FI, RHHI, or A/B MAC may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1194OTN.pdf>.

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

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 Related Change Request (CR) #: CR 8206
 Related CR Release Date: February 22, 2013
 Effective Date: April 1, 2013
 Related CR Transmittal #: R1194OTN
 Implementation Date: April 1, 2013

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April 2013 update of hospital outpatient prospective payment system

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8228 which describes changes to the outpatient prospective payment system (OPPS) to be implemented in the April 2013 OPPS update. CR 8228 describes changes to and billing instructions for various payment policies implemented in the April 2013 OPPS update. The April 2013 integrated outpatient code editor (I/OCE) and OPPS Pricer will reflect the healthcare common procedure coding system (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 8228. Make sure that your billing staffs are aware of these changes.



Background

Change request (CR) 8228 describes changes to and billing instructions for various payment policies implemented in the April 2013 OPPS update. The April 2013 integrated outpatient code editor (I/OCE) and OPPS Pricer will reflect the HCPCS, ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 8228.

The April 2013 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2013 I/OCE CR which is CR 8242. Upon release of CR 8242, a related *MLN Matters*[®] article can be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8242.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. Key changes to and billing instructions for various payment policies implemented in the April 2013 OPPS update are as follows:

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

New services

New services listed in Table 1 (also included in Attachment A, CR 8228) are assigned for payment under the OPPS, effective April 1, 2013.

Table 1 – New services payable under OPPS effective April 1, 2013

HCPCS	Effective date	Status indicator (SI)	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9734	4/01/2013	S	0067	U/S trtmt, not leiomyomata	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with or without magnetic resonance guidance	\$3,300.64	\$660.13
C9735	4/01/2013	T	0150	Anoscopy, submucosal inj	Anoscopy; with directed submucosal injection(s), any substance	\$2,365.97	\$473.20

Note: HCPCS code C9735 describes the administration/injection procedure for Solesta and should only be reported with HCPCS code L8605 (Injectable bulking agent dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies).

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OPPS (continued)

Payment reduction for single session cobalt-60 based stereotactic radiosurgery (SRS)

Section 634 of the American Taxpayer Relief Act of 2012 (see <http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf>) requires that effective April 1, 2013, CMS reduce the payment amount for Cobalt-60 based Stereotactic Radiosurgery (SRS) described by *Current Procedural Terminology (CPT®)* code 77371 to an amount equal to the payment amount for the linear accelerator based SRS procedure described by HCPCS code G0173. This requirement does not apply to rural hospitals, as defined in sections 1886 (d)(2)(D) and 1866(d)(5)(C), or to sole community hospitals, as defined in section 1886 (d)(5)(D)(iii) of the Social Security Act. (See http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the Internet.)

In Addendum B of the 2013 OPSS/ASC final rule (see <http://www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf>) that was published on the CMS website on November 1, 2012, CPT® code 77371 was assigned to APC 0127 (Level IV stereotactic radiosurgery, MRgFUS, and MEG) and HCPCS code G0173 to APC 0067 (Level III Stereotactic Radiosurgery, MRgFUS, and MEG) effective January 1, 2013.

Consistent with the requirements set forth in Section 634 of the American Taxpayer Relief Act of 2012, CPT® code 77371 will remain in APC 0127 but the payment rate for the procedure will be reduced to equal the payment rate for APC 0067 effective April 1, 2013 (except in rural and sole community hospitals), where the payment rate will remain at the APC 0127 level). The OPSS PRICER will provide the appropriate payment rate for CPT® code 77371 based on the site of service of where the procedure is performed. Table 2 shows the APC assignment and payment rate for CPT® code 77371 and HCPCS code G0173 effective April 1, 2013.

Table 2 – OPSS APC and payment rate for 77371 and G0173

CPT/HCPCS code	Long descriptor	April 2013 APC	April 2013 payment rate	
			Rural Hospitals and other excepted hospitals	All other hospitals
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	0127	\$7,911	\$3,301
G0173	Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session	0067	\$3,301	

Inpatient telehealth pharmacologic management (HCPCS code G0459)

Effective January 1, 2013, CMS established HCPCS code G0459 to track remotely-delivered inpatient pharmacologic management services provided to patients with mental disorders in rural hospitals. HCPCS code G0459 is paid under the Medicare physician fee schedule and assigned to OPSS status indicator “B” to indicate that the code is not recognized by OPSS when submitted on an outpatient hospital Part B bill type.

HCPCS code G0459 did not appear in Addendum B of the CY 2013 OPSS/ASC final rule that was published on the CMS website on November 1, 2012. Therefore, CMS is providing the short and long descriptors, as well as the OPSS status indicator, for this service in Table 3 below (also included in Attachment A, CR 8228).

Table 3 – New inpatient telehealth pharmacologic management HCPCS code

HCPCS code	Short descriptor	Long descriptor	SI	APC
G0459	Telehealth inpt pharm mgmt	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	B	N/A

**Billing for drugs, biologicals, and radiopharmaceuticals
drugs and biologicals with payments based on average sales price (ASP) effective April 1, 2013**

In the CY 2013 OPSS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will

(continued on next page)

OPPS (continued)

incorporate changes to the payment rates in the April 2013 release of the OPPS Pricer. The updated payment rates, effective April 1, 2013, will be included in the April 2013 update of OPPS Addendum A and Addendum B.

Drugs and biologicals with OPSS pass-through status effective April 1, 2013

Five drugs and biologicals have been granted OPSS pass-through status effective April 1, 2013. These items, along with their descriptors and APC assignments, are identified in Table 4.

