Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

May 2013

In this issue

Medical documentation problems contribute to denied claims

Using data and analysis from First Coast Services Options Inc., (First Coast) Florida hospitals are improving their medical documentation of services they provide Medicare beneficiaries to ensure those services are paid in full.

First Coast recently presented analysis showing hospitals in Florida may be short-changing themselves by as much as $360 million in potential lost reimbursements, because the medical documentation filed with each claim falls short of Medicare standards for demonstrating medical necessity for hospital services.

In 2012, First Coast found 9,100 denied Medicare claims lacked the necessary medical documentation in order to be paid. Since First Coast presented its concern to hospitals through webcasts, many hospitals have begun improving medical documentation in their facilities with the goal to reduce the number of denied claims.

Cheryl MacKinnon, Director of Government Insurance for Lee Memorial Health System (LMHS), said First Coast webinars were important to their efforts in improving the health system's experience with documentation of physician orders and patient history.

After reviewing the initial educational materials from First Coast, LMHS began tracking additional document requests (ADR) and requests for more information about individual claims from the recovery auditor. Their strategy evolved quickly to employing two staff members to develop and manage a revised process for tracking such requests on a daily basis.

Sixteen months into the process, the ADR and recovery auditor tracking system produces monthly reports that LMHS uses to improve medical documentation. "We can tell when (requests for documentation for) one DRG is going up or going down and be proactive about improving our process," MacKinnon said.

Second, LMHS placed two nurses in their surgical scheduling area to review patient charts in advance of surgery to ensure the chart clearly demonstrated the medical necessity of the scheduled procedure.

MacKinnon said this was a critical component to improving their experience with prepayment review of medical claims. "This was once viewed as a problem for the billing office. Now we see it requires a clinical component in reviews and appeals. It is a much greater collaborative effort," she said.

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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.

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Documentation *(continued)*

MacKinnon cited DRG 470, major joint replacement, as an example of how LMHS changed its approach to medical documentation. She said the data suggested the system was on a prepayment review.

"We worked with our orthopedic physicians and surgical teams to focus on improving documentation. By working collaboratively, it helped us see the whole picture. Now the physicians and their offices know well before the service is provided what we need in order to get a claim paid," MacKinnon said. MacKinnon says the system is no longer seeing the level of ADR and recovery auditor requests they were experiencing prior to January 2012.

"In the beginning it was a baby-step process with a few of our targeted DRGs. Once we began, it became a self-improving process as our physicians and their staffs learned what to expect for all procedures, not just those DRGs we were focused on," MacKinnon said.

Though the analysis showed a clear majority of the denials fell short due to incomplete documentation of medical necessity, First Coast also denied hospital claims for inappropriate levels of care such as an inpatient admission for an ear infection and a series of other reasons such as incorrect diagnosis codes applied to procedures.

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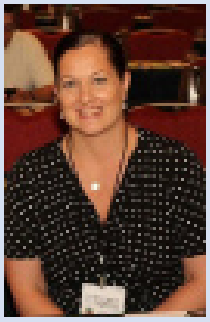
-Cheryl McKinnon,
Lee Memorial Health System



In its February update to medical providers, First Coast Provider Outreach and Education staff presented the data from the analysis and offered tips on how providers might improve medical documentation. First Coast Provider Outreach and Education staff illustrated three examples of DRGs where documentation resulted in a paid claim versus a denial. Staff cautioned that it is the physician's expert opinion as reflected in the medical record documentation that determines medical necessity.

First Coast continues to assist providers with improving medical documentation, hosting a webcast Tuesday, June 13, 11:30 a.m. to 1 p.m. on "Prepayment medical review of hospital review of hospital claims." Click *here* to register for this event.

In addition, recorded webcasts which summarize the issue for health providers may be reviewed on *First Coast's provider education* Web pages.

CMS releases comparative billing reports on E/M services

The Centers for Medicare & Medicaid Services (CMS) issued national provider comparative billing reports (CBR) in May to assist providers with addressing the documentation and billing practices of evaluation and management services (E/M) for Medicare beneficiaries.

CBRs, produced by SafeGuard Services, sent select providers a state and national comparison of billing and payment patterns related to E/M services.

According to CMS, the CBR is intended to help providers identify potential errors in their billing practice of E/M services provided to Medicare beneficiaries.

A CBR contains peer comparisons with state and national data which can be used to provide helpful insights into coding and billing practices.

To review a sample of the evaluation and management services CBR, please visit the *CBR Services* website, or call the SafeGuard Services' provider help desk at 530-896-7080.

First Coast Service Options Inc., (First Coast) also maintains abundant information to assist providers in improving their billing practices. For more information about documenting and billing E/M services, click on the First Coast E/M page *http://medicare.fcso.com/Landing/233030.asp*.

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

National physician payment transparency program: open payments

Provider types affected

This *MLN Matters*® special edition article is intended to inform physicians and teaching hospitals of the National Physician Payment Transparency Program (Open Payments) being implemented by CMS to satisfy Section 6002 of the Affordable Care Act.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) published, February 8, 2013, a final rule that is intended to increase public awareness of financial relationships between manufacturers of drugs, devices, biologicals and medical supplies, as well as between applicable group purchasing organizations (GPOs), and physicians and teaching hospitals. Known as the "National Physician Payment Transparency Program: Open Payments," this is one of many steps in the Affordable Care Act designed to create greater transparency in the health care market.

Background

On February 8, 2013, CMS published a final rule, titled the "Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests."

