Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

April 2013

In this issue

Widespread probe results of end-stage renal disease services

Provider types affected

First Coast Service Options Inc. (First Coast) conducted a widespread probe in response to an aberrant billing pattern identified for *CPT® 90960* (End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with four or more face-to-face physician visits per month) billed by specialty 39-Nephrology and 11-Internal Medicine.

Puerto Rico is ranked number two in the nation with a carrier-to-nation ratio of 2.60. A sample of 100 claims was requested among the top performing providers in Puerto Rico. The results of the widespread probe yielded a 51.62 percent error rate.

Twenty one of the one hundred claims were down coded because the documentation did not support the level of service billed. Forty five claims were denied due to:

- no documentation submitted to support the services billed;
- insufficient documentation to support the billed service including no evidence that a face-to face visit was made;
- illegible documentation;
- progress notes not signed by the physician or the physician's signature was illegible; and
- documentation submitted did not match the dates of service requested.

The following is a brief summary of Medicare requirements for billing end-stage renal disease services.

A physician's services, furnished to dialysis patients who are treated as outpatients, are divided into two major categories: direct patient care and administrative services. Medicare covers physician services furnished to beneficiaries on continuous ambulatory peritoneal dialysis (CAPD).

A. Direct patient care services

These services are part of the medical treatment furnished to an individual patient that:

- Are personally furnished by a physician to an individual patient;
- Contribute directly to the diagnosis or treatment of an individual patient; and
- A physician must ordinarily perform.

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

Publication staff:
Terri Drury
Martin Smith
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

ESRD probe *(continued)*

They include:

- Visits to the patient during dialysis, in conjunction with review of laboratory test results, nurses' notes, and any other medical documentation, as a basis for adjustment of the patient's medication or diet or the dialysis procedure, prescription of medical supplies, and evaluation of the patient's psychosocial status and the appropriateness of the treatment modality.
- Medical direction of staff in delivering services to a patient during a dialysis session;
- Pre and post-dialysis examinations where medically appropriate;
- Insertions of a catheter for patients on maintenance peritoneal dialysis who are not provided an indwelling catheter;
- Services which must be furnished at a time other than during the dialysis procedure; e.g., monthly and semi-annual examinations to review health status and treatment; and
- Other services furnished during dialysis; e.g., declotting of shunts, needle insertions into fistulae, care during immediately life-threatening complications related to the dialysis procedure, and care of nonrenal conditions.

B. Administrative services

A component of the facility's cost or charge for dialysis is for "administrative services" furnished by physicians. Administrative services are differentiated from physicians' direct patient care services because they constitute supervision of staff or are not directly related to the care of an individual patient, but benefit all patients and the facility as a whole.

The administrative type of physician's services are services that are supportive of the facility as a whole and have benefit to patients in general. Examples of such services include participation in management of the facility, advice on and procurement of facility equipment and supplies, supervision of staff, staff training, and staff conferences. The carrier will disallow all claims for these services with an explanation that such services are paid as part of the dialysis services that are included in the facility charge for dialysis.

The Centers for Medicare & Medicaid Services (CMS) requires that any Medicare service provided or ordered must be authenticated by the author – the one who provided or ordered that service. Authentication may be accomplished through the provision of a hand-written or an electronic signature; however, stamp signatures are unacceptable.

In addition, any documentation submitted to substantiate the medical necessity for a service billed to Medicare must clearly identify the patient, date of service, and the provider of the service. The purpose of the authentication (signature) requirement is to ensure that the services rendered have been accurately and appropriately documented, reviewed, and authenticated.

CMS outlines signature requirements for medical documentation as well as exceptions to the guidelines in the *Medicare Program Integrity Manual, Pub. 100-08, Chapter 3, Section 3.4.1.1*

ESRD-related visits may be furnished as a Medicare telehealth service and for general Medicare telehealth policy see *Pub. 100-02, Medicare Benefit Policy manual, Chapter 15, Section 270*. For claims processing instructions see *Pub. 100-04, Medicare Claims Processing Manual Chapter 12, Section 190*.

Providers are encouraged to review the complete requirements for billing end-stage renal disease services in the following Internet-only manuals (IOM):

Medicare Claims Processing Manual, Chapter 8, Section 140.

Medicare Benefit Policy Manual, Chapter 11, Section 80.2

The answer is right at your fingertips

Available Monday-Friday, from 10 AM-2 PM ET, First Coast's Live Chat will allow you to connect with a team of experts who will respond to your **website-related inquiries** and help you get the most out of every visit to *medicare.fcso.com*.

Reporting tax identification numbers for CMS-855 forms

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8258, which furnishes guidance regarding the reporting of tax identification numbers (TINs) in Sections 5 and 6 of the Form CMS-855. Make sure that your staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

In Chapter 15 of the "*Medicare Program Integrity Manual*," Section 15.5.6.1 has been added to advise Medicare contractors of new instructions regarding the reporting of TINs of owning and managing organizations and individuals.

The content of the new section is as follows:

Consistent with Sections 1124 and 1124A of the Social Security Act, the TINs (employer identification numbers or social security numbers) of all entities and individuals listed in Sections 5 and 6, respectively, of the Form CMS-855 must be disclosed. If a Medicare contractor receives an initial, reactivation, revalidation, or change of ownership Form CMS-855 application from a provider and the provider fails to disclose the TIN of a particular organization or individual listed in Section 5 or 6, the contractor shall follow normal development procedures for requesting the TIN. In doing so, if the contractor learns or determines that the TIN was not furnished because the entity or person in question is foreign, the contractor shall take the following steps:

a. The contractor shall ask the provider (via any means) whether the person or entity is able to obtain a TIN or, in the case of individuals, an individual taxpayer identification number (ITIN).

(1) If the provider fails to respond to the contractor's inquiry within 30 days, the contractor shall follow the instructions in (c) below.

(2) If the provider states that the person or entity is able to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the person or entity must obtain a TIN/ITIN, and (ii) the provider must furnish the TIN/ITIN on the Form CMS-855 with a newly-signed certification statement within 90 days of the contractor's request.

(3) If the provider states that the person or entity is unable to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the provider must submit written documentation to the contractor explaining why the person or entity cannot legally obtain a TIN or ITIN, and (ii) the explanation – which can be in any written format and may be submitted electronically or via fax – must be submitted within 30 days of the contractor's request.

b. If the provider timely submits the explanation in (a)(3) above, the contractor shall forward the explanation to the appropriate contact at the Centers for Medicare & Medicaid Services (CMS). CMS will notify the contractor as to how the application should be handled.

c. If the provider fails to timely respond to the contractor's inquiry in (a) or fails to timely furnish the TIN/ITIN in (a)(2), the contractor shall – unless another CMS instruction directs otherwise - reject the application in accordance with the procedures identified in Chapter 15.

In addition, for purposes of Section 15.5.6.1 only, the term "change of ownership" - as used in the first paragraph of this section - refers to (1) CHOW, acquisition/merger, and consolidation applications submitted by the new owner, (2) change in majority ownership applications submitted by a home health agency (HHA), and (3) change of information applications in which a new entity or individual (e.g., owner, managing employee, corporate director) is being added in Section 5 or 6.

Additional information

The official instruction, CR 8258 issued to your FI, carrier, RHHI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R459PI.pdf* on the CMS website.

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

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CMS offers new tools for electronic health record incentive programs

The Centers for Medicare & Medicaid Services (CMS) recently added new resources for health care providers as they transition to greater use of electronic health records (EHR).

Stage 2 Tool Kit

In March, CMS released its new interactive *Stage 2 Toolkit*, which includes materials on Stage 2 and the 2014 clinical quality measure (CQM) requirements. Stage 2 represents the second EHR incentive program benchmark in a series for health care providers to show they have converted their business operations from predominantly paper records to conducting tracking and care delivery processes through electronic methods. The toolkit includes the following information:

- An overview of Stage 2
- Stage 2 FAQs
- How the Stage 2 provisions affect Stage 1 requirements
- Comparison tables of Stage 1 and Stage 2 criteria
- Details about payment adjustment and hardship exemptions
- 2014 CQMs, including descriptions, technical release notes, and the recommended core sets for EPs and eligible hospitals

The earliest that the criteria for Stage 2 will be effective is October 1, 2013, for eligible hospitals and critical access hospitals. For eligible professionals such as physicians, the earliest effective date is January 1, 2014. To receive any incentive payment under the Medicare EHR incentive program, providers must enroll before 2014.

Incentive payments

Since January 2011, 180,000 health care providers have received $10.3 billion in payments for participating in the EHR incentive programs. This includes nearly 14 thousand individual providers and 91 hospitals in Florida.

Incentive program audits

CMS performs audits on Medicare providers who are participating in the EHR incentive programs. To help providers gather supporting documentation and prepare for a potential audit, CMS recently added a new fact sheet. The fact sheet and a sample audit request letter for both EPs and eligible hospitals are also available on the *Educational Resources* Web page of the EHR incentive programs website.

Updated FAQs

To keep you updated with information on the EHR incentive programs, CMS also recently added several new FAQs and answers to the *EHR FAQ database*.

Can attestation information submitted for the EHR incentive programs be updated, changed, cancelled or withdrawn after successful submission in the EHR registration and attestation system?

How can an EP that is new to a practice meet the patient volume/practice predominantly criteria to be eligible for the Medicaid EHR Incentive Program?

How should EPs select menu objectives for the Medicare and Medicaid EHR Incentive Programs?

Visit the *Medicare EHR incentive programs* website for answers to these questions and the latest news on the EHR incentive programs.

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

Implementation of the award for the jurisdiction E Medicare administrative contractor

The Centers for Medicare & Medicaid Services (CMS) has awarded the jurisdiction E (JE) A/B Medicare administrative contractor (MAC) contract for the administration of the Part A and Part B Medicare fee-for-service claims in the states and territories of California, Hawaii, Nevada, American Samoa, Guam and the Northern Marianas to Noridian Administrative Services, LLC (NAS).

The J-E workloads (known as jurisdiction 1) are currently being processed by Palmetto Government Benefit Authorizers (PGBA). NAS' address is:

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

For more information about this change, here is the link to the *CR 8226*.

Clarification of duplicate claims section of the CMS Internet–only manual

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

The purpose of this change request (CR) is for clarification only and does not constitute any change in Medicare policy. The Centers for Medicare & Medicaid Services (CMS) is alerting providers to the update of the Medicare Internet-Only Manual (IOM), Chapter 1, Section 120: "Detection of Duplicate Claims."

Caution – What you need to know

Change request (CR) 8121, from which this article is taken, alerts providers that the claims processing systems contain edits which identify duplicate claims and suspect duplicate claims. All exact duplicate claims or claim lines are auto-denied or rejected (absent appropriate modifiers). Suspect duplicate claims and claim lines are suspended and reviewed by the Medicare contractors to make a determination to pay or deny the claim or claim line.

Go – What you need to do

Please be aware that Medicare contractors examine and compare to the prior bill any bill that is identified as a suspect duplicate. If the services (revenue or HCPCS codes) on a claim duplicate the services for the other, contractors will check the diagnosis. If the diagnosis codes are duplicates, contractors will request an explanation before making payment. The official instruction for CR 8121 spells out what your Medicare contractor looks for when analyzing the history of paid and pending claims, duplicate claims and the criteria for detecting suspect duplicate claims.

Background

Some claims that appear to be duplicates are actually claims or claim lines that contain an item or service, or multiple instances of an item or service, for which Medicare payment may be made. Correct coding rules applicable to all billers of health care claims encourage the appropriate use of condition codes or modifiers to identify claims that may appear to be duplicates, but are in fact, not.

For example, there are some Healthcare Common Procedure Coding System (HCPCS) modifiers that are appropriate to be appended to some services and can indicate that a claim line is not a duplicate of a previous line on the claim. Level I modifiers would typically be used by a biller to indicate that a potential duplicate claim or claim line is not, in fact, a duplicate. Level II modifiers may also be used. The Level II modifiers "RT" and "LT," for example, indicate that a service was performed on the right and left side of the body, respectively.

However, not every HCPCS code has an appropriate modifier to indicate that a claim line is not a duplicate. In that case, the claims and claim lines are reviewed by Medicare contactors' local software modules for a determination, or they suspend for contractor review.

Key points of CR 8121

Exact duplicates

A. Submission of institutional claims

Claims or claim lines that have been determined an exact duplicate are rejected and do not have appeal rights. An exact duplicate for institutional claims is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- Health insurance claim (HIC) number;
- Type of bill;
- Provider identification number;
- From date of service;
- Through date of service;
- Total charges (on the line or on the bill); and
- HCPCS, *CPT*®-4, or procedure code modifiers.

Whenever any of the following claim situations occur, your Medicare contractor develops procedures to prevent duplicate payment of claims. This includes, but is not limited to:

- Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider.
- Outpatient bill is submitted for services on the day of an inpatient admission or the day before the day of admission to the same hospital.
- Outpatient bill overlaps an inpatient admission period.
- Outpatient bill for services matches another outpatient bill with a service date for the same revenue code at the same provider or under a different provider number.

B. Claims submitted by physicians, practitioners, and other suppliers (except DMEPOS suppliers)

Claims or claim lines that have been determined an exact duplicate are denied. Such denials may be appealed. An exact duplicate for physician and other

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Duplicate *(continued)*

supplier claims submitted to a MAC or carrier is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- HIC number;
- Provider number;
- From date of service;
- Through date of service;
- Type of service;
- Procedure code;
- Place of Service; and
- Billed amount.

C. Claims submitted by DMEPOS suppliers

Claims or claim lines that have been determined an exact duplicate are denied. Such denials may not be appealed. An exact duplicate for DMEPOS Supplier claims submitted to a DME MAC is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- HIC number;
- From date of service;
- Through date of service;
- Place of service;
- HCPCS;
- Type of service;
- Billed amount; and
- Supplier.

Suspect duplicates

Suspect duplicates are claims or claim lines that contain closely aligned elements and require that the claim be reviewed.

A. Criteria for detecting suspect duplicates on institutional claims

A "suspect duplicate" claim is a claim being processed which, when compared to Medicare's history or pending files, begins with these characteristics:

- Match on the beneficiary information;
- Match on provider identification; and
- Same date of service or overlapping dates of service.

B. Suspect duplicate claims submitted by physicians and other suppliers (including DMEPOS claims)

The criteria for identifying suspect duplicate claims submitted by physicians and other suppliers vary according to the type of billing entity, type of item or service being billed, and other relevant criteria. The denial of claim as a duplicate of another claim may be appealed when the denial is based on criteria other than those specified above for exact duplication.

The purpose of CR 7818 is to both create and update NCD hard-coded Medicare shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes, plus all associated editing such as procedure codes, HCPCS/*CPT*® codes, denial messages, frequency edits, place of service (POS)/type of bill (TOB)/provider specialty editing, etc. The requirements described in CR 7818 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the Medicare NCDs listed as an attachment to CR 7818. To access that attachment, visit *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals-Items/R1122OTN.html*.

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

Additional information

You can find the official instruction, CR 8121, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2678CP.pdf*. If you have any questions, please contact your FI, carrier, A/B MAC, RHHI, or DME MAC at their toll- free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*. If you have questions, please contact your carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Physician delegation of tasks in skilled nursing facilities

Provider types affected

This *MLN Matters*® article special edition (SE) is intended for physicians, non-physician practitioners (NPPs) and providers who bill for services related to beneficiaries in skilled nursing facilities (SNFs) and nursing facilities (NFs).

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is publishing this article to provide clarification of federal guidance regarding Section 3108 of the Affordable Care Act (ACA), related to physician delegation of certain tasks in SNFs and NFs to NPPs (NPPs are formerly "physician extenders") such as nurse practitioners (NPs), physician assistants (PAs), or clinical nurse specialists (CNSs).

This article addresses the authority of NPs, PAs, or CNSs to perform certain tasks such as conducting physician visits and writing orders, and to sign certifications and re-certifications.

Background

CMS is clarifying the regulatory differences concerning physician delegation of tasks in SNFs and NFs. The distinction in policies between these two settings (SNFs and NFs) is based in statute and regulation. Improper application of these regulations may affect a facility's compliance and payment to providers.

The key to accurate application is to identify:

1. In which setting, SNF or NF, the physician services are being provided;
2. Whether the task must be performed personally by the physician; and
3. Whether or not the NPP is employed by the facility.

The "setting" is determined by whether the visit to a patient in a certified bed is:

1. To a resident whose care is paid for by Medicare Part A in a SNF; or
2. To a resident whose care is paid for by Medicaid in a NF.

Key points

The requirements for long-term care facilities, specified in 42 CFR section 483.40(e)(2), provide that, "A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under state law or by the facility's own policies." The following bullets outline when and which tasks may be delegated:

Physician required and other medically necessary visits during a SNF stay:

A required physician visit includes the initial comprehensive visit in a SNF and every alternate required visit thereafter. (See 42 CFR 483.40(c)(4).) The initial comprehensive visit in a SNF is the initial visit during which:

- The physician completes a thorough assessment; and
- Develops a plan of care and writes or verifies admitting orders for the resident.
- The initial comprehensive visit must occur no later than 30 days after a resident's admission into the SNF. The physician may not delegate the initial comprehensive visit in a SNF.
- NPPs may perform other medically necessary visits prior to and after the physician's initial comprehensive visit.
- Once the physician has completed the initial comprehensive visit in the SNF, the physician may then delegate alternate visits to a PA, NP, or CNS who is licensed as such by the State and performing within the scope of practice in that state. These alternate visits, as well as medically necessary visits, may be performed and signed by the NPP (physician co-signature is not required).