Table 4 – Drugs and Biologicals with OPSS Pass-Through Status Effective April 1, 2013

HCPCS code	Long descriptor	APC	Status indicator effective 4/1/13
C9130*	Injection, immune globulin (Bivigam), 500 mg	9130	G
C9297*	Injection, omacetaxine mepesuccinate, 0.01 mg	9297	G
C9298*	Injection, ocriplasmin, 0.125 mg	9298	G
J7315	Mitomycin, ophthalmic, 0.2 mg	1448	G
Q4127	Talymed, per square centimeter	1449	G

Note: The HCPCS codes identified with an “*” indicate that these are new codes effective April 1, 2013.

Additional information on HCPCS Code C9298 (Injection, Ocriplasmin, 0.125 mg)

Jetrea (ocriplasmin) is packaged in a sterile, single-use vial containing 0.5 mg ocriplasmin in a 0.2 mL solution for intravitreal injection (2.5 mg/mL). As approved by the FDA, the recommended dose for Jetrea (NDC 24856-0001-00) is 0.125 mg. Use of the contents of an entire single-use vial to obtain one recommended dose for one eye of one patient per the FDA-approved label would result in reporting 4 units of C9298 on a claim.

In addition, as indicated in 42 CFR 414.904 (See <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=769ce9ced61112db9a3240a3f403e23c&rgn=div8&view=text&node=42:3.0.1.1.1.11.1.3&idno=42>), CMS calculates an average sales price (ASP) payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label, and any additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit. In addition, no payment is made for amounts of product in excess of that reflected on the FDA-approved label.

Additional information related to HCPCS code J7315 (Mitomycin, ophthalmic, 0.2 mg):

HCPCS Code J7315 should only be used for Mitosol and should not be used for compounded mitomycin or other forms of mitomycin.

Flucelvax (Influenza virus vaccine)

Flucelvax (Influenza virus vaccine) was approved by the FDA on November 20, 2012. Although this vaccine recently received FDA approval, CPT® code 90661, which was established by the CPT® editorial panel effective January 1, 2008, describes Flucelvax.

Since January 1, 2008, CPT® code 90661 has been assigned to OPSS status indicator “E” (not covered by Medicare) because the product associated with this code had not received FDA approval until recently. CMS is revising the status indicator for CPT® code 90661 from “E” to “L” (Influenza vaccine; pneumococcal pneumonia vaccine) effective November 20, 2012. This change will be reflected in the April 2013 I/OCE. Table 5, provides the descriptors and OPSS status indicator for CPT® code 90661.

Table 5 – Flucelvax Flu Vaccine OPSS status indicator

HCPCS code	Short descriptor	Long descriptor	APC	SI effective 11/20/12
90661	Flu vacc cell cult prsv free	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use	N/A	L

Updated payment rates for certain HCPCS codes effective January 1, 2013, through March 31, 2013

The payment rates for two HCPCS codes: J9263 and Q4106 were incorrect in the January 2013 OPSS Pricer.

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OPPS (continued)

The corrected payment rates are listed in Table 6 (also included in Attachment A, CR 8228), and they have been installed in the April 2013 OPSS Pricer, effective for services furnished on January 1, 2013, through March 31, 2013. Your contractor will adjust any claims previously processed with the incorrect rates if you bring such claims to the attention of your contractor.

Table 6 – Updated payment rates for HCPCS codes effective January 1, 2013, through March 31, 2013

HCPCS code	SI	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9263	K	1738	Oxaliplatin	\$3.95	\$0.79
Q4106	K	1245	Dermagraft	\$42.55	\$8.51

Changes to OPSS Pricer logic

Effective April 1, the OPSS Pricer will respond to hospital billed lines that contain the stereotactic radiosurgery services reimbursed under APC 0127 and reduce the reimbursement to APC 0067, unless the hospital is exempted by statute. OPSS Pricer will apply the reduction of reimbursement to line item payment before applying coinsurance logic so that coinsurance is based on the payment amount remaining after the reduction.

Coverage determinations

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

Update to the Medicare Benefit Policy Manual

CR 8228 updates the reference link in the *Medicare Benefit Policy Manual*, Chapter 6, Sections 20.5.2 and 20.7, to the list of hospital outpatient therapeutic services that may be furnished under general supervision or are defined as non-surgical extended duration therapeutic services (NSEDTS). The updated link is <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website. The revised list of services reflects changes in the required supervision level for certain services in 2012 and 2013, based upon the recommendations of the hospital outpatient payment panel.

Additional information

The official instruction, CR 8228, issued to your FIs, RHHIs, and A/B MACs regarding this change via two transmittals. The first updates the *Medicare Benefit Policy Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R169BP.pdf>. The second updates the “*Medicare Claims Processing Manual*” and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2664CP.pdf> on the CMS website

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

MLN Matters® Number: MM8228
 Related Change Request (CR) #: CR 8228
 Related CR Release Date: March 1, 2013
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April 2013 Medicare physician fee schedule database update

Provider types affected

This *MLN Matters*® article is for physicians and other providers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FI), A/B Medicare administrative contractors (A/B MAC), and regional home health intermediaries (RHHI)) for services paid under the Medicare physician fee schedule (MPFS).

What you need to know

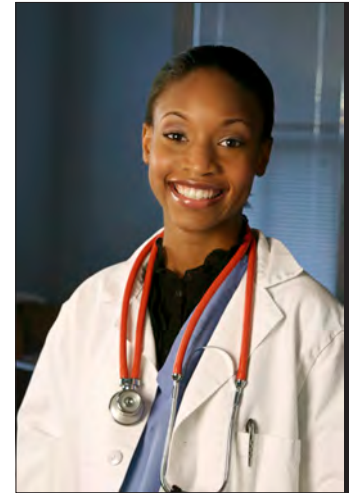
This article is based on change request (CR) 8169 and instructs Medicare contractors to download and implement a new Medicare physician fee schedule data base (MPFSDB), effective January 1, 2013.