With this program, applicable manufacturers and applicable GPOs will begin tracking and reporting payments and other transfers of value made to physicians and teaching hospitals, as well as certain ownership interests held in the organizations by physicians and their immediate family members. CMS will collect the data annually, aggregate it, and publish it on a public website as required by the Affordable Care Act.

As noted by Peter Budetti, M.D., Deputy Administrator for Program Integrity of the Centers for Medicare & Medicaid Services (CMS), US Department of Health and Human Services, and Director of the CMS Center for Program Integrity in a February 1, 2013, CMS press release:

"You should know when your doctor has a financial relationship with the companies that manufacture or supply the medicines or medical devices you may need. Disclosure of these relationships allows patients to have more informed discussions with their doctors." While financial ties alone do not signify an inappropriate relationship, Open Payments will create public transparency, which aims to:

- Promote transparent information regarding financial relationships.
- Disclose the nature and extent of financial relationships between the industry and the physicians and teaching hospitals.
- Discourage inappropriate influences on research, education, and clinical decision-making.
- Curtail potential conflicts of interest that can compromise clinical integrity and patient care.

Final rule details - relevant definitions

1. **Applicable manufacturers**: Those entities that operate in the United States and (1) are engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply, but not if such covered drug, device, biological or medical supply is solely for use by or within the entity itself or by the entity's own patients (this definition does not include distributors or wholesalers (including, but not limited to, re-packagers, re-labelers, and kit assemblers) that do not hold title to any covered drug, device, biological or medical supply); or (2) are entities under common ownership with an entity described in part (1) of this definition, which provide assistance or support to such entities with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological or medical supply.

2. Applicable GPOs: Those that operate in the United States and purchase, arrange for purchase, or negotiate the purchase of a covered drug, device, biological, or medical supply for a group of individuals or organizations that are not solely using the covered supply.

3. Covered products: Any drug and biologic for which payment is available under Medicare, Medicaid or the Children's Health Insurance (CHIP) program, either separately (such as through a fee schedule) or as part of a bundled payment (for example, under the hospital inpatient prospective payment system), and require a prescription to be dispensed.

Any device or medical supply for which payment is available under Medicare, Medicaid or the Children's Health Insurance (CHIP) program, either separately (such as through a fee schedule) or as part of a

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Physician *(continued)*

bundled payment (for example, under the hospital inpatient prospective payment system (IPPS)), and require premarket approval by or premarket notification to the U.S. Food and Drug Administration (FDA).

4. Teaching hospitals: Hospitals that receive payment for Medicare direct graduate medical education (GME), IPPS indirect medical education (IME), or psychiatric hospital IME programs.

Implementation timeline

In order to give applicable manufacturers and applicable GPOs sufficient time to prepare after publication of the final rule, industry data collection will begin on August 1, 2013.

For the 2013 open payments program cycle, it will be abbreviated with only five months of data to be collected and reported, as compared to the 12-month cycles in subsequent years (January through December). Then, applicable manufacturers and applicable GPOs will submit the data to CMS by March 31, 2014, and CMS will make the data publicly available by September 30, 2014.

CMS is developing an electronic system to facilitate the reporting process and the reported information will be easily aggregated, downloaded, and searchable on the program website.

Industry data collection requirements

The law specifies that, annually:

- Applicable manufacturers of covered drugs, devices, biologicals, and medical supplies must report payments or other transfers of value they make to physicians and teaching hospitals to CMS.
- Applicable manufacturers and applicable GPOs must report to CMS ownership or investment interests held by physicians or their immediate family members. Payments and other transfers of value to these physicians must also be reported.
- Applicable GPOs must report to CMS payments or other transfers of value made to physician owners or investors if they held ownership or an investment interest at any point during the reporting year. Reportable payments or other transfers of value include such things as consulting fees, honoraria, gifts, entertainment, food and beverages, travel and lodging, and other items.

Research payments

The statute requires applicable manufacturers to report numerous types of payments to physicians and teaching hospitals, including consulting fees, food and beverages, and research payments. Please note, however, that research payments, or other transfers of value may be delayed from publication on the website until the date of FDA approval or up to 4 years from the date of report (whichever is first), when made under a product research or development agreement in connection with: 1) Research on, or development of, a new drug, device, biologic, or medical supply, or a new application of an existing drug, device, biologic, or medical supply; or 2) Clinical investigations regarding a new drug, device, biologic, or medical supply.

Opportunity to review and correct information prior to publication

The law requires CMS to provide the physicians and teaching hospitals, who are being reported about, at least 45 days to review and dispute the information related to them that was submitted by applicable manufacturers and applicable GPOs.

The review and correction period starts at least 60 days before the information is made public each year. Any disputed payments or transfers of value will need to be resolved directly between the disputer (physician or teaching hospital) and the relevant applicable manufacturer or applicable GPO. After the 45 days, applicable manufacturers and applicable GPOs will have an additional 15 days to submit corrections based on any disputes identified by physicians, teaching hospitals, and physician owners/investors.

> *"You should know when your doctor has a financial relationship with the companies that manufacture or supply the medicines or medical devices you may need. Disclosure of these relationships allows patients to have more informed discussions with their doctors."*
>
> - Peter Budetti, M.D., Deputy Administrator for Program Integrity of the Centers for Medicare & Medicaid Services

Physicians should maintain their own records of any interaction with applicable manufacturers and applicable GPOs. This can help facilitate the review of the data that is submitted about them.

CMS will notify the physician and teaching hospital communities when the reported information is ready for review using an online posting and through notifications via CMS' listserv, i.e., electronic mailing lists to which physicians may subscribe including the CMS' open payments listserv (located at *http://go.cms.gov/openpayments* on the CMS website).