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Physician *(continued)*

Certifications/Re-certifications in SNFs:

- 42 CFR 424.20(e)(2) (which reflects the requirements of section 1814 (a)(2) of the Social Security Act (Act)) states that NPs and CNSs who are not employed by the facility and who are working in collaboration with a physician may sign the required initial certification and re- certifications of a beneficiary's need for SNF level of care.

> ***Once the physician has completed the initial comprehensive visit in the SNF, the physician may then delegate alternate visits to a PA, NP, or CNS who is licensed as such by the State and performing within the scope of practice in that State. These alternate visits, as well as medically necessary visits, may be performed and signed by the NPP (physician co-signature is not required).***
>
> - *MLN Matters*® special edition 1308

- Effective with services furnished on or after January 1, 2011, physician assistants who are not employed by the facility are authorized to perform the required initial certification and periodic re-certifications of a beneficiary's need for a SNF level of care.

Performance of Physician Tasks in NFs:

- Similar to a SNF, the initial comprehensive visit in a NF is the initial visit during which:
- The physician completes a thorough assessment; and
- Develops a plan of care and writes or verifies admitting orders for the resident.
- The initial comprehensive visit must occur no later than 30 days after admission.

Note: At the option of the state, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a NP, CNS, or PA who is not an employee of the facility but who is working in collaboration with a physician.

In other words, NPPs that have a direct relationship with a physician and who are not employed by the facility may perform the initial comprehensive visit, any other required physician visit, and other medically necessary visits for a resident of a NF as the state allows. NPPs may also perform other medically necessary visits prior to and after the physician initial comprehensive visit.

Medically necessary visits performed by NPs, CNSs, and PAs employed by the facility may not take the place of the physician required visits, nor may the visit count towards meeting the required physician visit schedule prescribed at 42 CFR 483.40(c)(1). However:

- At the option of the state, NPs, PAs, and CNSs who are employees of the facility, while not permitted to perform visits required under the schedule prescribed at 42 CFR 483.40(c)(1), are permitted to perform other medically necessary visits and write orders based on these visits.
- For example, if a resident complains of a headache, the NP, CNS, or PA employed by the NF may assess the resident and write orders to address the condition;
- The physician is not required, other than by state law as applicable, to verify and sign orders written by NPPs who are employed by the facility for other medically necessary visits; and
- These medically necessary visits performed by NPs, CNSs, and PAs employed by the facility may not take the place of the physician required visits, nor may the visit count towards meeting the required physician visit schedule prescribed at 42 CFR 483.40(c)(1).

NPs, PAs and CNSs must collaborate with a physician:

- In contrast to the initial SNF visit, NPPs may provide initial NF visits and other required visits under 42 CFR 483.40(c)(3) and (f) if the state permits it;
- Required physician tasks, such as verifying and signing orders in an NF, may be delegated to a PA, NP, or CNS who is not an employee of the facility, but who is working in collaboration with a physician; and
- Orders written by an NPP who is employed by the NF and are written during visits that are not required visits, and are therefore "other medically necessary visits," do not require physician co-signature except as mandated by state law.

CMS is issuing this clarification because, where a NPP is permitted to perform a medically necessary visit, the

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Physician *(continued)*

- For residents in a Medicaid stay, the NPP must follow the provisions outlined for care in NFs.
- In a dually-certified nursing home, any required physician task for a Medicaid beneficiary in a Medicaid stay, at the option of the state, may be performed by a NPP who is not an employee of the facility but who is working in collaboration with a physician.

In a dually-certified nursing home and at the option of a physician, required physician visits for a Medicare beneficiary in a Part A Medicare stay may be alternated between personal visits by the physician and visits by a NPP after the physician makes the initial first visit.

The following table summarizes the requirements for NPPs to perform visits, sign orders, and sign certifications and re-certifications, when this function is permitted under the scope of practice for the state.

Authority for NPPs to perform visits, sign orders and sign certifications/re-certifications when permitted by the state*

Provider type	Initial Comprehensive Visit /Orders	Other Required Visits^	Other Medically Necessary Visits & Orders+	Certification/ Recertification
SNFs				
PA, NP & CNS employed by the facility	May not perform/ May not sign	May perform alternate visits	May perform and sign	May not sign
PA, NP & CNS not a facility employee	May not perform/ May not sign	May perform alternate visits	May perform and sign	May sign subject to State requirements
NFs				
PA, NP & CNS employed by the facility	May not perform/ May not sign	May not perform	May perform and sign	Not applicable ±
PA, NP & CNS not a facility employee	May perform/ May sign	May perform	May perform and sign	Not applicable ±

*This reflects clinical practice guidelines

^Other required visits are the required monthly visits.

+Medically necessary visits may be performed prior to the initial comprehensive visit.

± This requirement relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.

Additional information

To review 42 CFR 483.40, go to *http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec483-40.pdf*. To review 42 CFR 424.20 go to *http://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol3/pdf/CFR-2009-title42-vol3-sec424-20.pdf*.

To review the memorandum that is the basis for this article and discusses physician delegation of tasks in SNFs and NFs go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-15-pdf*.

To review the Section 3108 of the Affordable Care Act (page 300), Permitting Physician Assistants To Order Post-Hospital Extended Care Services, go to: *http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf* on the Internet

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CMS releases electronic PEPPER reports for long-term care providers

The Centers for Medicare & Medicaid Services (CMS) recently released fourth quarter 2012 statistical information on long-term acute care hospitals (LTCHs), critical access hospitals (CAHs), inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs), hospices, and partial hospitalization programs (PHPs) from Medicare's Program for Evaluating Payment Patterns Electronic Report (PEPPER).

According to CMS, the PEPPER reports contain a number of changes from previous releases. The April PEPPER reports include:

A new report for long-term acute care hospitals, "short stays for respiratory system diagnoses"

Changes for critical access hospitals include a new report called single complication or co-morbidity (CC) and major complication or co-morbidity (MCC), or "single CC/MCC" and, the discontinuation of the "One-day stays for Chest Pain/Atherosclerosis" report

For partial hospitalization programs, the new PEPPER report revises days of service with 4 units, group therapy, and 60+ days of service measure and modifies the way PHP episodes of care are reported.

Changes for hospice PEPPER reports which include modifications in the way hospice claims are evaluated.

PEPPER is a free report comparing facilities' Medicare billing practices with other similar providers in the state, Medicare administrative contractor (MAC) or fiscal intermediary (FI) jurisdiction, and country. PEPPER reports also summarize provider-specific data statistics for Medicare services that may be at risk for improper payments.

Many providers use PEPPER reports to track areas for improving medical documentation and to develop and implement internal compliance programs to minimize their risk from fraud and abuse. For more information about the PEPPER program, please refer to *CMS' PEPPER user's guide*.

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

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).

Diagnosis code update for add-on payments for blood clotting factor administered to hemophilia inpatients

Note: This article was revised March 22, 2013, to add a reference to article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information remains unchanged. This article was previously published in the November 2011 edition of *Medicare A Connection*, Pages 77-78.

Provider types affected

This article is for providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for inpatient services provided to Medicare beneficiaries with hemophilia.

Provider action needed

This article is based on change request (CR) 7553 which provides updates to diagnosis codes required in order to allow add-on payments under the inpatient prospective payment system (IPPS) for blood clotting factor administered to hemophilia inpatients. Be sure your billing staffs are aware of the updates.

Background

The September 1, 1993, IPPS Final Rule (58 FR 46304) states that payment will be made for the blood clotting factor only if an ICD-CM diagnosis code for hemophilia is included on the bill.

CR 7553 updates the "*Medicare Claims Processing Manual*" (Pub. 100-04, Chapter 3 (Inpatient Hospital Billing, Section 20.7.3 (Payment for Blood Clotting Factor Administered to Hemophilia Inpatients)) with the following diagnosis code changes in order to allow add-on payments under the IPPS:

Add - effective October 1, 2011

Effective for discharges on or after October 1, 2011, payment may be made if one of the following diagnosis codes is reported:

ICD-9-CM Code	Descriptor
286.52	Acquired hemophilia
286.53	Antiphospholipid antibody with hemorrhagic disorder
286.59	Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors

Add - effective October 1, 2013

Effective for discharges on or after October 1, 2013, payment may be made if the following ICD-10 diagnosis code is reported:

ICD-10 Code	Descriptor
D6831	Hemorrhagic disorder due to intrinsic circulating anticoagulants

Terminate - effective September 30, 2011

Effective for discharges as of September 30, 2011, the add-on payment will not be made for:

ICD-9-CM Code	Descriptor
286.5	Hemorrhagic disorder due to intrinsic circulating anticoagulants

Note: The add-on payment criteria for blood clotting factors administered to hemophilia inpatients will not be updated until April 2, 2012. Therefore, providers that include diagnosis codes 286.52, 286.53 or 286.59 on inpatient claims with discharge dates after October 1, 2011, prior to the April 2012 implementation will not receive the add-on payment. Providers may contact their Medicare contractors to have any affected claims adjusted once CR 7553 is implemented. Your Medicare contractor(s) will not search claims history but will adjust affected claims when brought to their attention.

Additional information

The official instruction, CR 7553, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2332CP.pdf*.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

For current information on the new ICD-10 implementation date of October 1, 2014, see SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*.

MLN Matters® Number: MM7553 Revised
Related Change Request (CR) #: CR 7553
Related CR Release Date: October 28, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2332CP
Implementation Date: April 2, 2012

Recovery of annual wellness visit overpayments

Note: This article was revised April 11, 2013, to reflect changes made to change request (CR) 8153. The revision clarified the types of contractors taking recovery actions. Information has been added in the last paragraph on page 2 of this article. The transmittal number, CR release date, and Web address of the CR was also changed. All other information is unchanged. It was previously published in the March 2013 edition of *Medicare A Connection*, Pages 19-20.

Provider types affected

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

What you need to know

This article is based on 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.

For providers who submit claims to Part B MACs or Medicare carriers, contractors will use procedures for recovering overpayments, as provided in the "*Medicare Financial Management Manual*", Chapter 3, Overpayments and Chapter 4, Debt Collection (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf*). For these overpayments that are recovered from providers, the beneficiaries will be notified that they are not responsible for reimbursing the providers for the recovered amount.

(continued on next page)

Medicare to cover MRIs for beneficiaries with FDA-approved implanted permanent pacemakers

Note: This article was revised March 22, 2013, to add a reference to article SE 1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf* on the CMS website. SE1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information is the same. The full article was published previously in the September 2011 edition of *Medicare A Connection*, Pages 20-21.

Provider types affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), carriers, or A/B Medicare administrative contractors (A/B MAC)) for providing magnetic resonance imaging (MRI) services to Medicare beneficiaries are affected.

What you need to know

This article, based on change request (CR) 7441, informs you that Medicare believes that the evidence is adequate to conclude that MRIs improve health outcomes for Medicare beneficiaries with implanted pacemakers (PMs) when the PMs are used according to the Food and Drug Administration (FDA)-approved labeling for use in an MRI environment.

Effective for services on or after July 7, 2011, Medicare will allow coverage of MRIs for beneficiaries with implanted PMs when the PMs are used according to the FDA-approved labeling for use in an MRI environment.

Effective for claims with dates of service on or after July 7, 2011, you should include the following information on MRI claims for beneficiaries with implanted PMs that are FDA-approved for use in an MRI environment:

- Appropriate MRI code;
- KX modifier; and
- ICD-9 code V45.01 (cardiac pacemaker).

Inclusion of the KX modifier on the claim line(s) means that the provider attests that documentation is on file verifying that FDA-approved labeling requirements are met. For such claims without the KX modifier, Medicare will deny MRI line items using the following remittance advice messages:

Group code of CO (contractual obligation); and

Claim adjustment reason code (CARC) 188 (This product/procedure is only covered when used according to FDA recommendations.).

As described previously in the *MLN Matters*® article MM 7296 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7296.pdf*), Medicare posted a separate decision on February 24, 2011, that allows coverage of MRIs for beneficiaries with implanted PMs or implantable cardioverter

(continued on next page)

Wellness *(continued)*

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/R1209OTN.pdf*.

To review the initial *MLN Matters*® article, MM7079, that describes the AWV along with the particulars of the PPPS go to *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7079.pdf*.

To review the *MLN Matters*® article, MM8107, that 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: April 11, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1209OTN
Implementation Date: July 1, 2013

MRI *(continued)*

defibrillators (ICDs) for use in an MRI environment in a Medicare-approved clinical study.

This policy is effective for claims with dates of service on and after February 24, 2011. Providers should follow the instructions issued in the MM7296 article and the additional instructions referenced below.

The following information should be included on MRI claims for beneficiaries with implanted PMs or ICDs for use in an MRI environment in a Medicare-approved clinical study:

- Appropriate MRI code;
- Q0 modifier;
- ICD-9 code V70.7 - Examination of participant in clinical trial (institutional claims only);
- Condition code 30 (institutional claims only); and
- ICD-9 code V45.02 (automatic cardiac defibrillator) or *CPT*® code V45.01 (cardiac pacemaker).
- MRI claims for beneficiaries with implanted PMs or ICDs for use in an MRI environment in a Medicare-approved clinical study that do not include all the line items listed above will be denied using the following remittance messages:
- Group code of CO;
- CARC B5 (Coverage/program guidelines were not met or were exceeded); and

Remittance advice remarks code (RARC) N386 (This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. If you do not have web access, you may contact the contractor to request a copy of the NCD).

Providers are reminded that ICD-10 implementation occurs on October 1, 2013. At that time the ICD-9 codes mentioned above will be replaced by the appropriate ICD-10 codes, which are:

- ICD-10 - Z006 - Encounter for examination for normal comparison and control in clinical research program;
- ICD-10- Z950 - Presence of cardiac pacemaker; and
- ICD-10- Z95810 - Presence of automatic implantable cardiac defibrillator.
- Medicare payment for these services is as follows:
- Professional claims (practitioners and suppliers) - based on the Medicare physician fee schedule (MPFS).
- Inpatient (type of bill (TOB) 11x) - Prospective payment system (PPS), based on the diagnosis-related group.
- Hospital outpatient departments (TOB 13x) - Outpatient PPS, based on the ambulatory payment classification.

Rural health clinics (RHCs)/federally qualified health centers (FQHCs) (TOB71x/77x) - All-inclusive rate, professional component only, based on the visit furnished to the RHC/FQHC beneficiary to receive the MRI. The technical component is outside the scope of the RHC/FQHC benefit. Therefore the provider of the technical service bills their carrier or A/B MAC on the ANSI X12N 837P or hardcopy Form CMS-1500 and payment is made under the MPFS.

Additional information

To view the article, MM7296, "Magnetic Resonance Imaging (MRI) in Medicare Beneficiaries with Implanted Permanent Pacemakers (PMs) or Implantable Cardioverter Defibrillators (ICDs)," visit *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7296.pdf* on the CMS website.

The official instruction, CR 7441, was issued to your FI, carrier, or A/B MAC regarding this change in two transmittals. The first modified the *National Coverage Determinations Manual* and is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R135NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2307CP.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*.

For current information on the new ICD-10 implementation date of October 1, 2014, see article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*.

MLN Matters® Number: MM7441
Related Change Request (CR) #: CR 7441
Related CR Release Date: September 22, 2011
Effective Date: July 7, 2011
Related CR Transmittal #: R2307CP, R135NCD
Implementation Date: September 26, 2011

Full implementation of ordering/referring edits delayed

Due to technical issues, the implementation of the phase 2 denial edits is being delayed. These edits would have checked certain claims for an approved or validly opted-out physician or non- physician who is an eligible specialty type with a valid individual national provider identifier (NPI). If this information were missing or incorrect, the following types of claims would deny:

- Claims from laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;
- Claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A home health agencies (HHAs).

CMS will advise you of the new implementation date in the near future. In the interim, informational messages will continue to be sent for those claims that would have been denied had the edits been in place. Language regarding beneficiary liability has also been updated in this version of the article.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, an advance beneficiary notice is not appropriate in this situation. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

Note: This article was previously revised on April 19, 2013, to add references to the CMS-1450 form and to add question h under the "Effects of edits on providers" section. Previously, it was revised on April 3, 2013, to advise providers to not include middle names and suffixes of ordering/referring providers on paper claims.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer.

If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first letter of the first name and the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html* on the CMS website.

Provider types affected

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

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), 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.

Important announcement on April 25, 2013: Temporary delay in implementing ordering and referring denial edits – Due to technical issues, implementation of the phase 2 denial edits is being delayed. These edits would have checked certain claims for an approved or validly opted-out physician or non-physician who is an eligible specialty type with

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Edits *(continued)*

a valid individual national provider identifier (NPI). If this information were missing or incorrect, the following types of claims would deny:

- Claims from laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;
- Claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A home health agencies (HHA).

Phase 2: CMS has not determined a date to turn on the Phase 2 edits to deny Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare.

The edits will compare the first letter of the first name and the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found on *http://www.cms.gov/Medicare/Provider-Enrollment-and- Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html*.

Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.

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 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 procedures;
- Claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A home health agencies (HHA).

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

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Edits *(continued)*

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 the 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.

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:

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:

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.[1] (1. NPIs were added only when the matching criteria verified the NPI.)

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 twice a week.

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." Information about the report will be displayed.