Background

Section 1848 (c) (4) of the Social Security Act (see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) authorizes the U.S. Secretary of Health and Human Services to establish ancillary policies necessary to implement relative values for physicians' services.

CR 8169, from which this article is taken, announces that the MPFSDB has been updated effective January 1, 2013; and new payment files have been created in order to reflect appropriate payment policy in line with the 2013 MPFS final rule, published in the *Federal Register* on November 16, 2012, as modified by the final rule correction notice, published in the *Federal Register* on January 2, 2013, and relevant statutory changes applicable January 1, 2013. The summary of changes in the April 2013 update consists of the following (all other indicators remain the same):

- 0309T Global indicator is being corrected to “ZZZ” (add-on). This change took effect January 1, 2013.
- For 36222 – 36228, their bilateral indicators are being corrected to “1” = 150 percent payment adjustment applies if billed with modifier 50. This change took effect January 1, 2013.
- 90785 Global indicator is being corrected to “ZZZ” (add-on). This change took effect January 1, 2013.
- The code short descriptors in the table on below are being corrected or adjusted as shown. These changes took effect January 1, 2013.



HCCPS code	Old short description	Revised short description
19301	Partical mastectomy	Partial mastectomy
31648	Bronchial valve addl insert	Bronchial valve remov init
31649	Bronchial valve remov init	Bronchial valve remov addl
31651	Bronchial valve remov addl	Bronchial valve addl insert
87631	Resp virus 3-11 targets	Resp virus 3-5 targets
95907	Motor&sens 1-2 nrv cndj tst	Nvr cndj tst 1-2 studies
95908	Motor&sens 3-4 nrv cndj tst	Nrv cndj tst 3-4 studies
95909	Motor&sens 5-6 nrv cndj tst	Nrv cndj tst 5-6 studies
95910	Motor&sens 7-8 nrv cndj test	Nrv cndj test 7-8 studies
95911	Motor&sen 9-10 nrv cndj test	Nrv cndj test 9-10 studies
95912	Motor&sen 11-12 nrv cnd test	Nrv cndj test 11-12 studies
95913	Motor&sens 13/> nrv cnd test	Nrv cndj test 13/> studies
95907-26	Motor&sens 1-2 nrv cndj tst	Nvr cndj tst 1-2 studies
95908-26	Motor&sens 3-4 nrv cndj tst	Nrv cndj tst 3-4 studies
95909-26	Motor&sens 5-6 nrv cndj tst	Nrv cndj tst 5-6 studies
95910-26	Motor&sens 7-8 nrv cndj test	Nrv cndj test 7-8 studies
95911-26	Motor&sen 9-10 nrv cndj test	Nrv cndj test 9-10 studies
95912-26	Motor&sen 11-12 nrv cnd test	Nrv cndj test 11-12 studies

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Physician (continued)

HCPSC code	Old short description	Revised short description
95913-26	Motor&sens 13/> nrv cnd test	Nrv cndj test 13/> studies
95907-TC	Motor&/sens 1-2 nrv cndj tst	Nvr cndj tst 1-2 studies
95908-TC	Motor&/sens 3-4 nrv cndj tst	Nrv cndj tst 3-4 studies
95909-TC	Motor&/sens 5-6 nrv cndj tst	Nrv cndj tst 5-6 studies
95910-TC	Motor&sens 7-8 nrv cndj test	Nrv cndj test 7-8 studies
95911-TC	Motor&sen 9-10 nrv cndj test	Nrv cndj test 9-10 studies
95912-TC	Motor&sen 11-12 nrv cnd test	Nrv cndj test 11-12 studies
95913-TC	Motor&sens 13/> nrv cnd test	Nrv cndj test 13/> studies
0195T	Arthrod presac interbody	Prescrl fuse w/o instr L5/S1
0196T	Arthrod presac interbody eac	Prescrl fuse w/o instr L4/L5
0206T	Pptr dbs alys car elec dta	Cptr dbs alys car elec dta
90700	Dtap vaccine > 7 yrs im	Dtap vaccine < 7 yrs im
90702	Dt vaccine > 7 yrs im	Dt vaccine < 7 yrs im

- G9157 will become an active code with a Procstat of “A” and a PC/TC indicator of “2” = Professional component only. Payment amounts are being included. All other indicators remain the same. This change took effect January 1, 2013.
- 33961 Global indicator is being corrected to “XXX”. This change took effect January 1, 2013.
- The TC components of the following nerve conduction test: 95907, 95908, 95909, 95910, 95911, 95912, and 95913, are having their physician supervision of diagnostic procedures indicators adjusted to “7A” = “Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.” (“77” = “Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under general supervision of a physician (TC only; PC always physician)”). These changes took effect January 1, 2013.
- 81161 is being added to the fee schedule with a Procstat of “X” = Statutory exclusion. This change took effect January 1, 2013.
- Q0507, Q0508, Q0509 are being added to the fee schedule with Procstat indicators of “E” = Excluded from physician fee schedule by regulation. These codes take effect April 1.
- The Procstat indicator of 3750F, 4142F, 6150F, 3517F is changing to “M” effective April 1.
- The Procstat indicator of G8559, G8560, G8561, G8562, G8563, G8564, G8565, G8566, G8567, G8568, Q0505 is changing to “I” effective April 1.
- For 23000, 32997, 32998, their bilateral indicators are being corrected to “1” = 150 percent payment adjustment applies if billed with modifier 50. These changes are effective April 1.