Penalties for failure of accurate, complete, and timely reporting of required information

The Affordable Care Act provides that violators of the reporting requirements will be subject to civil monetary penalties (CMPs), capped annually at $150,000 for failure to report, and $1,000,000 for known failure

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Physician *(continued)*

to report. These CMPs only apply to applicable manufacturers and applicable GPOs. CMS finalized that the HHS Office of Inspector General (OIG) and CMS reserve the right to audit, evaluate, or inspect the records of applicable manufacturers and applicable GPOs for their compliance with the reporting requirements.

In order to facilitate these inspections, applicable manufacturers and applicable GPOs must maintain all records and documents for at least five years from the date of payments or other transfers of value or ownership or investment interest is published publicly on the website.

State law preemption

Section 6002 of the Affordable Care Act also preempts any state or local laws requiring reporting of the same types of information regarding payments or other transfers of value made by applicable manufacturers to covered recipients.

No state or local government may require the separate reporting of any information regarding a payment or other transfer of value that is required to be reported under this statute; unless such information is being collected by a federal, state, or local government agency for public health surveillance, investigation, or other public health purposes or health oversight.

Additional information

For more information, please refer to the final rule, CMS-5060-F, "Transparency Reports and Reporting of Physician Ownership or Investment Interests," which is available at *http://www.gpo.gov/fdsys/pkg/FR-2013-02-08/html/2013-02572.htm* or email questions to openpayments@cms.hhs.gov.

There is also a dedicated CMS website for open payments, which can be found at *http://go.cms.gov/openpayments* on the CMS website.

Also available for physicians to learn more about Open Payments is a continuing medical education (CME) activity, "Are You Ready for the National Physician Payment Transparency Program?"

Accessible via MedScape, and accredited by the Accreditation Council for Continuing Medical Education, physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70 percent on the post-test. Through the activity, participants will learn more about Open Payments, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify physician information in advance of website publication.

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Update to AIC requirements for ALJ and Federal District Court appeals

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) requires an annual reevaluation of the dollar amount in controversy required for an administrative law judge (ALJ) hearing (third level review) or federal district court (fifth level) review.

- **ALJ hearing request**: The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2012, is $130. This amount increased to $140 for ALJ hearing requests filed on or after January 1, 2013.
- **Federal district court review**: The amount that must remain in controversy for federal district court review requests filed on or before December 31, 2012, is $1,300. This amount increased to $1,400 for appeals to federal district court filed on or after January 1, 2013.

Training module on the 'Open Payments' available

The Centers for Medicare & Medicaid Services has produced a training module called: "Are You Ready for the National Physician Payment Transparency Program?" and accredited by the Accreditation Council for continuing medical education. Physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70 percent on the post-test. Through the activity, participants will learn more about "open payment," the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify their information in advance of website publication.

The module features Dr. Peter Budetti, Deputy Administrator and Director of the Center for Program Integrity and Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity and Director of the Data Sharing and Partnership Group.

Medscape accounts are free and users do not have to be health care professionals to register. Registration is on the landing page of *www.medscape.com*.

Instructions for accessing the Medscape module

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

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

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

Step 4: To view the "Are You Ready for the National Physician Payment Transparency Program?" module, use this link: *http://www.medscape.org/viewarticle/780900*.

Update to Chapter 15 of the *Medicare Program Integrity Manual*

Provider types affected

This *MLN Matters*® article is intended for physicians, providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), 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) 8222, which makes several revisions to Chapter 15 of the Centers for Medicare & Medicaid Services (CMS) *Medicare Program Integrity Manual.* The key clarification is as follows:

Sections 15.25.1.2 and 15.25.2.2 (Reconsideration Requests) are revised as follows: Consistent with 42 CFR 498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request of a provider enrollment denial or revocation at any time prior to the hearing officer's (HO's) decision. The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:

- The initial determination itself,
- The findings on which the initial determination was based,
- The evidence considered in making the initial determination, and
- Any other written evidence submitted under 42 CFR 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

Additional information

The official instruction, CR 8222 issued to your FI, RHHI, carrier, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R461PI.pdf* on the CMS website.

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

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

Note: This article was updated May 20 and May 22, 2013, to update all statements in the *Benefit Coverage Summary* and *IPPE* sections of the article regarding when a beneficiary is eligible for the IPPE. It was previously published in the March 2013 edition of *Medicare A Connection*, Pages 15-16. All other information remains unchanged.

Provider types affected

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

Provider action needed

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

Background

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

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

The information in this special edition *MLN Matters* article reminds health care professionals that Medicare now pays for these benefits as well as a broad range of other preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their "Welcome to Medicare" physical exam within the first 12 months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the preventive ultrasound screening as part of their "Welcome to Medicare" physical exam.

Benefit coverage summary - the initial preventive physical examination – ("Welcome to Medicare" physical exam)

Effective for dates of service on or after January 1, 2005: Medicare beneficiaries whose Medicare Part B effective date is on or after January 1, 2005, are covered for a one-time IPPE visit. A beneficiary is only eligible for an IPPE within the first 12 months of his or her Medicare Part B effective date. The IPPE is a preventive evaluation and management (E/M) service that includes the following seven components:

1. A review of an individual's medical and social history with attention to modifiable risk factors,
2. A review of an individual's potential (risk factors) for depression,
3. A review of the individual's functional ability and level of safety,
4. An examination to include an individual's height, weight, blood pressure measurement, and visual acuity screen,
5. Performance of an electrocardiogram (EKG) and interpretation of the EKG,
6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements, and
7. Education, counseling, and referral (including a brief written plan such as a checklist provided to the individual for obtaining the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits).