Phase 2: 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. CMS has not determined a date to turn on the phase 2 edits. 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

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Edits *(continued)*

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:
- 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;
- Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
- 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). Please read the information on the Medicare provider/supplier enrollment Web page about Internet-based PECOS before you begin.

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.

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.

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. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement.

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," and read the information that has been posted there. Download and read the documents in the *Downloads* section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that page.

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 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 two 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

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Edits *(continued)*

(chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in Medicare.

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 twice a week 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.

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the ordering and referring file found on CMS.gov.
- On paper claims (CMS-1450), you would capture the attending physician's last name, first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.
- On paper claims (CMS-1500 and CMS-1450), do not enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the ordering/referring name field, as their use could cause the claim to fail the edits.
- 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.

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.

h. How will the technical vs. professional components of imaging services be affected by the edits?

Consistent with the Affordable Care Act and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable x-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

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: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad 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 un-licensed 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.

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Edits *(continued)*

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

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*.

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* on the CMS website.

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*.

MLN Matters® Number: SE1305
Related Change Request (CR) #: 6421, 6417, 6696, 6856
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R781OTN
Implementation Date: N/A

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

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

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

Effective and notice dates

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

Contents

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an advance beneficiary notification (ABN) signed by the beneficiary. **Note:** Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

New LCDs

APSYCH: Psychiatric diagnostic evaluation and psychotherapy services

LCD ID number: L33130 (Florida/Puerto Rico/U.S. Virgin Islands)

The psychiatry section of the *CPT*® book includes diagnostic, psychotherapy, and other psychiatry services provided to an individual, family, or group and are reported without regard to setting. A new coding structure in this section of the 2013 *CPT*® book addresses coding concepts that reflect the different work performed by physicians and other qualified health care professionals.

Some of the psychiatry services may be reported with evaluation and management (E/M) services.

Historically, psychotherapy services have been an outlier, confirmed by data analysis, which led to the development of multiple psychiatry-related local coverage determinations (LCDs).

This new LCD was developed to address the recent restructuring of the coding in the psychiatry section of the 2013 *CPT*® book and consolidate the following psychiatry-related LCD's currently found in the First Coast Service Options Inc. (First Coast) website: psychiatric diagnostic evaluation, psychotherapy, interactive complexity services, family psychotherapy, and group psychotherapy. These LCD's will be retired once the new LCD becomes effective.

Effective date

This revision is effective for services rendered **on or after June 4, 2013**. First Coast Service Options Inc. (First Coast) LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

Revisions to LCDs

ANCSVCS: Noncovered services – updated revision to the LCD

LCD ID number: L28991 (Florida)

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

The local coverage determination (LCD) for noncovered services was most recently revised January 29, 2013. Since that time, the LCD was revised based on change request (CR) 8228, transmittal 2664, dated March 1, 2013. The "*CPT*®/HCPCS Codes" section of the LCD was updated to remove *CPT*® code *90661*.

The effective date of this revision is for claims processed **on or after April 1, 2013, for services rendered on or after November 20, 2012**.

In addition, *CPT*® code *20999* was removed from the "*CPT*®/HCPCS Codes" section of the LCD and replaced with HCPCS code C9734. The effective date of this revision is for services rendered **on or after April 1, 2013**. Also, the LCD was revised to asterisk those "listed" codes that contain additional information beyond the *CPT*® descriptor and separate out all "unlisted" procedure codes into their own individual list.

Effective date

This LCD revision is effective for services rendered **on or after April 1, 2013**. First Coast Service Options Inc. (First Coast) LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

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

Revisions to LCDs

AJ0881: Erythropoiesis stimulating agents – LCD revision

LCD ID number: L28836 (Florida)

LCD ID number: L28869 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for erythropoiesis stimulating agents was most recently revised January 1, 2013. Since that time, the LCD has been revised under the "Indications" section for Peginesatide (OMONTYS®) based on the U.S. Food and Drug Administration (FDA) recently issuing a voluntary nationwide recall of all lots of Omontys® (peginesatide) injection by Affymax, Inc. and Takeda Pharmaceuticals Company Limited effective February 23, 2013. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated. Also, the LCD "Coding Guidelines" attachment was updated based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8050, transmittal 2582. Verbiage was added for the coding requirements and frequency of billing units for HCPCS code J0890. The effective date of this revision is for services rendered **on or after April 1, 2013**.

Effective date

This LCD revision is effective for services rendered **on or after February 23, 2013**. First Coast Service Options, Inc. LCD's are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

AJ1459: Intravenous immune globulin – LCD revision

LCD ID number: L28895 (Florida)

LCD ID number: L28917 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for intravenous immune globulin was most recently revised January 1, 2013.

Since that time, based on the Centers for Medicare & Medicaid Services (CMS) change request 8228, transmittal 2664 (April 2013 Update of the Hospital Outpatient Prospective Payment System [OPPS]), dated March 1, 2013, the LCD was revised to add HCPCS code C9130 under the "CPT®/ HCPCS Codes" section of the LCD.

In addition, the "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections of the LCD were updated.

Effective date

This LCD revision is effective for services rendered **on or after April 1, 2013**. First Coast Service Options Inc. (First Coast) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.*

Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

A64566: Posterior tibial nerve stimulation (PTNS) – revision to the LCD

LCD ID number: L32306 (Florida/Puerto Rico/US. Virgin Islands)

The local coverage determination (LCD) for posterior tibial nerve stimulation (PTNS) was effective January 31, 2012. Since that time, a revision was made to the LCD based on an external reconsideration request. Language was added to the "Limitations" and "Utilization Guidelines" sections of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after April 23, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

Revisions to LCDs

A90901: Biofeedback – LCD revision

LCD ID number: L28785 (Florida)

LCD ID number: L28786 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for biofeedback was most recently revised January 1, 2013. Since that time, the LCD was revised based on data analysis which identified this service as a high risk for improper claim(s) payment. A trend was noted with several providers who were billing physical therapy services (i.e., *CPT*® codes *97032*, *97110*, *97112*, *97140*, *97150*, *97530*, and HCPCS code G0283) with biofeedback for urinary incontinence on the same date of service. Revisions to the LCD include the following:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the following statement was added to the eighth paragraph: "The requirements for anorectal and electromyography studies (EMG) can be found in the LCD for Anorectal Manometry and EMG of the Urinary and Anal Sphincters."
- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD a new section titled "Limitations of Coverage" was added with the following statements:

  "It is not expected that physical therapy or occupational therapy services would be billed on the same day as biofeedback therapy. If physical therapy or occupational therapy is billed on the same date of service as biofeedback, these claims will be developed for supporting documentation and subject to medical review."

  "If physical therapy or occupational therapy services are rendered for indications beyond the scope of the indications addressed in this LCD, all requirements for rehabilitative services must be met. These requirements can be found in the Therapy and Rehabilitative Services LCD."

  "Biofeedback training will not be covered for mechanical urinary incontinence, psychosomatic conditions, or functional urinary incontinence as these types of urinary incontinence are not amendable to biofeedback training."
- The "Documentation Requirements" section of the LCD was updated; and
- The "Sources of Information and Basis for Decision" section of the LCD was updated.

In addition, the "Coding Guidelines" attachment of the LCD was revised in the last paragraph under the section "Coding Guidelines."

Effective date

This LCD revision is effective for services rendered **on or after June 4, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

Revisions to LCDs

ATHERSVCS: Therapy and rehabilitation services – LCD revision

LCD ID number: L28992 (Florida)

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

The local coverage determination (LCD) for therapy and rehabilitation services was most recently revised January 1, 2013.

Since that time, the LCD was revised based on change request (CR) 8005, transmittal 2622, dated December 21, 2012, which included updates to the language in the Centers for Medicare & Medicaid Services (CMS) Manual System, *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Sections 10.6.

Therefore, the 'Documentation Requirements" section of the LCD was revised to add "Functional Reporting" information. The "Documentation Requirements" section of the LCD was also updated under "Progress Report" to reflect the current CMS language in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 220.3D. This LCD revision is effective for dates of service **on or after January 1, 2013.**

Effective date

The LCD revision related to CR 8005 is effective for claims processed **on or after January 7, 2013**, for services rendered **on or after January 1, 2013**. First Coast Service Options Inc. (First Coast) LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.*

Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

ANCSVCS: Noncovered services – CAC revision to the LCD

LCD ID number: L28991 (Florida)

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

The local coverage determination (LCD) for noncovered services was most recently revised April 1, 2013. Since that time, a revision was made to the LCD.

The following codes were evaluated and determined not to be medically reasonably and necessary at this time based on the current published evidence (e.g., peer-reviewed medical literature, published studies): HCPCS code G0455 was added to the "Local Noncovered Decisions-Devices" section of the LCD.

CPT® codes *0310T*, *0312T*, *0313T*, *0314T*, *0315T*, *0316T*, *0317T*, *43206* and *43252* were added to the "Local Noncoverage Decisions-Procedures" section of the LCD and *CPT*® code *88375* was added to the "Local Noncovered Decisions-Laboratory Procedures" section of the LCD. In addition, under the "Related Documents" section of the LCD a reference page was included.

Effective date

This revision is effective for services rendered **on or after June 4, 2013**. First Coast Service Options Inc. (First Coast) LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.*

Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

Revisions to LCDs

ASKINSUB: Skin substitutes – revision to the LCD

LCD ID number: L28985 (Florida)

LCD ID number: L29327 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for skin substitutes was most recently revised January 1, 2013. Since that time, a revision was made to the LCD based on the Centers for Medicare & Medicaid Services (CMS) change request 8228, transmittal 2664 (April 2013 Update of the hospital outpatient prospective payment system [OPPS]), dated March 1, 2013. HCPCS Code C9367 was deleted from the section of the LCD "The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products".

Effective date

This LCD revision is effective for claims processed **on or after April 1, 2013**, for services rendered **on or after January 1, 2013**. First Coast Service Options Inc. (First Coast) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

A93975: Duplex scanning – revision to the LCD

LCD ID number: L28830 (Florida)

LCD ID number: L28863 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for duplex scanning was most recently revised February 28, 2013.

Since that time, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add diagnosis codes V67.00 (Follow-up examination following surgery, unspecified) and V67.09 (Follow-up examination following other surgery) for *CPT®* codes *93975* and *93976* to be consistent with the Part B LCD for duplex scanning.

Effective date

This LCD revision is effective for claims processed **on or after April 16, 2013**, for services rendered **on or after July 26, 2004**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

A78459: Myocardial imaging, positron emission tomography (PET) scan

LCD ID number: L28933 (Florida)

LCD ID number: L28954 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for myocardial imaging, positron emission tomography (PET) scan was most recently revised October 1, 2011.

Since that time, the LCD was revised based on data analysis that revealed overutilization for Carrier to Nation ratio for *CPT®* code *78492* (Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress), and HCPCS codes A9526 (Nitrogen N-13 ammonia, diagnostic, per study dose, up to 40 millicuries) and A9555 (Rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries). The following sections of the LCD were revised:

- CMS national coverage policy
- Indications and limitations of coverage and/or medical necessity
- Documentation requirements
- Utilization guidelines

Effective date

This LCD revision is effective for services rendered **on or after June 4, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD attachments in the Jump to Section…drop down menu at the top of the LCD page.

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

Additional information

Provenge®: criteria for prepayment review

Provenge® (sipuleucel-T) is an autologous cellular immunotherapy for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Provenge® (sipuleucel-T) was approved by the Food and Drug Administration (FDA) in 2010 and was one of the first federally-approved cancer drugs that use the body's own immune system to fight the disease.

In June 2011, the Centers for Medicare & Medicaid Services (CMS) proposed that the evidence was adequate to conclude that the use of autologous cellular immunotherapy treatment – (sipuleucel-T) Provenge® improved health outcomes for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer, and thus is reasonable and necessary for this on-label indication under 1862(a)(1)(A) of the Social Security Act.

The recommended course of therapy for Provenge® is three complete doses (approximately $33,000 allowed dollars per dose), given at approximately two week intervals. Provenge® is administered via intravenous infusion over a period of approximately 60 minutes.

National coverage determination (NCD), autologous cellular immunotherapy treatment

CMS developed a national coverage determination (NCD), Autologous Cellular Immunotherapy Treatment (110.22), outlining the indications and limitations of coverage for Provenge®, which became effective on June 30, 2011.

In an effort to prevent improper payments and protect the Medicare Trust Fund, First Coast Service Options Inc. (First Coast) implemented two edits based on the requirements outlined in the NCD. The first edit applies to the dual diagnosis requirement. If the claim does not meet the dual diagnosis requirement in the NCD the claim automatically denies.

If the claim meets the dual diagnosis requirement, the second edit auto-develops and an additional documentation request (ADR) is sent to the provider requesting medical records. The ADR letter requests documentation that demonstrates the medical necessity of the billed service, which includes the patient's history and physical, progress notes, nurses notes, treatments, lab values, order for the treatment with Provenge® and infusion records.

Each claim must stand alone, meaning the documentation in the submitted record must support the medical necessity of the service(s) billed on each individual claim. The contractor does not know if or which prior claim may contain documentation to support a current claim that is subject to medical review. So, although the provider may have already submitted some (e.g., history and physical [H&P]) of the same records with an earlier claim, the documentation for each additional claim must also support the service under review.

First Coast understands the burden placed on providers in requesting medical records and has worked diligently to reduce the paperwork burden when possible by implementing editing criteria that exclude beneficiary(s) from being subject to editing once medical necessity for a specific service has been established.

For example, Tysabri® is a drug that is administered every four weeks (indefinitely) for certain indications. Once First Coast determines that the coverage criteria for Tysabri® based on the submitted documentation for the beneficiary has been met, subsequent claims, for that beneficiary are "excluded from further review. "

Since Provenge® is given approximately every two weeks it is probable that a provider may bill for the second and possibly third dose prior to the first claim (first dose) being medically reviewed due to the time it takes for the provider to receive the ADR, respond to the ADR and for the review to be completed.

First Coast considered implementing an exclusion table for beneficiaries that met the requirements for Provenge® based on the medical record review of the first dose. However, given the short interval between doses, enough time has not lapsed to put in place the necessary editing to avoid subsequent claims from being developed for the medical records.

In addition, First Coast has identified documentation issues through medical record review of the second and third doses that would have resulted in Comprehensive Error Rate Testing (CERT) errors had the claim been sampled by the CERT contractor. Due to the potential impact of these large dollar claims on the CERT error rate, prepayment review is necessary to prevent improper payments and protect the Medicare Trust Fund.

Provenge *(continued)*

Utilization of the paperwork segment (PWK)

An option providers may want to consider is the utilization of the paperwork segment (PWK) of electronic transactions.

PWK is a segment within the 2300/2400 Loop of the 837 professional and institutional electronic transactions that provides the link between electronic claims and additional documentation.

PWK allows providers to submit electronic claims that require additional documentation through the dedicated PWK process, by mailing or faxing the medical records without waiting on the ADR and have the documentation received and imaged by the contractor allowing more timely claims adjudication.

Using the PWK process eliminates the need for costly development and allows providers and Medicare contractors to utilize efficient, cost-effective electronic data interchange or EDI technology, which creates a significant cost savings.

Although PWK ultimately will allow electronic submission of additional documentation, the submission of additional documentation can only be submitted via fax or mail at this time. Providers that submit claim(s) via PWK should experience a reduction in the period of time between the receipt and adjudication of claims. Here is a link to more information regarding PWK: *http://medicare.fcso.com/EDI_news/203963.asp*.

Tips for avoiding denials

Top reasons for denials and tips to avoid denials:

- Non response to documentation request (ADR letters): respond to ADRs timely and consider use of PWK.
- Failure to meet NCD (110.22) dual diagnosis requirements: review CMS' NCD requirements at Pub. 100-03, Chapter 1, Part 2 Sections 90-160.26. Refer to *http://medicare.fcso.com/Publications_A/2011/213006.pdf#page=12* (Part A) or *http://medicare.fcso.com/Publications_B/2011/212769.pdf#page=12* (Part B).
- Insufficient documentation: Ensure you submit sufficient medical records such as a physician order for Provenge®

FDA labeled indication and NCD criteria are met for coverage as supported by the following:

- Documentation regarding means of castration (e.g., surgically by bilateral orchiectomy or documentation of 3 or more months of chemical castration and agent used or the medical documentation from the treating physician includes a clear statement of failure of chemical castration)
- Medical records should specifically address evidence of progressive disease after surgical or chemical castration (examples may include: changes in size of lymph nodes or parenchymal masses on physical examination or radiographic studies, bone scan progression, PSA progression, etc.)
- Evidence that the patient is asymptomatic or minimally symptomatic (should include a note about the patient's level of activity)
- Other lab values or other test results relevant to the above criteria
- Infusion record for the date of service billed on the claim

Ensure the submitted records and signatures are legible. For information about Medicare's signature requirements see: *http://medicare.fcso.com/medical_documentation/166303.asp*

Self-administered drug (SAD) list – Part A: C9399/J3490/J3590

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare.

Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered **on or after June 17, 2013**, the following drug has been added to the MAC J-9 Part A SAD list.