Additional information

The official instruction, CR 8169, issued to your carrier, FI, A/B MAC, or RHHI regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2663CP.pdf>.

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

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April update for 2013 DMEPOS fee schedule

Provider types affected

This *MLN Matters*® article is for physicians, other providers, and suppliers submitting claims to Medicare contractors (A/B Medicare administrative contractors (MACs), carriers, and durable medical equipment MACs (DME MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider action needed

This article is based on change request (CR) 8204 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure staffs are aware of changes.

Background

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

Key points of CR 8204

The coverage indicators for healthcare common procedure coding system (HCPCS) codes L8680, L8682, L8683, L8684, L8685, L8686, L8687, and L8688 have changed from invalid for Medicare (“I”) to special coverage instructions apply (“D”), effective January 1, 2013. This change to the coverage indicators for codes L8680 and L8682 through L8688 are noted in the 2013 HCPCS correction file, posted at <http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html>.

The 2013 fee schedule amounts for HCPCS codes L8680 and L8682 through L8688 are in the following table. The fee schedule amounts for these codes were updated for 2013 by applying the 2013 0.8 percent update factor to the 2012 fee schedule amounts.

Note: These codes are all categorized as “prosthetic/orthotic” and fall under the claim processing jurisdiction of local carriers rather than the DME MACs.

State	L8680	L8682	L8683	L8684	L8685	L8686	L8687	L8688
AL	\$432.04	\$5,607.35	\$4,935.72	\$648.16	\$12,299.59	\$7,848.15	\$16,006.69	\$10,213.57
AR	\$432.00	\$5,606.82	\$4,935.27	\$726.11	\$12,298.45	\$7,847.38	\$16,005.21	\$10,212.60
AZ	\$440.40	\$5,715.74	\$5,031.17	\$732.55	\$12,537.39	\$7,999.88	\$16,316.14	\$10,411.02
CA	\$440.40	\$5,715.74	\$5,031.17	\$732.55	\$12,537.39	\$7,999.88	\$16,316.14	\$10,411.02
CO	\$440.03	\$5,710.88	\$5,026.89	\$743.25	\$12,526.69	\$7,993.03	\$16,302.26	\$10,402.12
CT	\$419.40	\$5,443.44	\$4,791.47	\$633.34	\$11,940.07	\$7,618.70	\$15,538.80	\$9,915.01
DC	\$421.17	\$5,466.07	\$4,811.39	\$738.58	\$11,989.72	\$7,650.40	\$15,603.42	\$9,956.24
DE	\$421.17	\$5,466.07	\$4,811.39	\$738.58	\$11,989.72	\$7,650.40	\$15,603.42	\$9,956.24
FL	\$432.04	\$5,607.35	\$4,935.72	\$648.16	\$12,299.59	\$7,848.15	\$16,006.69	\$10,213.57
GA	\$432.04	\$5,607.35	\$4,935.72	\$648.16	\$12,299.59	\$7,848.15	\$16,006.69	\$10,213.57
IA	\$431.78	\$5,603.95	\$4,932.79	\$790.76	\$12,292.16	\$7,843.39	\$15,997.03	\$10,207.38
ID	\$435.71	\$5,654.72	\$4,977.44	\$736.69	\$12,403.49	\$7,914.43	\$16,141.88	\$10,299.82
IL	\$441.29	\$5,727.21	\$5,041.26	\$791.05	\$12,562.56	\$8,015.93	\$16,348.90	\$10,431.93
IN	\$441.29	\$5,727.21	\$5,041.26	\$791.05	\$12,562.56	\$8,015.93	\$16,348.90	\$10,431.93
KS	\$431.78	\$5,603.95	\$4,932.79	\$790.76	\$12,292.16	\$7,843.39	\$15,997.03	\$10,207.38
KY	\$432.04	\$5,607.35	\$4,935.72	\$648.16	\$12,299.59	\$7,848.15	\$16,006.69	\$10,213.57
LA	\$432.00	\$5,606.82	\$4,935.27	\$726.11	\$12,298.45	\$7,847.38	\$16,005.21	\$10,212.60

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DMEPOS (continued)