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Aneurysm *(continued)*

IPPE important reminders:

The IPPE is a unique benefit available only for beneficiaries new to the Medicare program and must be received within the first 12 months of the effective date of their Medicare Part B coverage.

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

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

Note: The deductible does not apply for an IPPE provided in a federally qualified health center (FQHC). Only the coinsurance/copayment applies.

Other preventive services and screenings covered under Medicare Part B include: Adult immunizations (flu, pneumococcal, and hepatitis B), bone mass measurements, cardiovascular screening, diabetes screening, glaucoma screening, screening mammograms, screening Pap test and pelvic exam, colorectal and prostate cancer screenings, diabetes self-management training, medical nutrition therapy for beneficiaries diagnosed with diabetes or renal disease, and smoking and tobacco-use cessation counseling. Benefits are subject to certain eligibility and other limitations.

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

Preventive ultrasound screening for abdominal aortic aneurysms (AAA)

Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time preventive ultrasound screening for AAA for beneficiaries who are at risk (has a family history of AAA or is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime).

Eligible beneficiaries must receive a referral for the screening as a result of their "Welcome to Medicare" physical exam. **There is no Part B deductible or coinsurance/copayment applied to this benefit.**

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

Additional information

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

MM5235 (2006), Implementation of a one-time only ultrasound screening for abdominal aortic aneurysms (AAA), Resulting from a referral from an initial preventive physical examination, *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5235.pdf*

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

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

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

The MLN preventive services educational products Web page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html*.

The CMS website provides information for preventive service covered by Medicare is at *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*.

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

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HIPAA eligibility system to replace CWF for insurance eligibility queries

Note: This article was revised on April 23, 2013, to update certain language to reflect the current status of this change. Also, clarifications have been made to the last question in the *Frequently asked questions* section. It was previously published in the December 2012 edition of *Medicare A Connection*, Pages 34-35. All other information remains unchanged.

Provider types affected

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

Provider action needed

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

What you need to know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that the Centers for Medicare & Medicaid Services (CMS) will implement in the coming months.

In April 2013, access to CWF eligibility query functions implemented in the multi-carrier system (MCS) and ViPS Medicare system (VMS), also referred to as PPTN and VPIQ, was terminated.

CMS intends to terminate access to the other CWF eligibility queries implemented in the fiscal intermediary standard system (FISS) direct data entry (DDE), often referred to the HIQA, HIQH, ELGA and ELGH screens and HUQA, soon thereafter.

This will not affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare contractor's interactive voice response (IVR) units and/or Internet portals.

Background

In 2005, CMS began offering HETS in a real-time environment to Medicare health care providers, suppliers and their billing agents, software vendors and clearinghouses.

HETS is Medicare's health care eligibility benefit inquiry and response electronic transaction, ASCX12 270/271 Version 5010, adopted under HIPAA.

HETS replaces the CWF queries, and is to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

Key points

General information

CMS plans to discontinue access to the CWF queries through the shared systems. Medicare providers and their agents that currently access the CWF queries through the shared system screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS

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

Frequently asked questions

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

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

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

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

(continued on next page)

HIPPA *(continued)*

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

By April 2014, HETS will return all of the information provided by the CWF eligibility queries that is needed to process Medicare claims.

Changes are currently underway in HETS to return psychiatric information to authorized providers and to return hospice period information in the same format as CWF. These changes will be in place before the April 2014 termination date for the FISS DDE CWF query access.

HETS returns additional information that CWF does not return. For example, HETS returns:

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

The *HETS 270/271 Companion Guide* provides specific details about the eligibility information that is returned in the HETS 271 response.

The guide is available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf*.

Additonal information

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

MLN Matters® Number: SE1249 Revised
Related Change Request (CR) #: N/A
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Implementation Date: N/A

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Billing and coverage for drug wastage

First Coast Service Options Inc. (First Coast) will consider payment for the unused and discarded portion of a single-use drug/biological product after administration of the appropriate (reasonable and necessary) dosage for the patient's condition. This applies to drugs priced through the Average Sales Price (ASP) drug/biological program.

The Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals, and other providers to provide injectable drug therapy incident to a physician's services in a fashion that maximizes efficiency of therapy in a clinically appropriate manner.

If a physician, hospital, or other provider must discard the unused portion of a single-use vial or other single-use package after administering a dose/quantity appropriate to the clinical context for a Medicare beneficiary, the program provides payment for the entire portion of drug or biological indicated on the vial or package label.

If less than a complete vial is administered at the time of service, and the unused portion is discarded, drug wastage must be documented in the patient's medical record with the date, time, and quantity wasted.

Upon review, any discrepancy between amount administered to the patient and the billed amount will be denied, unless wastage is clearly documented.

The amount billed as "wastage" must not be administered to another patient or billed again to Medicare. All procedures for drug storage, reconstitution and administration should conform to applicable Federal Drug Administration (FDA) guidelines and provider scope of practice.

Note: For billing purposes, First Coast does not require the use of modifier JW. Drug wastage is billed by combining on a single line the wastage and administered dosage amount.

Manual medical review of outpatient therapy claims begins April 1

What you need to know

Effective April 1, 2013, recovery auditors will begin the process of reviewing all therapy claims, which have exceeded the $3,700 threshold cap for the year. Importantly, there are two separate thresholds triggering manual medical reviews (MMRs) and build upon the separate therapy caps as follows: one for occupational therapy (OT) services, and; one for physical therapy (PT) and speech-language pathology (SLP) services combined.