- C9399 /J3490/ J3590 Injection, Signifor® (pasireotide)

The evaluation of drugs for addition to the self-administered drug (SAD) list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

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

Medicare claims processing guidance for implementing ICD-10

Note: This article was revised on March 27, 2013, to add a reference to article MM8207 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8207.pdf*), which alerts DMEPOS providers and suppliers of modifications being made to the claims processing systems to report the appropriate NCD/LCD captured during claim processing based on their associations with either ICD-9 or ICD-10 diagnosis codes, the claim line service date, and the and the ICD-10 diagnosis code effective date. This article was revised March 21, 2013, to add a reference to article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE 1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information remains unchanged. This article was previously published in the September 2011 edition of *Medicare A Connection*, Pages 20-21.

Provider types affected

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

Provider action needed

For dates of service on and after October 1, 2013, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2013. Make sure your billing and coding staffs are aware of these changes.

Key points of CR 7492

General reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to *http://www.cms.gov/Medicare/Coding/ICD10/index.html* for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 PCs.

General claims submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2013. Institutional claims containing ICD-9 codes for services on or after October 1, 2013, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2013, will also be returned as unprocessable.

You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2013, submit claims with the appropriate ICD-9 diagnosis code.

For dates of service on or after October 1, 2013, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2013, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2013, submit with the appropriate ICD-10 procedure code.

Remember that ICD-10 codes may only be used for services provided on or after October 1, 2013. Institutional claims containing ICD-10 codes for services prior to October 1, 2013, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2013, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Claims that span the ICD-10 implementation date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

(continued on next page)

ICD-10 *(continued)*

Table A – institutional providers

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH Date
11x	Inpatient Hospitals (incl. TERFHA hospitals, prospective payment system hospitals, long term care hospitals, critical access hospitals	If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
12x	Inpatient Part B hospital services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
13x	Outpatient hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
14x	Non-patient laboratory services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
18x	Swing beds	If [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
21x	Skilled nursing (inpatient Part A)	If the [Swing bed/SNF] claim has a discharge or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
22x	Skilled nursing facilities (inpatient Part B)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
23x	Skilled nursing facilities (outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
32x	Home health (inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH
3x2	Home health – request for anticipated payment (RAPs)*	* Note - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	*See Note
34x	Home health – (outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
71x	Rural health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
72x	End stage renal disease (ESRD)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

(continued on next page)

ICD-10 *(continued)*

Bill type	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
73x	Federally qualified health clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74x	Outpatient therapy	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
75x	Comprehensive outpatient rehab facilities	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
76x	Community mental health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
77x	Federally qualified health clinics (effective 4/4/10)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
81x	Hospice- hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
82x	Hospice – non hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
83x	Hospice – hospital based	N/A	N/A
85x	Critical access hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Table B - Special outpatient claims processing circumstances

Scenario	Claims processing requirement	Use FROM or THROUGH Date
3-day /1-day payment window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional claims

Type of claim	Claims processing requirement	Use FROM or THROUGH/TO Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.	**FROM**

ICD-10 *(continued)*

Table D – Supplier claims

Supplier type	Claims processing requirement	Use FROM or THROUGH/TO date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).	**FROM**

Additional information

The official instruction, CR 7492 issued to your carrier, FI, RHHI, or MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R950OTN.pdf*.

See article MM 7818, available at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7818.pdf*, for information on the creation and updating of hard-coded Medicare shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes and the operational changes needed to implement the conversion.

If you have any questions, please contact your carrier, FI, RHHI, or 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*.

For current information on the new ICD-10 implementation date of October 1, 2014, see article SE 1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*.

MLN Matters® Number: MM7492 Revised
Related Change Request (CR) #: CR 7492
Related CR Release Date: August 19, 2011
Effective Date: October 1, 2013
Related CR Transmittal #: R950OTN
Implementation Date: January 1, 2012

CMS prepares for ICD-10 with national coverage determination changes

Note: This article was revised on March 26, 2013, to add further information on accessing the spreadsheets attached to change request (CR) 8197. All other information remains the same.

Provider types affected

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

Provider action needed

CR 8197, from which this article is taken, creates and updates national coverage determination (NCD) hard-coded shared system edits that contain International Classification of Diseases (ICD)-9 diagnosis codes with the comparable ICD-10 diagnosis codes, along with all related coding infrastructure such as procedure codes, Healthcare Common Procedure Coding System/*Current Procedural Terminology*® (HCPCS/*CPT*®) codes, messages, frequency edits, place of service/type of bill (POS/TOB), provider specialties.

The requirements it describes reflect the operational changes that are necessary to implement the conversion of the Medicare shared system coding from ICD-9 to ICD-10 specific to 30 NCDs that are attachments to CR 8197.

In order to be prepared to meet the timeline to implement the new ICD-10 diagnosis codes on October 1, 2014, the shared systems began implementation of the necessary changes to the NCDs in the January 2013, quarterly release with CR 7818, followed by CR 8109 in the April 2013, quarterly release and culminates with this CR split between the July 2013, and October 2013, quarterly releases.

(continued on next page)

NCD *(continued)*

See the *Background* and *Additional information* sections of this article for further details regarding these changes, and be sure that you are ready for ICD-10 implementation by October 1, 2014.

Background

As announced in CMS-40-F, 45 CFR Part 162 [CMS–0040–F] RIN 0938–AQ13, "Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements, and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD–10–CM and ICD–10–PCS) Medical Data Code Sets" (September 5, 2012), effective October 1, 2014, all Medicare claims submissions will convert from the 9th Edition (ICD-9) to the 10th Edition (ICD-10).

(You can find this document at *http://www.gpo.gov/fdsys/pkg/FR-2012-09-05* on pages 54663-54720.)

All Health Insurance Portability and Accountability Act (HIPAA)-covered entities must adhere to the conversion, which will require business and systems changes throughout the health care industry. In accordance, per the ICD-10 final rule, published in the January 16, 2009, *Federal Register*, (see *http://www.gpo.gov/fdsys/pkg/FR-2009-01-16/pdf/E9-740.pdf*).

The Secretary of the Department of Health and Human Services adopts the ICD-10-CM and ICD-10-PCS code sets for use in appropriate HIPAA standard transactions (including those submitted in both electronic and paper formats) effective October 1, 2014.

General information found in spreadsheets in the attachments

Thirty spreadsheets are attached to CR 8197 indicating certain affected ICD-9 codes and their corresponding ICD-10 codes as they relate to their respective NCDs, in addition to the rest of the coding infrastructure specific to each NCD. To access the attachments, go to the *Downloads* section at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R1199OTN.html*.

Each spreadsheet contains the following information:

- NCD number/title;
- Internet-only manual (IOM) searchable link related to the NCD; and
- Medicare coverage database (MCD) searchable link related to the NCD.
- Within each spreadsheet, there are three tabs:
- ICD diagnosis;
- ICD; and,
- Rule description.

Spreadsheets attached to CR 8197 explain the following NCDs:

20.4	Implantable automatic defibrillator
20.7	Percutaneous transluminal angioplasty
20.16	Cardiac output monitoring by thoracic electrical bioimpedance
20.30	Microvolt T-wave alternans
20.31	Intensive cardiac rehabilitation programs
20.31.1	The Pritikin program
20.31.2	Ornish program for reversing heart disease
40.1	Diabetes outpatient self-management training
40.7	Outpatient intravenous insulin treatment
50.3	Cochlear implantation
100.14	Surgery for diabetes
110.4	Extracorporeal photopheresis
110.8.1	Stem cell transplantation
150.10	Lumbar artificial disc replacement
180.1	Medical nutrition therapy
190.1	Histocompatibility testing
190.3	Cytogenetic studies
190.5	Sweat test
190.8	Lymphocyte mitogen response assays
190.11	Home prothrombin time/international normalized ratio monitoring for anticoagulation management
210.2	Screening pap smears and pelvic examinations for early detection of cervical or vaginal cancer
210.4	Smoking and tobacco-use cessation counseling
210.4.1	Counseling to prevent tobacco use
210.7	Screening for the human immunodeficiency virus infection
210.10	Screening for sexually transmitted infections and high-intensity behavioral counseling to prevent STIs
220.4	Mammograms
220.6.16	FDG PET for infection and inflammation

(continued on next page)

NCD *(continued)*

220.6.19	Positron emission tomography (NaF-18) to identify bone metastasis of cancer
260.1	Adult liver transplantation
260.9	Heart transplants

Should your contractor deny claims associated with the NCDs addressed by CR 8197, they will use:

- Group code PR (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed advance beneficiary notice of noncoverage (ABN) is on file).
- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
- Claim adjustment reason code (CARC) 50: These services are non-covered services because this is not deemed a "medical necessity" by the payer; and

Additionally, where appropriate and not specifically indicated in the various attached spreadsheets, they will use:

- Remittance advice remark code (RARC) N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Additionally, NCD 190.11 includes a change to CR 6313 dated 1/8/09, and is also a change to the spreadsheet attached to CR 8109/TR1162.

Likewise, NCD 110.4 includes a change to CR 7806/TR2551 correction dated 9/24/12 that removed 996.88 from CR 7806 dated 8/3/12, and a change to the spreadsheet attached to CR 7818 dated 9/14/12.

Additional information

The official instruction, CR 8197 issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1199OTN.pdf*.

You will find spreadsheets that contain all affected ICD-9 codes and their corresponding ICD-10 codes as they relate to their respective NCDs, in addition to the rest of the coding infrastructure specific to each NCD as attachments to this CR. To access those spreadsheets, visit the *Downloads* section at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R1199OTN.html*.

If you have any questions, please contact your carrier, FI, 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: MM8197
Related Change Request (CR) #: CR 8197
Related CR Release Date: March 15, 2013
Effective Date: Please note that the implementation date is prior to the effective date in order to be prepared to meet the timeline to implement the new ICD-10 diagnosis codes on October 1, 2014. The shared systems began implementation of the necessary changes to the NCDs in the January 2013 systems release with CR 7818, followed by CR 8109 in the April 2013 release, and finishing up with this CR split between the July 2013 and October 2013 releases (analysis and design/implementation).
Related CR Transmittal #: R1199OTN
Implementation Date: July 1, 2013

Temporary bypass of common working file qualifying stay edit C7123 for all SNF and SB claims

Due to an issue with qualifying stay edit C7123, the Centers for Medicare & Medicaid Services (CMS) has instructed contractors to bypass edit C7123 for all skilled nursing facility (SNF) and swing bed (SB) claims until the common working file (CWF) logic is corrected to identify prior qualifying hospital stays.

Once contractors implement the bypass they will release any affected SNF and SB claims currently suspending in their systems. Providers may adjust those claims that incorrectly rejected with C7123 or bring these affected claims to the attention of your contractor to be adjusted.

CMS is currently drafting a transmittal to implement the appropriate qualifying stay bypass criteria for edit C7123 in order to prevent incorrect system rejections. Contractors will continue to bypass edit C7123 until this transmittal is implemented.

Preparing for ICD-10 - inclusion of type of bill 33X

Note: This article was revised March 22, 2013, to add a reference to article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information remains unchanged.

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs) who submit claims to Medicare fiscal intermediaries (FIs), Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Provider Action Needed

You must include International Classification of Diseases, 10th Edition (ICD-10) codes on 33x type of bills (TOB) that you submit with dates of service/discharge on or after October 1, 2013, and ICD-9 codes on those that you submit with dates of service/discharge before that date. Do not submit such bills with both types of codes included. Change request (CR) 7704, from which this article is taken, provides guidance on reporting claims submissions and date span requirements for 33x TOBs containing ICD-10 codes with dates of service on and after October 1, 2013. You should make sure that your billing staffs are aware of these 33x TOB coding requirements.

Background

On October 1, 2013, all Medicare claims submissions of diagnosis and hospital inpatient procedure coding will require a change from the ICD-9 to the 10th Edition (ICD-10). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, necessitating systems changes throughout the entire health care industry.

The Centers for Medicare & Medicaid Services (CMS) released CR 7492, on August 19, 2011, to provide guidance on reporting, claims submissions and date span requirements for ICD-10 diagnosis codes, effective October 1, 2013. You can find the associated *MLN Matters*® article ("Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10)") at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7492.pdf*.

CR 7492, however, did not include TOB 33x as a bill type for the requirements provided. CR 7704, from which this article is taken, adds TOB 33x to all requirements identified in CR 7492. You should note that your FI, A/B MAC or RHHI will return to provider (RTP) 33x bill types they receive that include ICD-9 codes, and which have dates of service or dates of discharge/through dates on or after October 1, 2013. When they do RTP these claims, they will use the following message: "For dates of service on or after October 1, 2013, claims may not contain ICD-9 codes. Please re-submit claim with the appropriate ICD-10 code."

Further, they will RTP any 33x TOB with through dates prior to October 1, 2013, which are billed with ICD-10 diagnosis codes, using the following message: "For dates of service prior to October 1, 2013, claims may not contain ICD-10 codes. Please re-submit claim with the appropriate ICD-9 code".

Finally, they will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim; using the following message: "Claims may not be submitted with both ICD-9 and ICD-10 diagnosis codes. Please correct. For dates of service prior to October 1, 2013, resubmit with the appropriate ICD-9 diagnosis code. For dates of service after October 1, 2013, resubmit with the appropriate ICD-10 diagnosis code".

Note: Medicare will allow HHAs to use the payment group code derived from ICD-9 codes on claims, which span October 1, 2013, but will require those claims to be submitted using ICD-10 codes.

Additional information

You can find more information about the inclusion of TOB 33x in the ICD-10 requirements by going to CR 7704, located at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1039OTN.pdf*.

See article MM7818, available at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7818.pdf*, for information on the creation and updating of hard-coded Medicare shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes and the operational changes needed to implement the conversion.

If you have any questions, please contact your FI, A/B MAC, or RHHI 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*. For information on the new ICD-10 implementation date of October 1, 2014, see article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*.

MLN Matters® Number: MM7704 Revised
Related Change Request (CR) #: CR 7704
Related CR Release Date: February 3, 2012
Effective Date: October 1, 2013
Related CR Transmittal #: R1039OTN
Implementation Date: July 2, 2012

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CMS prepares for conversion to ICD-10

Note: This article was revised March 27, 2013, to add a reference to article MM8207 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8207.pdf*) to alert DMEPOS providers and suppliers of modifications being made to the claim processing systems to report the appropriate NCD/LCD captured during claim processing based on their associations with either ICD-9 or ICD-10 diagnosis codes, the claim line service date, and the ICD-10 diagnosis code effective date. It was previously revised, to add information on accessing the attachment to change request (CR) 7818. All other information is unchanged. This information was previously published in the October 2012 edition of *Medicare A Connection*, Page 13.

Provider types affected

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

Provider action needed

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

Background

On October 1, 2014, all Medicare claims submissions will convert from the International Classification of Diseases, 9th Edition (ICD-9) to the 10th Edition (ICD-10). The transition will require business and systems changes throughout the health care industry. All covered entities, as defined by the Health Insurance Portability and Accountability Act (HIPAA), must adhere to the conversion. In accordance with HIPAA, the Secretary of the Department of Health and Human Services adopts standard medical data code sets for use in standard transactions adopted under this law. According to the ICD-10 Final Rule, published in the *Federal Register* of January 16, 2009 (see *http://www.gpo.gov/fdsys/pkg/FR-2009-01-16/pdf/E9-743.pdf*), the Secretary adopts the ICD-10-CM and ICD-10-PCS code sets for use in appropriate HIPAA standard transactions.

Entities covered under HIPAA (which include Medicare and its providers submitting claims electronically) are bound by these requirements and must comply. Medicare will also require submitters of paper claims to use ICD-10 codes on their claims according to the same compliance date. The purpose of CR 7818 is to both create and update NCD hard-coded Medicare shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes, plus all associated editing such as procedure codes, HCPCS/*CPT*® codes, denial messages, frequency edits, place of service (POS)/type of bill (TOB)/provider specialty editing, etc. The requirements described in CR 7818 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the Medicare NCDs listed as an attachment to CR 7818. To access that attachment, visit *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals-Items/R1122OTN.html*.

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

Additional information

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

To access the attachment to CR 7818, visit *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals-Items/R1122OTN.html*. 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: MM7818
Related Change Request (CR) #: CR 7818
Related CR Release Date: September 14, 2012
Effective Date: October 1, 2014
Related CR Transmittal #: R1122OTN
Implementation Date: January 7, 2013

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

Provider types affected

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

What You Need to Know

This article is based on change request (CR) 8281, which instructs Medicare contractors to make programming changes to incorporate updates to the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists. It also instructs the fiscal intermediary standard system (FISS) and the VIPs Medicare system (VMS) maintainers to update Medicare remit easy print (MREP) and PC Print. Please make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARC and appropriate RARC that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions.

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. CR 8281 lists only the changes that have been approved since the last code update CR (CR 8154, Transmittal 2618, issued on December 21, 2012, available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8154.pdf*), and does not provide a complete list of codes for these two code sets.

Note: In case of any discrepancy in the code text as posted on Washington Publishing Company (WPC) website and as reported in any CR, the WPC version should be implemented.

Changes in CARC List Since CR 8154

These are the changes in the CARC database since the last code update CR 8154. The full CARC list must be downloaded from the WPC website, available at *http://wpc-edi.com/Reference* on the Internet.

New codes – CARC: None

Modified codes – CARC:

Code	Modified narrative	Effective date
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 01/20/2013	11/1/2013

(continued on next page)

Remittance *(continued)*

Code	Current narrative	Effective date
18	Exact duplicate claim/service (Use only with group code OA) Start: 01/01/1995 | Last Modified: 01/20/2013	1/20/2013
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 01/20/2013	11/1/2013
133	The disposition of the claim/service is pending further review. (Use only with Group Code OA) Start: 02/28/1997 | Last Modified: 01/20/2013	1/20/2013

Deactivated codes – CARC:

Code	Current narrative	Effective date
125	Submission/billing error(s). At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 11/01/2013	11/1/2013

Changes in RARC list since CR 8154

These are the changes in the RARC database since the last code update CR 8154. The full RARC list must be downloaded from the WPC website, available at *http://wpc-edi.com/Reference* on the Internet.