State	L8680	L8682	L8683	L8684	L8685	L8686	L8687	L8688
MA	\$419.40	\$5,443.44	\$4,791.47	\$633.34	\$11,940.07	\$7,618.70	\$15,538.80	\$9,915.01
MD	\$421.17	\$5,466.07	\$4,811.39	\$738.58	\$11,989.72	\$7,650.40	\$15,603.42	\$9,956.24
ME	\$419.40	\$5,443.44	\$4,791.47	\$633.34	\$11,940.07	\$7,618.70	\$15,538.80	\$9,915.01
MI	\$441.29	\$5,727.21	\$5,041.26	\$791.05	\$12,562.56	\$8,015.93	\$16,348.90	\$10,431.93
MN	\$441.29	\$5,727.21	\$5,041.26	\$791.05	\$12,562.56	\$8,015.93	\$16,348.90	\$10,431.93
MO	\$431.78	\$5,603.95	\$4,932.79	\$790.76	\$12,292.16	\$7,843.39	\$15,997.03	\$10,207.38
MS	\$432.04	\$5,607.35	\$4,935.72	\$648.16	\$12,299.59	\$7,848.15	\$16,006.69	\$10,213.57
MT	\$440.03	\$5,710.88	\$5,026.89	\$743.25	\$12,526.69	\$7,993.03	\$16,302.26	\$10,402.12
NC	\$432.04	\$5,607.35	\$4,935.72	\$648.16	\$12,299.59	\$7,848.15	\$16,006.69	\$10,213.57
ND	\$440.03	\$5,710.88	\$5,026.89	\$743.25	\$12,526.69	\$7,993.03	\$16,302.26	\$10,402.12
NE	\$431.78	\$5,603.95	\$4,932.79	\$790.76	\$12,292.16	\$7,843.39	\$15,997.03	\$10,207.38
NH	\$419.40	\$5,443.44	\$4,791.47	\$633.34	\$11,940.07	\$7,618.70	\$15,538.80	\$9,915.01
NJ	\$419.40	\$5,443.44	\$4,791.47	\$633.34	\$11,940.07	\$7,618.70	\$15,538.80	\$9,915.01
NM	\$432.00	\$5,606.82	\$4,935.27	\$726.11	\$12,298.45	\$7,847.38	\$16,005.21	\$10,212.60
NV	\$440.40	\$5,715.74	\$5,031.17	\$732.55	\$12,537.39	\$7,999.88	\$16,316.14	\$10,411.02
NY	\$419.40	\$5,443.44	\$4,791.47	\$633.34	\$11,940.07	\$7,618.70	\$15,538.80	\$9,915.01
OH	\$441.29	\$5,727.21	\$5,041.26	\$791.05	\$12,562.56	\$8,015.93	\$16,348.90	\$10,431.93
OK	\$432.00	\$5,606.82	\$4,935.27	\$726.11	\$12,298.45	\$7,847.38	\$16,005.21	\$10,212.60
OR	\$435.71	\$5,654.72	\$4,977.44	\$736.69	\$12,403.49	\$7,914.43	\$16,141.88	\$10,299.82
PA	\$421.17	\$5,466.07	\$4,811.39	\$738.58	\$11,989.72	\$7,650.40	\$15,603.42	\$9,956.24
RI	\$419.40	\$5,443.44	\$4,791.47	\$633.34	\$11,940.07	\$7,618.70	\$15,538.80	\$9,915.01
SC	\$432.04	\$5,607.35	\$4,935.72	\$648.16	\$12,299.59	\$7,848.15	\$16,006.69	\$10,213.57
SD	\$440.03	\$5,710.88	\$5,026.89	\$743.25	\$12,526.69	\$7,993.03	\$16,302.26	\$10,402.12
TN	\$432.04	\$5,607.35	\$4,935.72	\$648.16	\$12,299.59	\$7,848.15	\$16,006.69	\$10,213.57
TX	\$432.00	\$5,606.82	\$4,935.27	\$726.11	\$12,298.45	\$7,847.38	\$16,005.21	\$10,212.60
UT	\$440.03	\$5,710.88	\$5,026.89	\$743.25	\$12,526.69	\$7,993.03	\$16,302.26	\$10,402.12
VA	\$421.17	\$5,466.07	\$4,811.39	\$738.58	\$11,989.72	\$7,650.40	\$15,603.42	\$9,956.24
VT	\$419.40	\$5,443.44	\$4,791.47	\$633.34	\$11,940.07	\$7,618.70	\$15,538.80	\$9,915.01
WA	\$435.71	\$5,654.72	\$4,977.44	\$736.69	\$12,403.49	\$7,914.43	\$16,141.88	\$10,299.82
WI	\$441.29	\$5,727.21	\$5,041.26	\$791.05	\$12,562.56	\$8,015.93	\$16,348.90	\$10,431.93
WV	\$421.17	\$5,466.07	\$4,811.39	\$738.58	\$11,989.72	\$7,650.40	\$15,603.42	\$9,956.24
WY	\$440.03	\$5,710.88	\$5,026.89	\$743.25	\$12,526.69	\$7,993.03	\$16,302.26	\$10,402.12
AK	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HI	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
PR	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
VI	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

- Take note that the 2013 fee schedule amounts for HCPCS codes L8680 and L8682 through L8688 will not appear on the 2013 DMEPOS fee schedule files. A separate public use file containing only the 2013 fee schedule amounts for codes L8680, and L8682 through L8688 is available for download on the CMS DMEPOS fee schedule website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html>.

(continued on next page)

DMEPOS *(continued)***Diabetic testing supplies**

- In accordance with Section 636(b) of the American Taxpayer Relief Act of 2012 (ATRA), effective for claims with dates of service on or after April 1, 2013, the 2009 fee schedule covered item update for non-mail order diabetic supplies is revised from 5 percent to -9.5 percent. Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as listed with the HCPCS codes below. As part of this update, the fee schedule amounts for these codes have been revised to reflect the change in the 2009 covered item update.
- A4233 Replacement Battery, Alkaline (Other Than J Cell), For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4234 Replacement Battery, Alkaline, J Cell, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4235 Replacement Battery, Lithium, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4236 Replacement Battery, Silver Oxide, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4253 Blood Glucose Test or Reagent Strips for Home Glucose Monitor, Per 50 Strips.
- A4256 Normal, Low and High Calibration Solution / Chips.
- A4258 Spring-powered Device for Lancet, Each.
- A4259 Lancets, Per Box of 100.

Also, effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the ATRA, the fee schedule amounts for non-mail order diabetic supplies will be further adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established in implementing the national mail order competitive bidding program under Section 1847 of the Social Security Act. The national competitive bidding program for mail order diabetic supplies is scheduled to take effect July 1, 2013. The definitions of mail order item and non-mail order item set forth in 42 CFR 414.402 is:

- Mail order item (KL HCPCS modifier) – Any item shipped or delivered to the beneficiary’s home, regardless of the method of delivery.
- Non-mail order item (KL modifier not applicable) – Any item that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront.

A CR instruction will be released for the July update to the 2013 DMEPOS fee schedule file to incorporate new national payment amounts. These amounts will be updated each time the amounts established in accordance with Section 1847 of the Act are updated. The single payment amount public use file for the national mail order competitive bidding program will be available at www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home.