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

Additional conditions include the requirement that all suppliers and providers who report on the beneficiary's claims for therapy services provide the national provider identifier (NPI) of the physician (or non-physician practitioner where applicable) who is responsible for reviewing the therapy plan of care.

Recovery auditors will complete two types of review:

Prepayment review

Eleven states will be participating in the Recovery Audit Prepayment Review Demonstration. All therapy claims that have exceeded the $3,700 therapy cap threshold for the year will be reviewed and compared to the medical record before the claim is processed for payment. The demonstration will occur in the following 11 states: FL, CA, MI, TX, NY, LA, IL, PA, OH, NC, and MO.

If the recovery auditors determine an improper claim has been submitted, a review results letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the recovery auditor findings and detailed description of the Medicare policy or rule that was violated.

Typical additional documentation requests (ADR) limits will not apply. All therapy claims at or above the $3,700 threshold cap will trigger the MMR process and will need to be reviewed by the recovery auditors.

The recovery auditors will conduct prepayment review within 10 business days of receiving the medical record.

The ADR will be sent to the provider by the Medicare administrative contractor (MAC) with instructions to send the records to the recovery auditor.

Post-payment review

In the remaining states, the recovery auditor shall conduct immediate post-pay reviews.

All therapy claims that have exceeded the $3,700 therapy cap threshold for the year will be reviewed and compared to the medical record after the claim has been processed for payment.

If the recovery auditor determines an improper payment has resulted, a demand letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the recovery auditor findings and detailed description of the Medicare policy or rule that was violated.

Typical ADR limits will not apply. All therapy claims at or above the $3,700 threshold cap will trigger the manual medical review process and will need to be reviewed by the recovery auditor.

The ADR will be sent to the provider immediately after the claim is paid. The ADR will be sent by the MAC to the provider with instructions to send the records to the recovery auditor. The threshold cap will accrue for claims with dates of service from January 1 through December 31, 2013. The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Private practices
- Part B skilled nursing facilities
- Home health agencies (TOB 34x)
- Outpatient rehabilitation facilities (ORFs)
- Rehabilitation agencies (comprehensive outpatient rehabilitation facilities)
- Outpatient hospitals

Questions

Additional guidance on the MMR process for therapy claims above the $3,700 threshold, as well as helpful medical review guidelines can be found on the *Therapy Cap Web page*. For all additional questions, please contact the appropriate recovery audit contractor (RAC) and/or A/B MAC in your region at their toll-free number, which may be found on the *Provider Compliance Group Interactive Map*.

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

National coverage determination for transcatheter aortic valve replacement

Provider types affected

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

Provider action needed

Change request (CR) 8255 is being issued to require that claims for TAVR carry an approved clinical trial number, effective for claims processed on or after July 1, 2013.

Given that TAVR is covered only under coverage with evidence development (CED), the Centers for Medicare & Medicaid Services (CMS) has ensured that the approved clinical trials and approved registry have obtained valid numbers from *http://www.clinicaltrials.gov* and that those numbers are maintained at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html*.

See the *Background* and *Additional information* sections of this article for further details regarding these changes. Please make sure that your billing staffs are aware of these changes.

Background

On May 1, 2012, CMS issued a national coverage determination (NCD) covering TAVR with CED. The TAVR NCD is available at *http://www.cms.gov/medicare-coverage-database/details/ncddetails.aspx?NCDId=355*.

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

The procedure is performed in a cardiac catheterization lab or a hybrid operating room/cardiac catheterization lab with advanced quality imaging and with the ability to safely accommodate complicated cases that may require conversion to an open surgical procedure.

The interventional cardiologist and cardiac surgeon jointly participate in the intra-operative technical aspects of TAVR.

CR 8255 requires that claims for TAVR carry an approved clinical trial number. Specific claims processing instructions are as follows:

- For professional claims processed on or after July 1, 2013, Medicare expects this numeric, 8-digit clinical trial (CT) registry number to be preceded by the alpha characters of "CT" in Field 19 of paper Form CMS-1500 claims or entered similarly in the electronic 837P in Loop 2300 REF01 (REF01=P4).

- Professional claim lines for *0256T, 0257T, 0258T, 0259T, 33361, 33362, 33363, 33364, 33365*, and *0318T* must have the CT registry number, a Q0 modifier, and a secondary diagnosis code of V70.7 (ICD-10=Z00.6). Such claims lines will be returned as unprocessable if the CT registry number, the modifier Q0, or the V70.7 (ICD-10=Z00.6) is not present.
- Claims for TAVR submitted without the CT registry number will be returned as unprocessable with the following messages:
- Claims adjustment remarks code (CARC) 16: "Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either NCPDP reject reason code, or remittance advice remark code that is not an alert.)";
- Remittance advice remarks code (RARC) MA50: "Missing/incomplete/invalid investigational device exemption number for FDA-approved clinical trial services.";
- RARC MA130: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."; and
- Group code-contractual obligation (CO).
- TAVR claims submitted without the Q0 modifier will be returned as unprocessable with the following messages:
- CARC 4: "The procedure code is inconsistent with the modifier used or a required modifier is missing.