Code	Current narrative	Effective date
N567	Not covered when considered preventative. Start: 03/01/2013	3/1/2013
N568	Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative. Start: 03/01/2013	3/1/2013
N569	Not covered when performed for the reported diagnosis. Start: 03/01/2013	3/1/2013
N570	Missing/incomplete/invalid credentialing data Start: 03/01/2013	3/1/2013
N571	Alert: Payment will be issued quarterly by another payer/contractor. Start: 03/01/2013	3/1/2013
N572	This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted. Start: 03/01/2013	3/1/2013
N573	Alert: You have been overpaid and must refund the overpayment. The refund will be requested separately by another payer/contractor. Start: 03/01/2013	3/1/2013

Modified codes – RARC:

Code	Current narrative	Effective date
N565	Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed. Start: 11/01/2012 | Last Modified: 03/01/2013	3/1/2013

(continued on next page)

Claim status category and claim status codes update

Provider types affected

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

What you need to know

Change request (CR) 8265, from which this article is taken, requires Medicare contractors to use only National Code Maintenance Committee-approved claim status category codes and claim status codes when sending Medicare healthcare status responses (277 transactions) to report the status of your submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

All code changes approved during the January 2013 Committee meeting will be posted on or about March 1, 2013, at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes* and are to be reflected in the X12 277 transactions issued on and after the date of implementation of CR 8265 (July 1, 2013).

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only National Code Maintenance Committee-approved claim status category codes and claim status codes to explain the status of submitted claims. These codes, which have been adopted as the National standard to explain the status of submitted claim(s), are the only such codes permitted for use in the x12 276/277 Health Care Claim Status Request and Response format.

The National Code Maintenance committee meets three times each year (February, June, and October) in conjunction with the Accredited Standards Committee (ASC) X12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of the newly added or changed codes. Therefore, on and after the date of implementation of CR 8265 (July 1, 2013), your Medicare contractor must: 1) Complete the entry of all applicable code text changes and new codes; 2) Terminate the use of deactivated codes; 3) Use these new codes for editing all x12 276 transactions and reflect them in the x12 277 transactions that they issue.

Additional information

The official instruction, CR 8265 issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2681CP.pdf* on the CMS website.

If you have any questions, please contact your carrier, FI, RHHI, 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: MM8265
Related Change Request (CR) #: CR 8265
Related CR Release Date: April 5, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2681CP
Implementation Date: July 1, 2013

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Remittance *(continued)*

Deactivated codes – RARC: NONE

Additional information

The official instruction, CR 8281, issued to your FI, RHHI, carrier, DME MAC, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2686CP.pdf* .

If you have any questions, please contact your FI, RHHI, 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: MM8281
Related Change Request (CR) #: CR 8281
Related CR Release Date: April 12, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2686CP
Implementation Date: July 1, 2013

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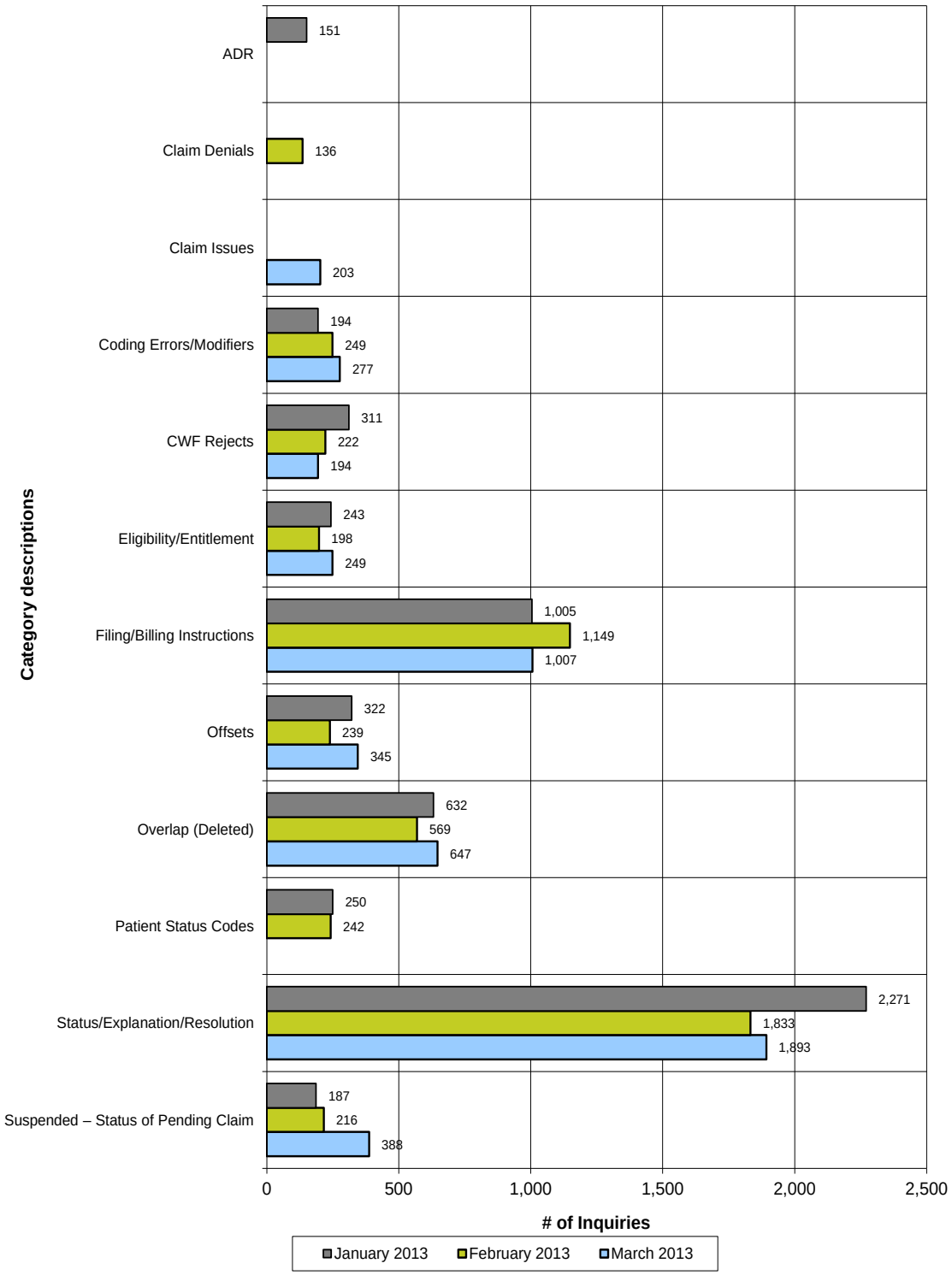
Top inquiries, rejects, and return to provider claims January 2013 - March 2013

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 January 2013 through March 2013.

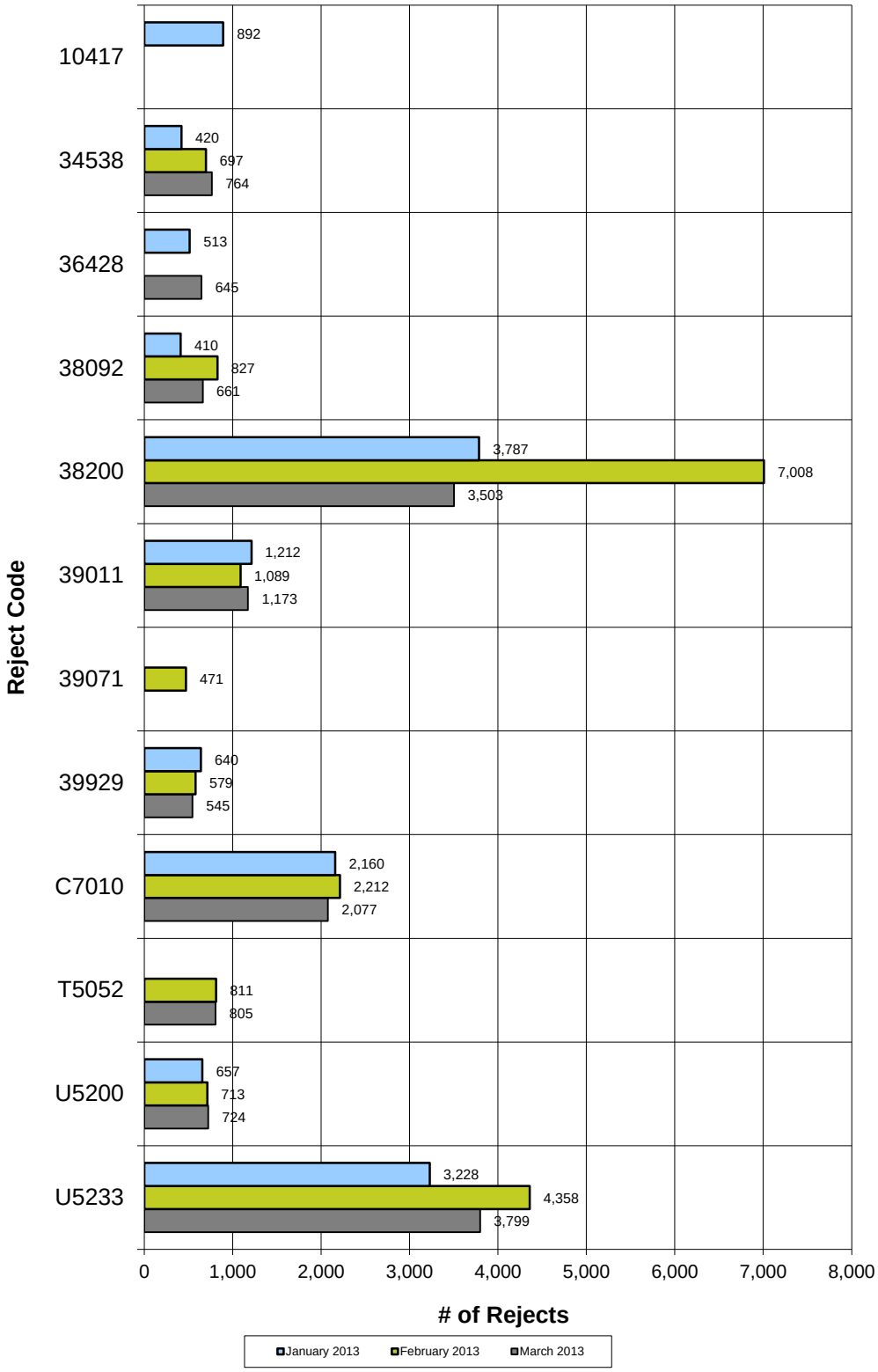
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Top inquiries for January-March 2013



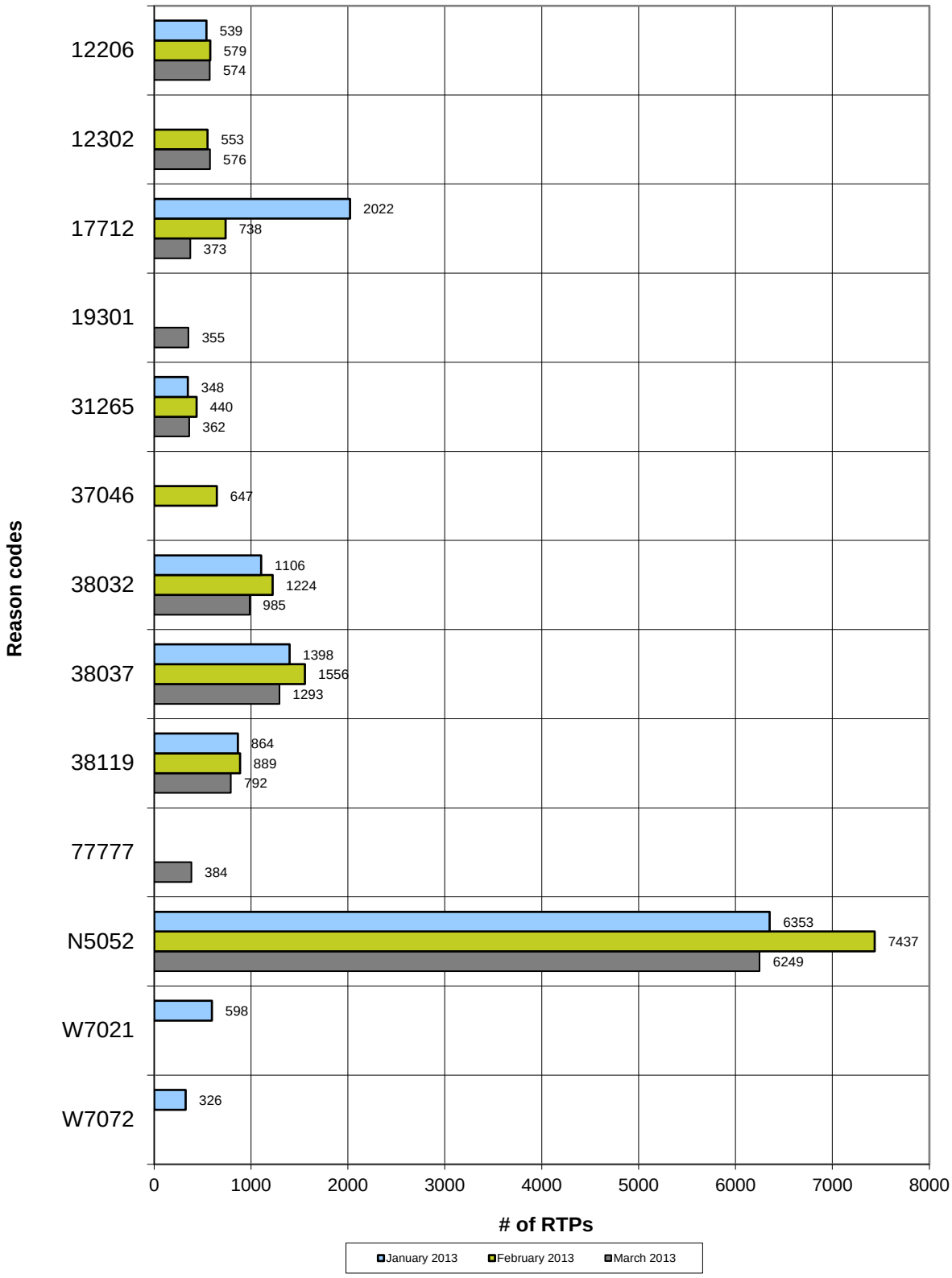
Part A top rejects for January 2013 through March 2013

Top rejects for January-March 2013



Part A top return to providers (RTPs) for January 2013 through March 2013

Top RTPs for January-March 2013



Data reporting on home health prospective payment system claims

Note: This article was revised April 3, 2013, to delete references to a new modifier and to revise/add policy language regarding the use of the Q codes. It was revised again April 19, 2013, to delete "and indicating whether services were added to the home health (HH) plan of care by a physician who did not certify the plan of care" from the "Provider action needed" section. The transmittal number, change request (CR) release date, and the Web address for accessing the CR were revised April 3. All other information remains the same. This article was previously printed in the February 2013 edition of *Medicare A Connection*, Pages 27-28.

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs) that bill regional home health intermediaries (RHHIs) or Medicare administrative contractors (A/B MACs) for home health services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8136 which adds new data reporting requirements for home health prospective payment system (HH PPS) claims. HHAs must report new codes indicating the location of where services were provided. Make sure that your billing staffs are aware of these changes.

Background

Generally, original Medicare makes payment under the HH PPS on the basis of a national standardized 60-day episode payment rate that is adjusted for the applicable case-mix and wage index. The national standardized 60-day episode rate pays for the delivery of home health services, which includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Claims must report all home health services provided to the beneficiary within the episode.

Healthcare Common Procedure Coding System (HCPCS) codes Q5001 through Q5009 currently describe where hospice services were provided (in the patient's home, assisted living facility, etc). These codes have been reported on hospice claims since 2007.

Medicare is planning to capture data to show where home health services were provided by requiring HHAs to report the location on the claim.

Effective for HH episodes beginning on or after July 1, 2013, HHAs are to use the HCPCS codes Q5001, Q5002, and Q5009 on home health claims to report where home health services were provided. The following table lists the definitions of the Q codes Q5001, Q5002, and Q5009, which were revised effective April 1, 2013:

HCPCS Code	Definition
Q5001	Hospice or home health care provided in patient's home/residence
Q5002	Hospice or home health care provided in assisted living facility
Q5009	Hospice or home health care provided in place not otherwise specified (NO)

The patient's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. Q code Q5002 should be used to indicate that home health services were provided at an assisted-living facility (as defined by the state in which the beneficiary is located). Conversely, Q code Q5001 should be used to indicate that home health services provided at a patient's residence except in the cases where the services are provided at an assisted living facility. Finally, Q code Q5009 may be reported in the rare instance an HHA believes the definitions of Q5001 and Q5002 do not accurately describe the location where services are provided.