Additional information

The official instruction, CR 8204 issued to your carrier, DME/MAC, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2661CP.pdf>. Current and past DMEPOS fee schedules can be viewed at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>. If you have any questions, please contact your carrier, DME/MAC, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.

MLN Matters® Number: MM8204

Related Change Request (CR) #: CR 8204

Related CR Release Date: February 22, 2013

Effective Date: January 1, 2013, for codes in effect on January 1, 2013; April 1, 2013, for all other changes.

Related CR Transmittal #: R2661CP

Implementation Date: April 1, 2013

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Medicare adjusts travel allowance fees for collection of specimens

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8203 which informs Medicare contractors and providers about changes to the clinical lab fee schedule related to travel allowances and specimen collection fees.

CR 8203 revises the payment of travel allowances when billed on a per mileage basis using health care common procedure coding system (HCPCS) code P9603 and when billed on a flat rate basis using HCPCS code P9604 for 2013. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Travel codes allow for payment either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. Medicare contractor discretion allows Medicare contractors to choose either a mileage basis or a flat rate, and how to set each type of allowance. Because of audit evidence that some laboratories abused the per mileage fee basis by claiming travel mileage in excess of the minimum distance necessary for a laboratory technician to travel for specimen collection, many Medicare contractors established local policy to pay on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the contractor.

Medicare Part B, allows payment for a specimen collection fee and travel allowance, when medically

necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Act. Payment for these services is made based on the clinical laboratory fee schedule.

New mileage rates

The new rate for HCPCS code P9603, where the average trip to patients' homes exceeds 20 miles round trip, is \$0.565 per mile, plus an additional \$0.45 per mile to cover the technician's time and travel costs, for a total of \$1.015 per mile. The actual total of \$1.015 is then rounded up to \$1.02 due to processing systems capabilities. Higher rates may be established if local conditions warrant it.

The new rate for HCPCS code P9604 is paid on a flat-rate trip basis travel allowance of \$10.15.

Note: Claims for these services will not be automatically adjusted. Providers must bring any previously paid claims to their contractors' attention.

Additional information

The official instruction, CR 8203, issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2675CP.pdf>.

More information may be found in Chapter 16, Section 60.2 of the *Medicare Claims Processing Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf>.

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

MLN Matters[®] Number: MM8203
 Related Change Request (CR) #: CR 8203
 Related CR Release Date: March 15, 2013
 Effective Date: January 1, 2013
 Related CR Transmittal #: R2675CP
 Implementation Date: June 17, 2013

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Inpatient prospective payment system hospital payment extensions per the American Taxpayer Relief Act of 2012

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8214 which provides information and implementation instructions for Sections 605 and 606 of the American Taxpayer Relief Act of 2012. See the *Background* and *Additional information* sections of this article for further details regarding these changes. Also, make sure that your staffs are aware of these changes.

Background

On January 2, 2013, President Obama signed into law the American Taxpayer Relief Act (ATRA) of 2012. See <http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf>. The new law extends several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (see <http://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.pdf> on the Internet). It also extends several provisions of the Affordable Care Act (see <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf> on the Internet). Specifically, the following Medicare Fee-For-Service (FFS) policies (with October 1, 2012, effective dates) have been extended.

Section 605 – Extension of Inpatient Hospital Payment Adjustment for Low-Volume Hospitals

The Affordable Care Act provided for temporary changes to the qualifying criteria and payment adjustment for low-volume hospitals for fiscal years 2011 and 2012. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This ATRA provision extends those temporary changes to the low-volume hospital payment adjustment through September 30, 2013, retroactive to October 1, 2012.

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 ATRA provision extends the MDH program until October 1, 2013, and is retroactive to October 1, 2012.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2013

Sections 3125 and 10314 of the Affordable Care Act amended the low-volume hospital adjustment



in Section 1886(d)(12) of the Social Security Act by revising, for 2011 and 2012, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment.

Prior to the recently enacted ATRA, beginning with 2013, the low-volume hospital qualifying criteria and payment adjustment had returned to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act. Section 605 of the ATRA extends, for 2013, the temporary changes in the low-volume hospital payment policy provided for in FYs 2011 and 2012 by the Affordable Care Act.

The Centers for Medicare & Medicaid Services (CMS) implemented the changes to the low-volume payment adjustment provided by the Affordable Care Act in the regulations at 42 CFR 412.101 in the 2011 IPPS/LTCH PPS final rule (75 FR 50238 through 50275) and intends to make conforming changes to the regulations at 42 CFR 412.101 for the provisions of section 605 of the ATRA in future rulemaking. You can review 42 CFR 412.101 at http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=62266c93cbd0d7a0f60ac0310d069e63&tpl=/ecfrbrowse/Title42/42cfr412_main_02.tpl.

To implement the extension of the temporary change in the low-volume hospital payment policy for 2013 provided for by Section 605 of the ATRA, in accordance with the existing regulations at 42 CFR 412.101(b)(2)(ii) and consistent with the CMS implementation of those changes in 2011 and 2012, CMS published a notice in the *Federal Register* (CMS-1588-N) updating discharge data source used to identify qualifying low volume hospitals and calculate the payment adjustment for 2013.

In that notice, CMS established that for 2013, the low-volume payment adjustment will be determined using 2011 Medicare discharge data from the March 2012 update of the MedPAR files. In Table 14 of the Addendum to that notice, CMS provides a list of the inpatient prospective payment system (IPPS) hospitals

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Inpatient *(continued)*

with fewer than 1,600 Medicare discharges based on the March 2012 update of the 2011 MedPAR files.