(continued on next page)

TAVR *(continued)*

Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.";

- RARC N29: "Missing documentation/orders/notes/summary/report/chart.";
- RARC MA130: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information." and
- Group code-contractual obligation (CO).
- For claims processed on or after July 1, 2013, the claim lines for *0256T, 0257T, 0258T, 0259T*, *33361*, *33362*, *33363*, *33364*, *33365* & *0318T* will be returned as unprocessable when billed without secondary diagnosis code V70.7 (ICD-10=Z00.6) with the following messages:
- CARC 16: "Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)";
- RARC M76: "Missing incomplete/invalid diagnosis or condition.";
- RARC MA130: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information." and
- Group code-contractual obligation (CO).

Medicare also requires the CT registry number on hospital claims for TAVR for inpatient hospital discharges on or after July 1, 2013.

Claims for TAVR for inpatient discharges on or after July 1, 2013, that do not have the registry number will be rejected. Medicare is ensuring the presence of the procedure codes and associated diagnosis and condition codes per CR 7897/TR 2552, issued September 24, 2012.

Additional information

The official instruction, CR 8255 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2689CP.pdf*. Add links to CR 7897 and CR 8168/TR 2628, issued January 7, 2013, for additional claims processing information.

Note: CR 8255 does not eliminate the previous instructions contained in CRs 7897 and 8168 that were not formally replaced or revised.

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

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Related CR Transmittal #: R2689CP
Implementation Date: October 7, 2013

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Mark your calendar - free webinar to prepare for ICD-10 transition

The Centers for Medicare & Medicaid Services (CMS) will offer a free webinar to help providers develop strategies for the transition to the International Classification of Diseases, Tenth Revision (ICD-10).

The webinar is scheduled for 10-11 a.m., EDT, Thursday, June 20. To reserve your place today, *click here*.

An additional webinar for providers in Central time will take place, noon, CDT, June 20. To reserve a spot for the Central time webinar, *click here*.

The webinar will inform about best practices and offer resources for providers in making the transition to ICD-10. Providers are encouraged to mark the date and time on their calendars and stay tuned to First Coast Service Options' *eNews* for webinar registration information.

The United States is planning its transition to ICD-10 for October 1, 2014. ICD-10 will control diagnoses and inpatient procedures for all health care providers covered by Health Insurance Portability and Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims.

In addition to the webinar, CMS offers *a number of online resources* to assist providers with the transition to ICD-10.

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.**

Revisions to LCDs

APULMDIAGSVCS: Pulmonary diagnostic services – revision to the LCD

LCD ID number: L28974 (Florida)

LCD ID number: L28976 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pulmonary diagnostic services was most recently revised January 1, 2012. Since that time, the LCD was revised based on an external reconsideration request to update language under the "Indications" section of the LCD. Revisions to the LCD include the following:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the language was updated in the fifth paragraph under "Indications." Under the same section of the LCD, the following statement was added: "Pulmonary function studies *94010*, *94060*, *94070*, and *94375* must be: (1) performed by a qualified physician, or (2) performed under the general supervision of a qualified physician by a technologist (i.e., medical assistant, nurse) who has been trained to perform these tests by a qualified physician."

Effective date

This LCD revision is effective for services rendered **on or after May 7, 2013**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (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*.

ABOTULINUMTOXINS: Botulinum toxins – revision to the LCD

LCD ID number: L28788 (Florida)

LCD ID number: L28790 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was most recently revised October 18, 2012. Since that time, the LCD was revised based on an external reconsideration request to add a new indication for Botox® (onabotulinumtoxinA), represented by HCPCS code J0585, which was approved by the Food and Drug Administration (FDA) on January 18, 2013. Revisions to the LCD include the following:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the following indication was added under the "FDA Indications for Botox®": "Treatment of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of anticholinergic medication."
- Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, ICD-9-CM diagnosis codes 596.51, 788.31, and 788.33 were added for HCPCS code J0585.
- The "Sources of Information and Basis for Decision" section of the LCD was updated.

In addition, the LCD "Coding Guidelines" attachment was revised to add the FDA indication as noted above for *CPT®* code *52287*.

Effective date

This LCD revision is effective for claims processed **on or after May 15, 2013**, for services rendered **on or after January 18, 2013**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (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*.

Retired LCDs

Psychiatry related services – Part A retired LCDs

LCD ID number: L28889, L28893, L28839, L28850 (Florida)
LCD ID number: L28911, L28915, L28872, L28883
(Puerto Rico/U.S. Virgin Islands)

Local coverage determinations (LCDs) A90832 (psychotherapy), A90785 (interactive complexity services), A90847 (family psychotherapy), and A90853 (group psychotherapy) are being retired because they are all being combined in a new LCD titled "psychiatric diagnostic evaluation and psychotherapy services" (APSYCH) that has been developed effective for services rendered **on or after June 4, 2013**. This new LCD addresses the recent restructuring of the coding in the psychiatry section of the 2013 *CPT*® book.

Effective date

These LCDs will be retired 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*.

Additional information

ASKINSUBSTITUTES: Application of bioengineered skin substitutes for treatment of diabetic and venous stasis ulcers of the lower extremities – draft LCD

LCD ID number: DL33134 (Florida/Puerto Rico/U.S. Virgin Islands)

The draft local coverage determination (LCD) for application of bioengineered skin substitutes for treatment of diabetic and venous stasis ulcers of the lower extremities was posted for comment on February 7, 2013.

During the comment period, First Coast Service Options Inc. (First Coast) received a substantial number of comments, as well as a large number of published clinical studies in support of coverage for various skin substitutes currently listed as non-covered in the draft LCD.

In order to give due diligence to the comments, including review of the medical literature received, the finalization of the draft LCD has been delayed. It is anticipated that the draft LCD will be finalized in the near future.