The location where services were provided should be reported along with the first billable visit in a HH PPS episode. In addition to reporting a service line according to current instructions, HHAs must report an additional line item with the same revenue code and date of service, reporting one of the three Q codes (Q5001, Q5002, and Q5009), one unit, and a nominal charge (e.g., a penny).

If the location where services were provided changes during the episode, the new location should be reported with an additional line corresponding to the first visit provided in the new location.

Note: Revisions to the definitions of the Q codes above (Q5001, Q5002, and Q5009) will be published in the HCPCS update March 31, 2013.

(continued on next page)

DMEPOS *(continued)*

Billing information

Note the following billing requirements:

- HCPCS codes Q5001, Q5002, or Q5009 must be reported on HH PPS claims containing revenue code 042x, 043x, 044x, 055x, 056x, or 057x or the claim will be returned to the provider.
- The line item date of service of the line reporting Q5001, Q5002, or Q5009 must match the earliest dated HH visit line (revenue codes 042x, 043x, 044x, 055x, 056x, or 057x) on the claim or the claim will be returned to the provider.
- When more than one line on an HH PPS claim reports Q5001, Q5002, or Q5009, then the same HCPCS code must not be reported on consecutive dates or the claim will be returned to the provider.
- Claim lines reporting Q5001, Q5002, or Q5009 are not included in the visit counts passed to the HH Pricer, nor are they counted in medical policy parameters that count number of visits.

Additional information

The official instruction, CR 8136 issued to your A/B MACs and RHHIs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2680CP.pdf*.

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

MLN Matters® Number: MM8136
Related Change Request (CR) #: CR 8136
Related CR Release Date: April 2, 2013
Effective Date: Home Health Episodes beginning on or after July 1, 2013
Related CR Transmittal #: R2680CP
Implementation Date: July 1, 2013

April update to the 2013 Medicare physician fee schedule database

Note: This article was revised March 26, 2013, to reflect a revised change request (CR) 8169 issued March 26, 2013. In this article, the CR transmittal number, CR release date, and the Web address for accessing the CR are revised. All other information remains the same.

Provider types affected

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

What you need to know

This article is based on 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 (HHS) 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 Medicare physician fee schedule (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 is effective January 1, 2013.

(continued on next page)

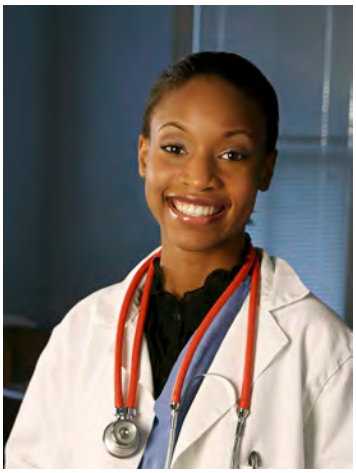
MPFS *(continued)*

- For *36222 – 36228*, their bilateral indicators are being corrected to "1" = 150 percent payment adjustment applies if billed with modifier 50. This change is effective January 1, 2013.
- *90785* Global indicator is being corrected to "ZZZ" (add-on). This change is effective January 1, 2013.
- The codes in the following table are having their short descriptors corrected or adjusted as shown on the next page. These changes are effective January 1, 2013.

HCPCS 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
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

(continued on next page)

MPFS *(continued)*



- 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 is effective January 1, 2013.
- *33961* Global indicator is being corrected to "XXX". This change is effective 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 are effective January 1, 2013.
- *81161* is being added to the fee schedule with a Procstat of "X" = Statutory exclusion. This change is effective 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 are effective April 1, 2013.
- The Procstat indicator of 3750F, 4142F, 6150F, 3517F is changing to "M" effective April 1, 2013.
- The Procstat indicator of G8559, G8560, G8561, G8562, G8563, G8564, G8565, G8566, G8567, G8568, Q0505 is changing to "I" effective April 1, 2013.
- 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, 2013.

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/R2677CP.pdf*.

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

MLN Matters® Number: MM8169
Related Change Request (CR) #: CR 8169
Related CR Release Date: March 26, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2677CP
Implementation Date: April 1, 2013

CMS releases hold on IPPS claims with technology add-on payments

The Centers for Medicare & Medicaid Services (CMS) recently identified an issue with the remittance advice associated with inpatient prospective payment (IPPS) system claims with new technology add-on payments and a date of discharge on or after April 1, 2013.

In the April 4, 2013, edition of *CMS Medicare FFS Provider e-News*, CMS wrote that it expects to resolve the issue by April 14, 2013. CMS has instructed Medicare contractors to hold such claims until it completes the correction. CMS will release held claims April 15, 2013.

Providers will experience little, if any, impact due to the hold. Under current law, Medicare contractors do not pay clean, electronic claims sooner than 14 calendar days after the date of receipt.

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

Automatic Medicare cuts affect drugs, durable medical equipment

Medicare fee-for-service claims were reduced by 2 percent for dates of service or dates of discharge on or after April 1, 2013, as a result of automatic budget cuts known as the sequester.

The Centers for Medicare & Medicaid Services (CMS) released the following frequently asked question (FAQ) to clarify how the reduction will affect durable medical equipment rentals.

Q: If a durable medical equipment capped rental period started before April 1, 2013, are the rental payments for months after April 1, 2013, subject to the 2 percent reduction?

A: Any claims for rental payments with a "FROM" date of service on or after April 1, 2013, will be subject to the 2 percent reduction, regardless of when the rental period began. For example, if a capped rental wheelchair was provided in February 2013, the monthly rental payment for May 2013 would be subject to the 2 percent sequestration reduction. The initial and subsequent monthly rental payments billed with a "FROM" date of service beginning on or prior to March 31, 2013 would not be affected by the 2 percent reduction.

Q: How long is the 2 percent reduction to Medicare fee-for-service claim payments in effect?

A: The law specifies that the 2 percent reduction to Medicare fee-for-service payments resulting from the sequestration order that the President was required to issue March 1, 2013, applies to all payments for services furnished in the one-year period after the reductions begin. For Medicare, the reductions begin on the first day of the first month after the order is issued, meaning they began April 1, 2013. Accordingly, this sequestration order covers all payments for services with dates of service or dates of discharge (or a start date for rental equipment or multi-day supplies) April 1, 2013, through March 31, 2014.

Q: Are drugs excluded from the 2 percent reduction?

A: No. All fee-for-service Medicare claim payments are subject to the 2 percent reduction. There are no exemptions provided in the law for drugs or any other health care item or service provided under the fee-for-service program.

Note: Previous FAQs related to sequestration were published in the March 2013 *Medicare A Connection*, Pages 34-35. You may also access the complete list at *http://medicare.fcso.com/faqs/answers/252060.asp*.

DMEPOS contract suppliers announced

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for round 2 and the national mail-order program of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

A list of contract supplier names is available at *www.dmecompetitivebid.com.* Contract supplier locations for each product category in each competitive bidding area can be found in the supplier directory at *www.medicare.gov/supplier*.

For additional information:

Press release

Fact sheet

New name for CBIC ombudsmen

CMS is changing the name of the competitive bidding implementation contractor (CBIC) ombudsmen to CBIC liaisons. This change will help distinguish the CBIC liaisons from the CMS Competitive Acquisition Ombudsman. The CBIC liaisons are now available to assist suppliers, referral agents, and other key stakeholders with questions and concerns about the program, provide assistance locating contract suppliers, and participate in educational events.

There is a dedicated CBIC liaison assigned in each of several regional geographic territories consisting of round 1, round 2, and national mail-order competitive bidding areas. A list of CBIC liaisons and their contact information is available at *www.dmecompetitivebid.com* under "Contact Us."

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

Reimbursement briefs

Implementation of CMS ruling 1455-R

On March 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued ruling 1455-R which establishes an interim process for hospitals to bill Medicare for Part B services following a denial of a claim for an inpatient admission as not reasonable and necessary. Affected providers shall follow temporary instructions for both the Part B types of bills (TOB), TOB 12x and TOB 13x that can be found at the following link: *http://www.cms.gov/Center/Provider-Type/Hospital/Other-Content-Types/Quick-Reference-CMS-1455-R.pdf*.

Requests to override timeliness

First Coast Service Options Inc. (First Coast) frequently receives requests to override timeliness on Part A claims when the reason is a patient status change. When submitting requests, Medicare providers must provide a detailed explanation that shows why the patient status is being changed.

The reason of "patient status" by itself is not justification enough to provide approval of a claim for claims filing timeliness. Claims filing timeliness requests will not be approved if a detailed explanation is not provided that substantiates why a claim could not have been filed timely, even for the reason of a correction to change the patient status.

Medicare payments for drugs used to treat macular degeneration

Providers who treat beneficiaries for age-related macular degeneration may be interested in the following report from the Office of the Inspector General (OIG) Medicare payments for drugs used to treat wet age-related macular degeneration (report OEI-03-10-00360). A summary and link to the full report are available on the following OIG website: *https://oig.hhs.gov/oei/reports/oei-03-10-00360.asp*.

Billing the correct units of service

The Centers for Medicare & Medicaid Services (CMS) guidance requires physicians and other providers to bill using the appropriate HCPCS or *CPT*® code and to accurately report the units of service.

Physicians and other providers should ensure that the units billed do not exceed the maximum number of units per day based on the code descriptor, reporting instructions associated with the code, and/or other CMS local or national policy.

CMS posts 2014 eligible hospital clinical quality measure update

The Centers for Medicare & Medicaid Services (CMS) recently updated the 2014 clinical quality measures (CQM) for eligible hospitals as well as the corresponding specifications for electronic reporting and access to the related data elements and value sets.

Clinical quality measures (CQM) gauge and track the quality of provided healthcare services. CQMs evaluate health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care coordination, patient engagements against established public health and clinical guidelines.

Beginning in 2014, CMS will use CQMs to align the electronic health record incentive programs and to reduce the burden on providers to report quality measures. The updated 2014 CQMs for eligible hospitals include new codes, logic corrections, and clarifications. CMS updates the specifications annually in order to ensure that specifications maintain alignment with current clinical guidelines, and remain relevant and actionable within the clinical care setting.

In the April 4, 2013, edition of *CMS Medicare FFS Provider e-News*, CMS provided a series of links to resources eligible hospitals may use to implement CQMs. Also, CMS recently updated the frequently asked questions section for the *Medicare EHR incentive programs for hospitals*.

2012 inpatient psychiatric facility prospective payment system changes

Note: This article was revised March 22, 2013, to add a reference to article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf* on the CMS website. SE 1239 announces the revised ICD-10 implementation date of October 1, 2014. All other content remains the same. This article was previously published in the October 2011 edition of *Medicare A Connection*.

Provider types affected

Hospitals submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for inpatient psychiatric services provided to Medicare beneficiaries and paid under the inpatient psychiatric facility prospective payment system (IPF PPS) are affected.

What you need to know

This article is based on change request (CR) 7506, which informs Medicare contractors about the FY 2012 update to the Medicare severity diagnosis related groups (MS-DRGs) and ICD-9-CM coding. The coding changes require an update to the IPF PPS' comorbidity adjustment, effective October 1, 2011. Please be sure to inform your staffs of these changes.

Background

The IPF PPS rate changes occurred on July 1, 2011. Please see the *MLN Matters*® article MM7367, "Update-Inpatient Psychiatric Facilities Prospective Payment System Rate Year 2012," issued on May 20, 2011, for the IPF PPS policy changes. To review this article, visit *http://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7367.pdf*.

DRG adjustment update

The IPF PPS has DRG specific adjustments for MS-DRGs. The Centers for Medicare & Medicaid Services (CMS) provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric MS-DRG will receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of Medicare's identified psychiatric DRGs, the IPF will still receive the Federal per diem base rate and all other applicable adjustments. The IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and MS-DRG classification system, in order to maintain consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note that these are the same adjustment factors in place since implementation.

Based on changes to the ICD-9-CM coding system used under the IPPS, the following changes are being made to the principal diagnoses that are used to assign MS-DRGs under the IPF PPS. The following table lists the FY 2012 new ICD-9-CM diagnosis codes that group to one of the MS-DRGs for which the IPF PPS provides an adjustment. This table is only a listing of FY 2012 new codes, and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the MS-DRGs. When coded as a principal diagnosis, these codes receive the correlating MS-DRG adjustment.

Diagnosis code	Description	MS-DRG
294.20	Dementia, unspecified, without behavioral disturbance	884
294.21	Dementia, unspecified with behavioral disturbance	884
310.81	Pseudobulbar affect	056,057
310.89	Other specified nonpsychotic mental disorders following organic brain damage	056,057
358.30	Lambert-Eaton syndrome, unspecified	056, 057
358.31	Lambert-Eaton syndrome, in neoplastic disease	056, 057
358.39	Lambert-Eaton syndrome in other diseases classified elsewhere	056, 057
331.6	Corticobasal degeneration	056, 057

The following table lists the FY 2012 invalid ICD-9-CM diagnosis code that is no longer applicable for the DRG adjustment.

Diagnosis code	Description	MS-DRG
310.8	Other specified nonpsychotic mental disorders following organic brain damage	884

The next table lists the 2012 revised ICD-9-CM diagnosis code that impacts the MS-DRG adjustment under the IPF PPS. The table only lists the 2012 revised code and does not reflect all of the currently valid ICD codes applicable for the IPF PPS MS-DRG adjustment.

Diagnosis code	Description	MS-DRG
317	Mild intellectual disabilities	884
318.0	Moderate intellectual disabilities	884
318.1	Severe intellectual disabilities	884
318.2	Profound intellectual disabilities	884
319	Unspecified intellectual disabilities	884

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Inpatient *(continued)*

The table below lists the seventeen MS-DRG adjustment categories for which CMS is providing an adjustment, their respective codes and their respective adjustment factors.

The MS-DRG adjustment factors, shown below, are effective October 1, 2011, and will continue to be paid for FY 2012.

MS-DRG	MS-DRG Description	Adjustment factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
080	Nontraumatic stupor & coma w MCC	1.07
081	Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnosis of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neurosis	0.99
882	Neurosis except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

The table to the right lists the FY 2012 new ICD-9-CM diagnosis codes which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment.

The table lists only the FY 2012 new codes, and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.

The FY 2012 IPF Pricer will be updated to include these codes in the comorbidity tables, effective for discharges on or after October 1, 2011.

Diagnosis code	Description	Comorbidity category
173.00	Unspecified malignant neoplasm of skin of lip	Oncology Treatment
173.01	Basal cell carcinoma of skin of lip	Oncology Treatment
173.02	Squamous cell carcinoma of skin of lip	Oncology Treatment
173.09	Other specified malignant neoplasm of skin of lip	Oncology Treatment
173.10	Unspecified malignant neoplasm of eyelid, including canthus	Oncology Treatment
173.11	Basal cell carcinoma of eyelid, including canthus	Oncology Treatment
173.12	Squamous cell carcinoma of eyelid, including canthus	Oncology Treatment
173.19	Other specified malignant neoplasm of eyelid, including canthus	Oncology Treatment
173.20	Unspecified malignant neoplasm of skin of ear and external auditory canal	Oncology Treatment
173.21	Basal cell carcinoma of skin of ear and external auditory canal	Oncology Treatment
173.22	Squamous cell carcinoma of skin of ear and external auditory canal	Oncology Treatment
173.29	Other specified malignant neoplasm of skin of ear and external auditory canal	Oncology Treatment
173.30	Unspecified malignant neoplasm of skin of other and unspecified parts of face	Oncology Treatment
173.31	Basal cell carcinoma of skin of other and unspecified parts of face	Oncology Treatment
173.32	Squamous cell carcinoma of skin of other and specified parts of face	Oncology Treatment
173.39	Other specified malignant neoplasm of skin of other and unspecified part of face	Oncology Treatment

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Inpatient *(continued)*

Diagnosis code	Description	Comorbidity category
173.40	Unspecified malignant neoplasm of scalp and skin of neck	Oncology Treatment
173.41	Basal cell carcinoma of scalp and skin of neck	Oncology Treatment
173.42	Squamous cell carcinoma of scalp and skin of neck	Oncology Treatment
173.49	Other specified malignant neoplasm of scalp and skin of neck	Oncology Treatment
173.50	Unspecified malignant neoplasm of skin of trunk, except scrotum	Oncology Treatment
173.51	Basal cell carcinoma of skin of trunk, except scrotum	Oncology Treatment
173.52	Squamous cell carcinoma of skin of trunk, except scrotum	Oncology Treatment
173.59	Other specified malignant neoplasm of skin of trunk, except scrotum	Oncology Treatment
173.60	Unspecified malignant neoplasm of skin of upper limb, including shoulder	Oncology Treatment
173.61	Basal cell carcinoma of skin of upper limb, including shoulder	Oncology Treatment
173.62	Squamous cell carcinoma of skin of upper limb, including shoulder	Oncology Treatment
173.69	Other specified malignant neoplasm of skin of upper limb, including shoulder	Oncology Treatment
173.70	Unspecified malignant neoplasm of skin of lower limb, including hip	Oncology Treatment
173.71	Basal cell carcinoma of skin of lower limb, including hip	Oncology Treatment
173.72	Squamous cell carcinoma of skin of lower limb, including hip	Oncology Treatment
173.79	Other specified malignant neoplasm of skin of lower limb, including hip	Oncology Treatment
173.80	Unspecified malignant neoplasm of other specified sites of skin	Oncology Treatment
173.81	Basal cell carcinoma of other specified sites of skin	Oncology Treatment
173.82	Squamous cell carcinoma of other specified sites of skin	Oncology Treatment
173.89	Other specified malignant neoplasm of other specified sites of skin	Oncology Treatment
173.90	Unspecified malignant neoplasm of skin, site unspecified	Oncology Treatment
173.91	Basal cell carcinoma of skin, site unspecified	Oncology Treatment
173.92	Squamous cell carcinoma of skin, site unspecified	Oncology Treatment
173.99	Other specified malignant neoplasm of skin, site unspecified	Oncology Treatment

The table below lists the FY 2012 invalid ICD-9-CM codes no longer applicable for the comorbidity adjustment. The FY 2012 IPF Pricer will be updated to remove these codes in the comorbidity tables, effective for discharges on or after October 1, 2011.