However, this list of IPPS hospitals with fewer than 1,600 Medicare discharges is not a listing of the hospitals that qualify for the low-volume adjustment in FY 2013 since it does not reflect whether or not the hospital meets the mileage criterion (that is, to qualify for the low-volume adjustment, the hospital also must be located more than 15 road miles from any other IPPS hospital).

In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for 2013, a hospital must meet both the discharge and mileage criteria.

In order to receive a low-volume hospital payment adjustment for 2013, consistent with the previously established procedure, CMS is continuing to require a hospital to notify and provide documentation to its FI or MAC that it meets the mileage criterion. For 2013, a hospital should make its request for low-volume hospital status in writing to its FI or MAC and provide documentation that it meets the mileage criterion by March 22, 2013, so that the applicable low-volume percentage increase can be applied to payments for its discharges occurring on or after October 1, 2012, (that is, the beginning of 2013).

A hospital that qualified for the low-volume payment adjustment in 2012 may continue to receive a low-volume payment adjustment in 2013, without reapplying, if it continues to meet the Medicare discharge criterion, based on the 2011 MedPAR data (shown in Table 14 of the *Federal Register* notice (available on the Internet as noted below) and the distance criterion.

However, the hospital must verify in writing to its FI or MAC that it continues to be more than 15 miles from any other “subsection (d)” hospital no later than March 22, 2013, in order for the applicable low-volume percentage increase be applied retroactively to payments for discharges occurring on or after October 1, 2012.

For requests for low-volume hospital status for 2013 received after March 22, 2013, if the hospital meets the criteria to qualify as a low-volume hospital, the FI or MAC will apply the applicable low-volume payment adjustment in determining payments to the hospital's 2013 discharges prospectively effective within 30 days of the date of the FIs or MACs status determination.

FIs/MACs will verify that the hospital meets the discharge criteria by using the Medicare discharges based on the March 2012 update of the 2011 MedPAR files as shown in Table 14 of the *Federal Register* Notice (CMS-1588-N) and available on the Internet at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html> (click on the link on the left side of the screen titled,



“FY 2013 IPPS Final Rule Home Page”). (CMS notes that in order to facilitate administrative implementation, the only source that CMS and the FIs/MACs will use to determine the number of Medicare discharges for purposes of the low-volume payment adjustment for 2013 is the data from the March 2012 update of the 2011 MedPAR file.)

The applicable low-volume payment adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, disproportionate share hospital (DSH), indirect medical education (IME), and outliers.

For sole-community hospitals (SCHs) and Medicare dependent hospitals (MDHs), the applicable low-volume percentage increase 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.

Reinstatement of dependent hospital status

In Section 606 of the ATRA, Congress reinstated the MDH program which had expired as of October 1, 2012. Generally, providers that were classified as MDHs prior to the expiration of the MDH provision will be reinstated as MDHs effective October 1, 2012, with no need to reapply for MDH classification. There are two exceptions:

MDHs that classified as sole-community hospitals (SCHs) on or after October 1, 2012 – In anticipation of the expiration of MDH, CMS allowed MDHs that applied for classification as an SCH by August 31, 2012, to be granted such status effective with the expiration of the MDH program. Hospitals that applied and were approved for SCH classification, received SCH status as of October 1, 2012.

Additionally, some hospitals that had MDH status as of the September 30, 2012, expiration of the MDH program may have missed the August 31, 2012, application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later

(continued on next page)

Inpatient *(continued)*

than October 1, 2012.

MDHs that requested a cancellation of their rural classification - In order to meet the criteria to become an MDH, a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at 42 CFR 412.103 at http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=62266c93cbd0d7a0f60ac0310d069e63&tpl=/ecfrbrowse/Title42/42cfr412_main_02.tpl on the Internet. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to October 1, 2012. All other former MDHs will be automatically reinstated as MDHs effective October 1, 2012. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations. Specifically, the regulations at 42 CFR 412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (412.108(b)(2)).
2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital (412.108(b)(4)).

Cancellation of MDH status

As required by the regulations at 42 CFR 412.108(b) (5), Medicare contractors must "evaluate on an ongoing basis" whether or not a hospital continues to qualify for MDH status. Therefore, the contractors will ensure that the hospital continues to meet the MDH criteria and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the contractor

provides written notification to the hospital.

It is important to note that despite the fact some providers do not qualify as MDHs, based on their Medicare utilization rates not meeting the threshold for MDH classification, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2012, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

Claims processing

Note that any claims impacted by the above provisions, i.e., those with a discharge date on or after October 1, 2012, through the implementation of the IPPS Pricer on April 1, 2013, will be reprocessed by your Medicare contractor. Further, such claims should be reprocessed on or before June 30, 2013.

Additional information

The official instruction, CR 8214 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/R11950TN.pdf>.

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

MLN Matters® Number: MM8214
 Related Change Request (CR) #: CR 8214
 Related CR Release Date: March 1, 2013
 Effective Date: October 1, 2012
 Related CR Transmittal #: R11950TN
 Implementation Date: April 1, 2013

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2013 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing may be accessed at <http://medicare.fcso.com/MEDPARD/>.

Source: CMS IOM Publication 100-04, Transmittal 2567, CR 8055

Reorganization of Chapter 13 of Medicare policy manual

Provider types affected

This *MLN Matters*[®] article is intended for physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs) for services provided in rural health clinics (RHCs) and federally qualified health centers (FQHCs) to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7824, which updates and reorganizes Chapter 13 of the “*Medicare Benefit Policy Manual*.” This chapter deals with Medicare RHCs and FQHCs. Chapter 13 is reorganized for easier use and updated to include more comprehensive information. There are no new policies contained in the manual.