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

New customized durable medical equipment HCPCS codes

This article was revised May 23, 2013, to reflect the revised change request (CR) 8158 issued May 21. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.

Provider types affected

This *MLN Matters*® article is intended is intended for home health agencies (HHAs), other providers, and durable medical equipment (DME) suppliers submitting claims to Medicare contractors (regional home health intermediaries (RHHIs), Part A Medicare administrative contractors (A MACs), or durable medical equipment Medicare administrative contractors (DME MACs) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Effective July 1, 2013, the Centers for Medicare & Medicaid Services (CMS) is adding three new Healthcare Common Procedure Coding System (HCPCS) codes for payment of customized DME.

Caution – what you need to know

CR 8158, from which this article is taken, announces the addition of the following HCPCS codes to the HCPCS code set:

- K0008 (Custom Manual Wheelchair/Base);
- K0013 (Custom Motorized/Power Wheelchair Base); and
- K0900 (Custom Durable Medical Equipment, Other Than Wheelchairs).

Go – what you need to do

Make sure that you only use these codes for items that meet the definition of "customized item" that is used specifically for Medicare payment purposes only. Very few items meet the Medicare regulatory definition of customized items. Effective July 1, 2013, you should bill claims for custom manual wheelchairs, custom power wheelchairs, and all other custom DME that is not a wheelchair base using these respective codes. Claims for items billed using these codes will be manually processed and evaluated to ensure that the item furnished meets the Medicare definition of customized item.

Background

Per 42 Code of Federal Regulations (CFR) Section 414.224(a), in order to be considered a customized DME item, a covered item (including a wheelchair) must be: 1) Uniquely constructed or substantially modified for a specific beneficiary according to a physician's description and orders; and 2) So different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

Customized DME items

For example, a wheelchair that is custom fabricated, or substantially modified, so that it can meet the needs of wheelchair-confined, conjoined twins facing each other is unique and cannot be grouped with any other wheelchair used for the same purpose. It is a one-of-a-kind item, fabricated to meet specific needs.

Conversely, items that: 1) Are measured, assembled, fitted, or adapted in consideration of a patient's body size, weight, disability, period of need, or intended use (i.e., custom fitted items); or 2) Have been assembled by a supplier, or ordered from a manufacturer, who makes available customized features, modification or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician do not meet the definition of customized items. These items are not uniquely constructed or substantially modified and can be grouped with other items for pricing purposes. The use of customized options or accessories or custom fitting of certain parts does not result in a wheelchair or other equipment being considered as customized.

Payment for customized DME items

CFR Section 414.224(b) further provides that the lump-sum payment made for purchase of the customized item is based on the Medicare contractor's individual consideration and judgment of a reasonable payment amount for each item.

The contractor's individual consideration takes into account: 1) Written documentation on the item's costs (including design, fabrication, and assembly costs), including at least the costs of labor (to the extent that they are reasonable) of those actually performing the customization; and 2) The types of materials (to the extent that they are reasonable) used in custom fabricating or substantially modifying an item. The contractor may need to require a detailed description of each phase of the construction process and labor skills needed to fabricate or modify the item in order to determine a reasonable amount. To facilitate the identification of, and to ensure appropriate payment for, customized DME that meet the criteria described above; CR 8158, from which this article is taken, announces that CMS has added three new HCPCS codes to the HCPCS code set, effective July 1, 2013:

(continued on next page)

DME *(continued)*

- K0008 Custom Manual Wheelchair/Base;
- K0013 Custom Motorized/Power Wheelchair Base; and
- K0900 Custom Durable Medical Equipment, Other Than Wheelchair.

Therefore, effective July 1, 2013, you should bill claims for custom manual wheelchairs using HCPCS code K0008, claims for custom power wheelchairs using HCPCS code K0013, and all other custom DME that is not a wheelchair base using HCPCS code K0900.

Additional information

The official instruction, CR 8158, issued to your Part A MAC or DME MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1239OTN.pdf*.

If you have any questions, please contact your Part A 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: MM8158
Related Change Request (CR) #: CR 8158
Related CR Release Date: May 21, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1239OTN
Implementation Date: July 1, 2013

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Drug/biological HCPCS code changes for July 2013

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8286 which informs Medicare contractors about the updating of specific drug and biological HCPCS codes which occurs quarterly. 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.

Key points of CR 8286

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS codes will no longer be payable for Medicare:

- J3487: Injection, Zoledronic Acid (Zometa), 1mg.
- J3488: Injection, Zoledronic Acid (Reclast), 1mg.
- J9002: Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10mg.

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS codes will be payable for Medicare:

- Q2033: Influenza Vaccine, Recombinant Hemagglutinin Antigens, For Intramuscular Use (Flublok).
- Q2050: Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg.
- Q2051: Injection, Zoledronic Acid, not otherwise specified, 1mg.

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS code will be accepted on claims, but not payable by Medicare:

- Q0090: Levonorgestrel-Releasing Intrauterine Contraceptive System (SKYLA), 13.5 mg.

Additional information

The official instruction, CR 8286 issued to your FI, carrier, RHHI, DME/MAC, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2695CP.pdf* on the CMS website.

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

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Implementation Date: July 1, 2013

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Standard operating rules for code usage in remittance advice

Note: This article was revised May 10, 2013. In the article, the change request (CR) release date, transmittal number, and the Internet address for accessing the CR were revised. The article was previously published in the February 2013 edition of *Medicare A Connection*, Pages 22-23. All other information remains the same.