Diagnosis code	Description	Comorbidity category
173.0	Other malignant neoplasm of skin of lip	Oncology Treatment
173.1	Other malignant neoplasm of skin of eyelid, including canthus	Oncology Treatment
173.2	Other malignant neoplasm of skin of ear and external auditory canal	Oncology Treatment
173.3	Other malignant neoplasm of skin of other and unspecified parts of face	Oncology Treatment
173.4	Other malignant neoplasm of scalp and skin of neck	Oncology Treatment
173.5	Other malignant neoplasm of skin of trunk, except scrotum	Oncology Treatment
173.6	Other malignant neoplasm of skin of upper limb, including shoulder	Oncology Treatment
173.7	Other malignant neoplasm of skin of lower limb, including hip	Oncology Treatment
173.8	Other malignant neoplasm of other specified sites of skin	Oncology Treatment
173.9	Other malignant neoplasm of skin, unspecified	Oncology Treatment

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Inpatient *(continued)*

Because CMS has a new requirement to include related ICD-10 codes where applicable, the following table provides the current equivalent ICD-10-CM code for informational purposes only.

The IPF PPS will be fully converted to ICD-10 by October 1, 2013. Note that the following ICD-10-CM codes were obtained from the ICD-10-CM 2011 mappings because the FY 2012 mappings are not available at this time.

Diagnosis code	ICD-10-CM	Description
173.0	C44.0	Malignant Neoplasm of Skin of Lip
173.1	C44.10	Malignant Neoplasm Skin Uns Eyelid Incl Canthus
	C44.11	Malignant Neoplasm Skin Rt. Eyelid Incl Canthus
	C44.12	Malignant Neoplasm Skin Left Eyelid Incl Canthus
173.2	C44.20	Malignant Neoplasm Skin Uns Ear & Ext Auricular canal
	C44.21	Malignant Neoplasm Skin Rt. Ear & Ext Auricular Canal
	C44.22	Malignant Neoplasm Skin Left Ear & Ext Auricular Canal
173.3	C44.30	Malignant Neoplasm of Skin unspecified Part Face
	C44.31	Malignant Neoplasm of Skin of Nose
	C44.39	Malignant Neoplasm of Skin other Parts of Face
173.4	C44.4	Malignant Neoplasm of Skin of Scalp and Neck
173.5	C44.51	Malignant Neoplasm of Anal Skin
	C44.52	Malignant Neoplasm of Skin of Breast
	C44.59	Malignant Neoplasm of Other Part of Trunk
173.6	C44.60	Malignant Neoplasm Skin Uns Up Limb Incl Shoulder
	C44.61	Malignant Neoplasm Skin Right Up Limb Incl Shoulder
	C44.62	Malignant Neoplasm Skin left Up limb Incl Shoulder
173.7	C44.70	Malignant Neoplasm of Skin Uns Law Limb Incl Hip
	C44.71	Malignant Neoplasm of Skin of Rt. Low Limb Incl Hip
	C44.72	Malignant Neoplasm of Skin Left of Lowe Limb Incl Hip
173.8	C44.8	Malignant Neoplasm of overlapping sides of Skin
173.9	C44.9	Malignant Neoplasm of Skin Unspecified

The table below lists the FY 2012 revised ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table only lists the FY 2012 revised codes and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.

Diagnosis code	Description	Comorbidity category
317	Mild intellectual disabilities	Development disabilities
318.0	Moderate intellectual disabilities	Development disabilities
318.1	Severe intellectual disabilities	Development disabilities
318.2	Profound intellectual disabilities	Development disabilities
319	Unspecified intellectual disabilities	Development disabilities
968.5	Surface (topical) and infiltration anesthetics	Poisoning

The ICD-10-CM codes for the revised diagnosis codes were obtained from the ICD-10-CM 2011 mappings.

Diagnosis code	Description	ICD-10-CM
317	Mild intellectual disabilities	F70 Mild intellectual disabilities
318.0	Moderate intellectual disabilities	F71 Moderate intellectual disabilities
318.1	Severe intellectual disabilities	F72 Severe intellectual disabilities
318.2	Profound intellectual disabilities	F73 Profound intellectual disabilities
319	Unspecified intellectual disabilities	F78 Other mental retardation
		F79 Unspecified mental retardation

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Inpatient *(continued)*

Diagnosis code	Description	Comorbidity category
968.5	Surface (topical) and infiltration anesthetics	T41.3x1A Poison by Local Anes Acc Unintentional Int Enc
		T41.3x2A Poison by Local Anes Self-Harm Init Enc
		T41.3x3A Poisoning by Local Anes Assault Initial Encntr
		T41.3x4A Poisoning by Local Anes Undet initial Enctr

The table below lists the seventeen comorbidity categories for which we are providing an adjustment, their respective codes, including the new FY 2012 ICD codes, and their respective adjustment factors.

Description of comorbidity	Diagnoses codes	Adjustment factor
Developmental disabilities	317, 3180, 3181, 3182, and 319.	1.04
Coagulation factor deficits	2860 through 2864.	1.13
Tracheostomy	51900 through 51909 and V440.	1.06
Renal failure, acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585.	1.11
Renal failure, chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859,586, V4511, V4512, V560, V561, and V562.	1.11
Oncology treatment	1400 through 2399 with a radiation therapy code 92.21-92.29 or chemotherapy code 99.25.	1.07
Uncontrolled Diabetes-mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093.	1.05
Severe protein calorie malnutrition	260 through 262	1.13
Eating and conduct disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959.	1.07
Drug and/or alcohol induced mental disorders	2910, 2920, 29212, 2922, 30300, and 30400.	1.03
Cardiac conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854.	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, V4611, V4612, V4613 and V4614.	1.12
Artificial openings—digestive and urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe musculoskeletal and connective tissue diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

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Inpatient *(continued)*

Additional information

The official instruction, CR 7506, 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/R2289CP.pdf*. If you have any questions, please contact your FI or A/B MAC 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*.

For current information on the new ICD-10 implementation date of October 1, 2014, see article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*.

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Related Change Request (CR) #: CR 8182
Related CR Release Date: August 26, 2011
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Related CR Transmittal #: R2289CP
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Outpatient laboratory services rendered in a critical access hospital

Provider types affected

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

Provider Action Needed

This article is based on change request (CR) 8025 which informs Medicare contractors about the implementation of the necessary system changes to apply beneficiary cost sharing for non-clinical diagnostic laboratory services rendered in an outpatient critical access hospital (CAH) setting. 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

Currently, all outpatient laboratory services, other than clinical diagnostic laboratory services, do not have coinsurance and/or deductible applied to them. Medicare beneficiaries are not liable for any coinsurance, deductible, copayment, or other cost sharing amounts for outpatient clinical diagnostic laboratory services. However, there are non-clinical diagnostic laboratory services for which coinsurance and deductible should be applicable. CR 8025 implements the necessary system changes to apply beneficiary cost sharing for non-clinical diagnostic laboratory services rendered in an outpatient CAH setting.

Per the regulation at CFR 413.70(b)(3)(iii), payment to a CAH, other than for clinical diagnostic laboratory tests, is subject to the Part B deductible and coinsurance amounts as determined under 410.152(k), 410.160, and 410.161. Medicare contractors will apply the correct coinsurance and deductible based on the HCPCS file.

Additional information

The official instruction, CR 8025 issued to your FI or A/B MAC, regarding this change may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2581CP.pdf*.

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

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Related Change Request (CR) #: CR 8025
Related CR Release Date: November 2, 2012
Effective Date: April 1, 2013
Related CR Transmittal #: R2581CP
Implementation Date: April 1, 2013

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Medicare beneficiary data for inpatient prospective payment system

Note: This article was revised on March 22, 2013, to reflect the revised change request (CR) 8078 issued on March 21. In this article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider types affected

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

What you need to know

This article is based on CR 8078 which requires Medicare contractors to update their IPPS, IRF, and LTCH provider specific files prospectively, within 30 days of the implementation date of CR 8078, using the latest year's SSI Ratio that is posted to the Centers for Medicare & Medicaid Services (CMS) website as of the implementation date of CR 8078. Separate instructions will be issued to CMS contractors regarding the settlement of cost reports that use the fiscal year (FY) 2010 SSI ratios.

Background

Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that for discharges occurring on or after May 1, 1986, an additional payment must be made to IPPS hospitals serving a disproportionate share of low income patients. The additional payment is determined by multiplying the Federal portion of the diagnosis-related group (DRG) payment by the disproportionate share hospital (DSH) adjustment factor. (See 42 CFR 412.106.)

Under IRF PPS, IRFs receive an additional payment amount to account for the cost of furnishing care to low income patients. The additional payment is determined by multiplying the federal prospective payment by the low income patient (LIP) adjustment factor. (See 42 CFR 412.624(e)(2).)

Under the LTCH PPS, the payment adjustment for short-stay outlier (SSO) cases at 42 CFR 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (i.e., the "IPPS comparable amount"). This calculation includes the DSH adjustment where applicable, using the best available SSI data at the time of claim payment (See 42 CFR412.529 (d)(4)).

CMS is providing its contractors with updated data for determining the disproportionate share adjustment for IPPS hospitals and the low income patient adjustment for IRFs, and updated data for determining payments for SSO cases under the LTCH PPS. The SSI/Medicare beneficiary data for hospitals are available electronically and contains the name of the hospital, CMS certification number, SSI days, total Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. The files are located at the following CMS website addresses:

- IPPS: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/AcuteInpatientPPS/dsh.html*;
- IRF: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/InpatientRehabFacPPS/SSIData.html*; and
- LTCH: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/LongTermCareHospitalPPS/download.html*

In addition, the data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during FY 2010 (cost reporting periods beginning on or after October 1, 2009, and before October 1, 2010). Please note that separate instructions will be issued to CMS contractors regarding the settlement of cost reports that use the fiscal year (FY) 2010 SSI ratios at a future date.

Additional information

The official instruction, CR 8078 issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1200OTN.pdf* on the CMS website.

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

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

Critical deadline approaches for LTCH quality reporting program

May 15 deadline for FY 2014 data submission

To avoid a 2 percent reduction in their annual payment update, long-term care hospitals (LTCH) face an important deadline for reporting activities related to the LTCH Quality Reporting (LTCHQR) program.

LTCHs are required to report information about percent of pressure ulcers, urinary tract and bloodstream infections associated with catheter use that patients experience within their facility. In 2012, CMS adopted three measures for data collection and reporting for October 1 through December 31, 2012 for the fiscal year (FY) 2014 payment update determination:

- Percent of residents with pressure ulcers that are new or worsened (NQF #0678)
- Urinary catheter-associated urinary tract infection (CAUTI) (NQF #0138)
- Central line catheter-associated bloodstream infection (CLABSI) (NQF #0139)

Current definitions for the three LTCH quality measures are available in the *LTCHQR Program Manual* in the "Downloads" section of at the bottom of the *LTCHQR program website*.

2015 payment update determination

In addition to engaging in data submission activities for the FY 2014 payment update determination, LTCHs should be collecting data on these three measures for the FY 2015 payment update determination.

For the four reporting periods in 2013, the final deadlines for data submission are August 15, 2013 for January through March 2013. Second, third and fourth quarter data is due November 15, 2013, February 15, 2014, and May 15, 2014, respectively for FY 2015 payment update determination.

More information about the *LTCH quality reporting program* is available on the CMS dedicated website.

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

Quarterly provider update

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

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

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

CMS administrator's ruling: Part B rebilling of denied hospital claims

Provider types affected

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

What you need to know

This article is based on change request (CR) 8185, which implements the Centers for Medicare & Medicaid Services (CMS) administrator's ruling CMS-1455-R, issued March 13, 2013. This ruling permits you to bill under Part B, certain services when an inpatient Part A claim is denied by a Medicare contractor for the reason that the inpatient admission was not reasonable and necessary. CR 8185 includes specific guidance for contractors to accept such Part B claims. Make sure that your billing staffs are aware of these changes. The ruling provides an interim policy to address certain Part A appeal decisions by administrative law judges (ALJs) and the Medicare Appeals Council, while CMS establishes permanent policy changes through notice and comment rulemaking under CMS-1455-P, issued concurrently with CMS-1455-R.

Background

When a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner may admit the beneficiary for inpatient care or treat him or her as an outpatient. In some cases, when the physician admits the beneficiary and the hospital provides inpatient care, a Medicare review contractor such as a Medicare administrative contractor (MAC), recovery auditor, or the comprehensive error rate testing contractor determines that inpatient care was not reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act and denies the associated Part A claim for payment. To date under the Medicare program, in these cases hospitals may bill a subsequent Part B inpatient claim for a limited set of medical and other health services referred to as "Part B Inpatient" or "Part B Only" services, specified in the "*Medicare Benefit Policy Manual* (MBPM)," Chapter 6, Section 10, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf*. Prior to CT8185, these Part B claims were considered new claims that are subject to the timely filing restrictions.

In an increasing number of cases, hospitals that have appealed these Part A inpatient claim denials to ALJs and the Medicare appeals council have received decisions upholding the Medicare review contractor's determination that the inpatient admission was not reasonable and necessary, but effectively requiring Medicare to issue payment for all Part B services that would have been payable had the beneficiary

been treated as a hospital outpatient (rather than an inpatient), instead of limiting payment to only the set of Part B inpatient services that are designated in the MBPM. Moreover, the decisions have required payment regardless of whether the subsequent hospital claim for payment under Part B is submitted within the otherwise applicable time limit for filing Part B claims. While these Medicare appeals council and ALJ decisions are contrary to CMS' longstanding policies, CMS is bound to effectuate each individual decision, which has created numerous operational difficulties. The Administrator's ruling establishes a standard process for effectuating these decisions and handling pending claims and appeals in the interim while CMS finalizes policy changes going forward. The administrator's ruling also addresses the scope of administrative review in these and other, similar cases.

The administrator's ruling establishes that, when a Part A claim for a hospital inpatient admission is denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, the hospital may submit Part B claims for services that would have been payable to the hospital had the beneficiary originally been treated as a hospital outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status.

Specifically, the hospital may bill for more Part B services than just those listed in the Manual section noted above, including all Part B services that would have been payable to the hospital had the beneficiary originally been treated as a hospital outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status, for example, outpatient visits, emergency department visits, and observation services. Such services that require an outpatient status cannot be billed for the time period the beneficiary spent in the hospital as an inpatient and cannot be included on the Part B inpatient claim.

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Claims *(continued)*

Hospitals may also bill separately for outpatient services provided in the three-day payment window (one day for hospital not subject to the Inpatient prospective payment system or IPPS) prior to the inpatient admission as the outpatient services that they were on an outpatient Part B claim (see the *Medicare Claims Processing Manual*, Chapter 4, Section 10.12, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*), including services that require an outpatient status.

Hospitals may only submit claims for Part B inpatient and Part B outpatient services that are reasonable and necessary in accordance with Medicare coverage and payment rules and must maintain documentation to support the services for which they are billing.

For claims filed under the administrator's ruling, the beneficiary's patient status remains inpatient as of the time of the inpatient admission and is not changed to outpatient, because the beneficiary was formally admitted as an inpatient and there is no provision to change a beneficiary's status after he or she is discharged from the hospital. CMS notes that because the beneficiary's patient status remains inpatient, rebilling under the ruling does not impact skilled nursing facility (SNF) eligibility.

The policy in the administrator's ruling's supersedes any other statements of policy on the issues therein and remains in effect until the effective date of the regulations that finalize CMS's proposed rule titled, "Medicare Program; Part B Inpatient Billing in Hospitals" (CMS-1455-P), which was issued concurrently with the administrator ruling and will establish a final policy that will apply prospectively from the effective date of the finalized regulations for CMS-1455-P.

Applicability

This interim policy applies to Part A hospital inpatient claims denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, as long as the denial is/was made:

(1) While the administrator's ruling is in effect;

(2) Prior to the effective date of the administrator's ruling, but for which the timeframe to file an appeal has not expired; or

(3) Prior to the effective date of the administrator's ruling, but for which an appeal is pending. The ruling does not apply to Part A hospital inpatient claim denials for which the timeframe to appeal expired prior to the effective date of the ruling (March 13, 2013). In addition, the ruling does not apply to other instances in which CMS currently provides for limited Part B inpatient billing when a beneficiary has no Part A coverage for an inpatient hospital stay (e.g., exhausted Part A benefit days). Finally, the ruling applies only to claim denials by a Medicare review contractor and not to hospital self-audits.