Additional information

The official instruction, CR 7824 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/R166BP.pdf>.

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

MLN Matters[®] Number: MM7824

Related Change Request (CR) #: CR 7824

Related CR Release Date: January 31, 2013

Effective Date: March 1, 2013

Related CR Transmittal #: R166BP

Implementation Date: March 1, 2013

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Current status of the \$3,700 therapy threshold manual medical review

For dates of service rendered October 1, 2012, through December 31, 2012

The Centers for Medicare & Medicaid Services (CMS) instructed Medicare administrative contractors to discontinue the preapproval process for therapy services with dates of services October 1, 2012, through December 31, 2012, as of December 17, 2012.

All preapproval requests received through December 18, 2012, have been completed by First Coast and decisions mailed to providers and beneficiaries.

All therapy claims submitted without preapproval for beneficiaries who have exceeded the \$3,700 therapy threshold will be subject to prepayment medical review.

Claims should be submitted in the usual manner. You must respond to all additional documentation requests.

For dates of service January 1, 2013, through December 31, 2013

Until further notice from CMS, all claims for therapy services that exceed the \$3,700 therapy threshold will be subject to prepayment medical review.

Once the beneficiary's claim is flagged for exceeding the \$3,700 therapy threshold, an additional documentation request will be sent asking for records to support medical necessity. You must respond to all additional documentation requests.

Although CMS is encouraging contractors to complete the medical review of records within 10 business days, it is important to remember that the 10 business days do not include claims processing or finalization timeframes.

Note: Providers are encouraged to utilize PWK for faxing documentation when appropriate. You may obtain additional information regarding PWK at http://medicare.fcso.com/EDI_news/203963.asp.

Educational Events

Provider outreach and educational events – April/May 2013

Medicare Part A: Medical review of outpatient therapy services

When: Tuesday, April 30

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: May 21-22

Location: Renaissance Tampa-International Plaza Hotel

Time: All Day **Delivery language:** English

Type of Event: Educational Seminar **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

- 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.
- 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.fcsso.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.fcsso.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': February 21, 2013, 2012 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-21-Enews.pdf>
- 'CMS Medicare FFS Provider e-News': February 28, 2013 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-28Enews.pdf>
- 'CMS Medicare FFS Provider e-News': March 7, 2013 – <https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-07-eNews.pdf>
- 'CMS Medicare FFS Provider e-News': March 14, 2013 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-14-eNews.pdf>

Source: CMS PERL 201302-03, 201302-04, 201303-01, 201303-03

Join First Coast in its signature annual educational event

Medifest 2013

Tampa – May 21-22

Renaissance Tampa International Plaza Hotel

Tallahassee – July 24-25

Four Points By Sheraton Tallahassee Downtown

Register in First Coast University today!

www.fcsouniversity.com

Addresses

First Coast Service Options

American Diabetes Association certificates

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

Claims/correspondence

Florida:

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

U.S. Virgin Islands:

First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

Electronic claim filing

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

Fraud and abuse

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

Freedom of Information Act requests

(relative to cost reports and audits)

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

Local coverage determinations

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

Medicare secondary payer (MSP) General information, conditional payment

Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital protocols, admission questionnaires, audits

MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, automobile accident cases, settlements/lawsuits, liabilities

Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections

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

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

Post-pay medical review

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

Provider enrollment

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

Redetermination

Florida:

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

U.S. Virgin Islands:

First Coast Service Options Inc.
P. O. Box 45097
Jacksonville, FL 32232-5097

Special delivery mail and courier services

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

Other Medicare carriers and intermediaries

Durable medical equipment regional carrier (DMERC)

DME, orthotic and prosthetic device, take-home supply, and oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare

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

Regional home health and hospice intermediary

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

Phone numbers

Customer service/IVR

Providers:

888-664-4112

Speech and hearing impaired

877-660-1759

Beneficiaries:

800-MEDICARE (800-633-4227)

Speech and hearing impaired

800-754-7820

Credit balance report

Debt recovery

904-791-6281

Fax

904-361-0359

Electronic data interchange

888-670-0940

Option 1 – Transaction support

Option 2 – PC-ACE support

Option 3 – Direct data entry (DDE)

Option 4 – Enrollment support

Option 5 – 5010 testing

Option 6 – Automated response line

Provider audit and reimbursement

904-791-8430

Provider education and outreach

Seminar registration hotline

904-791-8103

Seminar registration fax

904-361-0407

Provider enrollment

877-602-8816

Websites

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

medicare.fcso.com

Centers for Medicare & Medicaid Services

Providers:

www.cms.gov

Beneficiaries:

www.medicare.gov

Addresses

Claims

Additional documentation

General mailing

Congressmen mailing

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

Redeterminations

Redeterminations on overpayments

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

Debt recovery (except for MSP)

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

Post-payment medical exams

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

Freedom of Information Act (FOIA*) related requests

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

Medicare fraud and abuse

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

Provider enrollment

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

Electronic Data Interchange (EDI*)

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

MSPRC DPP debt collection – Part A

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

Credit balance

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

Audit and reimbursement department

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

Overnight mail and other special handling postal services

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

Other Medicare carriers and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary

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

Railroad Medicare

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

Phone Numbers

Providers

Customer service – free of charge

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

For the hearing and speech impaired (TDD)

1-888-216-8261

Interactive voice response (IVR)

1-877-602-8816

Beneficiary

Customer service – free of charge

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

For the hearing and speech impaired (TDD)

1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number

1-904-361-0407

Audit And Reimbursement Department

Fax number
1-904-361-0407

Websites

Providers

First Coast – MAC J9

medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services

www.medicare.gov