Treatment of pending appeals and denials and submitting part b claims under the ruling

The ruling provides hospitals with notice of their right to either submit Part B claims following denial of a Part A inpatient admission as described above, or continue to pursue an appeal of the Part A denial. In order to prevent duplicate billing and payment, a hospital may not have simultaneous requests for payment under both Parts A and B for the same services provided to a single beneficiary on the same dates of service. Thus, if a hospital chooses to submit a Part B claim for payment following the denial of a Part A inpatient admission, consistent with the Ruling, the hospital cannot also maintain its request for payment for the same services on the Part A claim. In this situation, the hospital must withdraw any pending appeal request on the Part A claim before submitting a Part B claim. If a contractor determines that a hospital has submitted a Part B claim for payment while a Part A appeal is pending (i.e., the request has not been withdrawn and a decision on the request has not been issued), the Part B claim for payment shall be denied as a duplicate and the Part A appeal will continue. Once the hospital submits a Part B claim, parties will no longer be able to request further appeals of the Part A claim. Rather, parties will be able to exercise their appeal rights for the subsequent Part B claim under existing procedures in 42 CFR part 405 Subpart I. If a Part A appeal is mistakenly processed after a hospital submits a Part B claim, no additional payment shall be made with respect to the Part A claim in effectuating the Part A decision.

Requests for withdrawal of pending Part A claim appeals must be sent to the adjudicator with whom the appeal is currently pending. Until and unless an appeal is withdrawn by the appellant, contractors will continue processing all pending Part A appeals that are subject to the ruling. The ruling also established a policy for handling appeals remanded from the ALJ level to the QIC level. Remanded cases will be returned to the ALJ level for adjudication of the Part A claim appeal. Information regarding requests for withdrawal will be available to appellants on the Office of Medicare

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Claims *(continued)*

Hearing and Appeals public website at *http://www.hhs.gov/omha* on the Internet.

Coding and submission of Part B claims

To receive payment under Part B, the hospital shall submit the Part B claims that are required under current policy, i.e., a Part B inpatient 12x type of bill (TOB) for services furnished during the inpatient admission and an 11x inpatient provider liable TOB. On the 12x TOB, the hospital must code the reasonable and necessary Part B services furnished during the inpatient admission, and must, when available, provide the Healthcare Common Procedure Coding System (HCPCS) code(s), *Current Procedure Terminology* (*CPT*®) code(s) and revenue code(s) that describe the reasonable and necessary services that were ordered and rendered in accordance with Medicare rules and regulations, and that are documented in the medical record. Also the hospital shall submit a 13x Part B outpatient TOB to receive payment for all reasonable and necessary Part B services furnished in the three-day payment window (one day for non-IPPS hospitals) prior to the inpatient admission.

Hospitals submitting Part B inpatient claims subject to this interim policy shall include condition code "W2" on the claim. By using the "W2" condition code on the Part B claim(s), the hospital acknowledges that the Part B claim is a duplicate of the previously denied Part A claim, that no payment shall be made with respect to the items or services included on the Part A claim, and that any amounts collected from the beneficiary with respect to the Part A claim will be refunded to the beneficiary. By using the "W2" condition code, the hospital attests that there is no pending appeal with respect to a previously submitted Part A claim, and that any previous appeal of the Part A claim is final or binding or has been dismissed, and that no further appeals shall be filed on the Part A claim.

Hospitals shall include the appropriate Part B billing treatment authorization code on the 121 or 131 TOB. The treatment authorization code is "A/B Rebilling". Once CR 8185 is implemented, hospitals billing a 837I claim shall place this appropriate Prior Authorization code into Loop 2300 REF02 (REF = G1) as follows: REF*G1*A/B Rebilling~

For direct data entry (DDE) or paper claims, hospitals are instructed, upon implementation of CR 8185, to use Field 5/MAP1715 (for DDE) or Treatment Authorization Field #63 (for paper). Additionally, hospitals shall also include in remarks on the 121 or 131 TOB:

- The original, denied inpatient claim (CCN/DCN/ICN) number, and
- The last adjudication date.

Once CR 8185 is implemented, providers billing a 837I claim shall place the DCN and last adjudication date shall be included in the Billing Notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234-99999999~

On both claim submission types, the word "ABREBILL," the original, denied inpatient DCN/CCN/ICN and last adjudication date shall be added to the Remarks Field (form locator #80) on the claim using the following format: "ABREBILL12345678901234-99999999," where the "12345678901234" is meant to represent the original claim DCN/ICN numbers from the inpatient denial and the second number string (99999999) is meant to represent the most recent adjudication date in mmddyyyy format.

Scope of review of pending appeals

As explained in the ruling, hospitals are solely responsible for both submitting claims for items and services furnished to beneficiaries and determining whether submission of a Part A or Part B claim is appropriate. Once a hospital submits a claim, the Medicare contractor can make an initial determination and determine any payable amount.

Accordingly, an appeals adjudicator's scope of review is limited to the claim(s) that are before them on appeal, and appeals adjudicators may not order payment for items or services that have not yet been billed or have not yet received an initial determination. If a hospital submits an appeal of a determination that a Part A inpatient admission was not reasonable and necessary, the only issue before the adjudicator is the propriety of the Part A claim, not any issue regarding any potential Part B claim the provider has not yet submitted.

Additional information

The official instruction, CR 8185, 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/R1203OTN.pdf*.

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

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Claims processing instructions for inlier bills and cost outlier bills with benefits exhausted

Provider types affected

This *MLN Matters*® special edition (SE) article is intended for providers who submit claims to fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs).

What You Need to Know

As a reminder, consistent with existing policy, the methodology for using benefit days and reimbursing for cost outliers is based on the beneficiary having a lifetime reserve (LTR) benefit day which they elect to use or a regular benefit (regular or coinsurance) day beginning the day after the day that a beneficiary incurs covered charges in an amount that results in a cost outlier payment for the provider.

Additional charges will be considered covered for every day thereafter for which a beneficiary has, and elects to use, an available benefit day.

Diagnosis related group (DRG) claims with cost outlier payments with discharge dates on or after October 1, 1997, must have an occurrence code (OC) 47 on the claim unless there are enough full and/or coinsurance days to cover all the medically necessary days or the only available benefits are LTR days and there are enough LTR days to cover all the medically necessary days. DRG claims without cost outlier payments can never have regular benefit days combined with LTR benefit days.

Any provider who has a claim reject because of PRICER return code 67, must determine the dollar amount of the cost outlier threshold. The dollar amount of the cost outlier threshold can be determined in one of two ways.

The first and preferred method is to use the cost outlier threshold amount returned with the remittance advice, other notice of claims returned to the provider or direct data entry (DDE) claims correction screen for bills submitted after systems changes have been made to provide this amount.

The second way is to use the instructions provided herein to download PC PRICER and calculate the amount based on data from the claim.

Once the cost outlier threshold is known, providers must add the daily covered charges for the claim until they determine the day that covered charges reach the cost outlier threshold. Providers must exclude days and covered charges during noncovered spans, e.g., during occurrence span code (OSC) 74, 76, or 79 dates. Providers must then submit the date of the first full day of cost outlier status (the day after the day that covered charges reach the cost outlier threshold) on the bill using OC 47. The OC 47 date cannot be equal to or during OSC 74, 76, or 79 dates.

Providers must determine the amount of regular, coinsurance, and LTR days the beneficiary has available per a common working file (CWF) inquiry (HIQA) or their A/MAC.

Any non-utilization/inlier days after the beneficiary exhausts coinsurance or LTR days before the OC 47 date will be coded using OSC 70. LTR days should be used as necessary and as elected by the beneficiary.

If coinsurance days are exhausted during the inlier portion of the stay and there is a period of non-utilization/inlier indicated by the presence of OSC 70 and the beneficiary elects not to use LTR days, covered charges are limited to the exact amount of the cost outlier threshold and both OC A3, which shows the last covered day, and OC 47, which shows the following day which is the first full day of cost outlier status, must be shown.

When coinsurance and/or LTR days are exhausted during the cost outlier portion of the stay, OC A3 should be used as appropriate to report the date benefits are exhausted.

Covered charges should be accrued to reflect the entire period of the bill if the bill is fully covered or the entire period up to and including the date benefits were exhausted, if benefits were exhausted. The following examples further illustrate current policy:

Assumptions for all of the following outlier examples

1. Cost outlier threshold amount is $50,000
2. Threshold amount is reached on the 25th day
3. Billed charges are $1,000 each day thereafter
4. Beneficiary elects to use any available LTR days

Example 1: LTR Days Cover Cost Outlier

- Dates of service: 1/1/13 - 1/31/13 discharge
- Medically necessary days: 30
- Covered charges: $55,000

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Inlier *(continued)*

- Benefits available: 30 LTR covered days: 30
- Noncovered days: 0
- Cost report days: 30
- All charges for Medicare approved revenue codes billed as covered
- No OC 47 needed
- Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges

Example 2: LTR days exhaust in the cost outlier

- Dates of service: 1/1/13 - 2/10/13 discharge
- Medically necessary days: 40
- Covered charges: $65,000
- Benefits available: 30 LTR covered days: 30
- Noncovered days: 10
- Cost report days: 30
- 30 days covered charges for Medicare approved revenue codes and 10 days noncovered charges
- OC 47: 1/26/13
- OC A3: 1/30/13
- Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges
- ($50,000 inlier and $5,000 outlier)

Example 3: LTR days exhaust prior to cost outlier

- Dates of service: 1/1/13 - 1/31/13 discharge
- Medically necessary days: 30
- Covered charges: $55,000
- Benefits available: 20 LTR covered days: 20
- Noncovered days: 10
- Cost report days: 25
- 25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
- OC 47: 1/26/13
- OC A3: 1/25/13
- OSC 70: 1/21/13-1/25/13
- Reimbursement: Full DRG payment, no cost outlier

Example 4: Coinsurance days exhaust prior to cost outlier and no ltr days are available

- Dates of service: 1/1/13 - 1/31/13 discharge
- Medically necessary days: 30
- Covered charges: $55,000
- Benefits available: 20 coinsurance
- Covered days: 20
- Noncovered days: 10
- Cost report days: 25
- 25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
- OC 47: 1/26/13
- OC A3: 1/25/13
- OSC 70: 1/21/13-1/25/13
- Reimbursement: Full DRG payment, no cost outlier

Example 5: Coinsurance days exhaust prior to cost outlier. ltr days exhaust in the cost outlier

- Dates of service: 1/1/13 - 2/10/13 discharge
- Medically necessary days: 40
- Covered charges: $65,000
- Benefits available: 20 coinsurance and 10 LTR Covered days: 30
- Noncovered days: 10
- Cost report days: 35
- 35 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
- OC 47: 1/26/13
- OC A3: 2/4/13
- OSC 70: 1/21/13-1/25/13
- Reimbursement: Full DRG payment plus cost outlier based on $60,000 covered charges ($50,000 inlier, $10,000 outlier, $5,000 noncovered)

Example 6: Full and coinsurance days cover cost outlier

- Dates of service: 1/1/13 - 1/31/13 discharge
- Medically necessary days: 30
- Covered charges: $55,000
- Benefits available: 10 full and 20 coinsurance
- Covered days: 30
- Noncovered days: 0
- Cost report days: 30

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Inlier *(continued)*

- All charges for Medicare approved revenue codes billed as covered
- No OC 47 needed
- Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges

Example 7: Coinsurance days and ltr days exhaust in the cost outlier

- Dates of service: 1/1/13 - 2/28/13 discharge
- Medically necessary days: 58
- Covered charges: $83,000
- Benefits available: 10 full, 30 coinsurance and 10 LTR Covered days: 50
- Noncovered days: 8
- Cost report days: 50
- 50 days covered charges for Medicare approved revenue codes and 8 days noncovered charges
- OC 47: 1/26/13
- OC A3: 2/19/13
- Reimbursement: Full DRG plus cost outlier based on $75,000 covered charges
- ($50,000 inlier, $25,000 outlier, $8,000 noncovered)

Example 8: LTR days exhaust prior to cost outlier and noncovered span(s) present

- Dates of service: 1/1/13 - 1/31/13 discharge
- Medically necessary days: 28
- OSC 76: 1/10/13 - 1/11/13
- Covered charges: $55,000
- Benefits available: 20 LTR Covered days: 20
- Noncovered days: 10
- Cost report days: 25
- 25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
- OC 47: 1/28/13
- OC A3: 1/27/13
- OSC 70: 1/23/13-1/27/13
- Reimbursement: Full DRG payment, no cost outlier.

Assumptions for all of the following inlier-only examples

1. Cost outlier threshold amount is $60,000
2. Threshold amount is not reached
3. Beneficiary elects to use any available LTR days

Example 9: Full and coinsurance days cover inlier and no cost outlier

- Dates of service: 1/1/13 - 2/15/13 discharge
- Medically necessary days: 45
- Covered charges: $55,000
- Benefits available: 10 full and 30 coinsurance
- Covered days: 40
- Noncovered days: 5
- Cost report days: 45
- All charges for Medicare approved revenue codes billed as covered
- No OC 47 needed
- OSC 70: 2/10/13-2/15/13
- Reimbursement: Full DRG payment based on $55,000 covered charges within Inlier

Example 10: Coinsurance days cover inlier and no cost outlier

- Dates of service: 1/1/13 - 1/31/13 discharge
- Medically necessary days: 30
- Covered charges: $55,000
- Benefits available: 20 coinsurance
- Covered days: 20
- Noncovered days: 10
- Cost report days: 30
- 30 days covered charges for Medicare approved revenue codes
- No OC 47 needed
- OSC 70: 1/21/13-1/31/13
- Reimbursement: Full DRG payment based on $55,000 covered charges within Inlier

Example 11: LTR days cover inlier and no cost outlier

- Dates of service: 1/1/13 - 1/31/13 discharge
- Medically necessary days: 30
- Covered charges: $55,000
- Benefits available: 20 LTR

(continued on next page)

Inlier *(continued)*

- Covered days: 20
- Noncovered days: 10
- Cost report days: 30
- 30 days covered charges for Medicare approved revenue codes
- No OC 47 needed
- OC A3: 1/31/13
- OSC 70: 1/21/13-1/31/13
- Reimbursement: Full DRG payment based on $55,000 covered charges within Inlier

When a beneficiary uses all of their available Part A days during the inlier portion of the stay (all coinsurance days are utilized and beneficiary elects not to use LTR days or only LTR days are utilized and there are not enough to cover the entire stay) and there is no outlier payment, you may not submit a 12x claim for Medicare covered ancillary services after the benefits exhaust.

When a beneficiary uses all of their available Part A days during the outlier portion of the stay (all coinsurance and elected LTR days), you may submit a 12x type of bill (TOB) claim for Medicare covered ancillary services after the benefits exhaust.

If benefits are exhausted prior to the stay, submit a no pay claim, which will be coded by the FI with no pay code B. Report any services that can be billed under the Part B benefit using 12x TOB.

As a reminder, you should verify your systems edit logic for correct application of this policy.

Additional information

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

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April 2013 claim hold lifted

The Centers for Medicare & Medicaid Services has directed its Medicare claims administration contractors to release all claims into processing that they have been holding as a result of technical issues associated with the April 2013 quarterly systems release.

The claim types being released on Wednesday, April 17, 2013, are

1. home health final claims
2. outpatient critical access hospital and rural health clinic claims where dollars have been applied to the beneficiary deductible,
3. inpatient prospective payment (IPPS) system claims with new technology add-on payments,
4. IPPS claims with outlier payments,
5. outpatient claims with outlier payments,
6. endstage renal disease claims with outlier payments, and
7. psychiatric hospital claims with outlier payments and no other payment. In summary, at this time all Medicare fee-for-service claims are being processed under normal procedures.

As a reminder, the Medicare claim administration contractors released the Medicare Advantage IPPS with indirect medical education claims as well as the assistant-at-surgery services and ambulatory surgical center claims into processing on Monday, April 15, 2013.

Source: CMS PERL 201304-07

Educational Events

Provider outreach and educational events – May/June 2013

Medifest 2013 - Fort Lauderdale

When: May 21-22
Location: Renaisssance 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

Medicare Part A: Prepayment review of hospital claims — inpatient DRGs

When: Thursday, June 13
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

Medicare Part A: Changes and regulations

When: Tuesday, June 18
Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

1. **Online** – Visit *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 with no national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.
2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 904-791-8103. Class materials will be faxed to you the day of the event.

Please note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking the *Education* section of our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit *medicare.fcso.com*, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

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

Other Educational Resources

CMS Medicare Provider e-News

The Centers for Medicare & Medicaid Services (CMS) Medicare Provider e-News is an official *Medicare Learning Network*® (*MLN*)-branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate.

To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to the latest e-News:

- 'CMS Medicare FFS Provider e-News': March 21, 2013, – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-21-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': March 28, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-28Enews.pdf*
- 'CMS Medicare FFS Provider e-News': April 4, 2013 –*http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-04-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': April 11, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-11-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': April 18, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-18Enews.pdf*
- 'CMS Medicare FFS Provider e-News': April 25, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-25Enews.pdf*

Source: CMS PERL 201303-04, 201303-05, 201304-02, 201304-04, 201304-08, 201304-10

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

Puerto Rico Contact Information

Back to Contents

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

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

Phone Numbers

Providers

Customer service – free of charge
Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-908-8433

For the hearing and speech impaired (TDD)
1-888-216-8261

Interactive voice response (IVR)
1-877-602-8816

Beneficiary

Customer service – free of charge
1-800-MEDICARE
1-800-633-4227

For the hearing and speech impaired (TDD)
1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number
1-904-361-0407

Audit And Reimbursement Department

Fax number
1-904-361-0407

Websites

Providers

First Coast – MAC J9
medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services
www.medicare.gov