Provider types affected

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

What you need to know

CR 8182, from which this article is taken, instructs your Medicare contractor to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set for code usage in electronic funds transfer and electronic remittance advice by January 1, 2014.

Background

The Health Insurance Portability and Accountability Act (HIPAA) amended Title XI of the Social Security Act by adding Part C (Administrative Simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996, which you can find at *http://aspe.hhs.gov/admnsimp/pl104191.htm#1173*.)

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions and by mandating the adoption of a set of operating rules for each of the HIPAA transactions. In December 2011 Congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to electronic data interchange (EDI) from paper has been slow and "disappointing." (You can find a copy of this testimony at *http://www.ncvhs.hhs.gov/*.)

Note: The same rules will also apply to standard paper remittance (SPR), as Medicare reports the same standard codes in both electronic and paper formats of remittance advice.

The EFT & ERA operating rule set includes the following rules:

(Please note that CR 8182 focuses only on rule numbers 3 and 4)

1. Phase III CORE 380 EFT enrollment data rule;

2. Phase III CORE 382 ERA enrollment data rule;

3. Phase III Core 360 uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule;

4. CORE-required code combinations for CORE-defined business scenarios for the phase III Core uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule;

5. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule; and

6. Phase III CORE 350 health care claim payment/advice (835) infrastructure rule.

HIPAA initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim/line has been adjudicated, and now the ERA/EFT operating rules under the Affordable Care Act are mandating a standard use of those standard codes.

The ERA/EFT operating rules mandate consistent and uniform use of remittance advice (RA) codes (group codes, claim adjustment reason codes (CARC) and remittance advice remark codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up;
- Faulty electronic secondary billing;
- Inappropriate write-offs of billable charges;
- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay.

Business scenarios

The CORE Phase III ERA/EFT operating rules define four business scenarios, and specify the maximum set

(continued on next page)

Advice *(continued)*

of the standard codes that a health plan may use. This list will be updated and maintained by a CORE task group when the two code committees update the lists and/or when there is need for additional combinations based on business policy change and/or federal/state mandate.

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for each business scenario is specified in the document: *Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule),* that is an attachment to CR 8182. This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published 4 times a year) in the future.

Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

Scenario #1 - Additional information required - missing/invalid/incomplete documentation This scenario refers to situations in which additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2 - Additional information required – missing/invalid/incomplete data from submitted claim This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3 - Billed service not covered by health plan. This scenario refers to situations in which the billed service is not covered by the health plan.

Scenario #4 - Benefit for billed service not separately payable

This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan. Finally, by October 7, 2013, the Medicare remit easy print (MREP) and PC print software will be modified as necessary.

Additional information

The official instruction, CR 8182, 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/R1233OTN.pdf.*

You will find a copy of the document: *Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule*) as an attachment to that CR.

If you have any 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*.

MLN Matters® Number: MM8182
Related Change Request (CR) #: CR 8182
Related CR Release Date: May 9, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R12330TN
Implementation Date: October 7, 2013

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Phase III electronic remittance advice (ERA) enrollment operating rules

Provider types affected

This *MLN Matters®* article is intended for physicians, providers and suppliers enrolling for electronic remittance advice (ERA) with Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHI), A/B Medicare administrative contractors (MACs) and durable medical equipment (DME MACs)).

What you need to know

Stop – impact to you

This article is based on change request (CR) 8223, which instructs Medicare contractors on the steps they must take to come into compliance with Phase III ERA enrollment operating rule requirements by October 1, 2013. Contractors must have paper-based ERA enrollment forms in compliance with Attachment 1 of CR 8223 no later than July 1, 2014.

Caution – what you need to know

Medicare contractors must update their electronic remittance advice (ERA) enrollment forms for new enrollments to comply with Attachment 1 of CR 8223. The contractors must comply with the following requirements:

1. Identify a maximum set of standard data elements to be requested from providers for enrollment to receive ERAs.

(continued on next page)

Phase III *(continued)*

2. Apply "controlled vocabulary" – predefined and authorized terms- for use when referring to the same data element.

3. Use standard data elements to appear on paper enrollment form in a standard format and flow, using consistent data elements and vocabulary as on the electronic form.

4. Use specific information or instruction to providers to assist in manual paper-based ERA enrollment.

5. Offer electronic ERA enrollment.

GO – what you need to do

Make sure that your billing staffs are aware of these updates to the ERA enrollment operating rules.

Background

Section 1104 of the Affordable Care Act requires the Secretary of Health and Human Services to adopt and regularly update standards, implementation specifications, and operating rules for the electronic exchange and use of health information for the purpose of financial and administrative transaction.

What you need to know about the ERA enrollment form

Providers who have a signed ERA enrollment form on file with a particular Medicare contractor or common electronic data interchange (CEDI) are not required to submit a new signed ERA enrollment form to the same Medicare contractor or CEDI each time they change their method of electronic billing or begin to use another type of electronic data interchange (EDI) transaction, e.g., changing from direct submission to submission through a clearinghouse or changing from one billing agent to another.

Additionally, providers are not required to notify their Medicare contractor or CEDI if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance.

Medicare contractors and CEDIs must inform providers that providers are obligated to notify them in writing in advance of a change that involves a change in the billing agent(s) or clearinghouse(s) used by the provider, the effective date on which the provider will discontinue using a specific billing agent and/or clearinghouse, if the provider wants to begin to use additional types of EDI transactions, or of other changes that might impact their use of ERA.

When a Medicare contractor or CEDI receives a signed request from a provider or supplier to accept ERA transactions from or send ERA transactions to a third party, the Medicare contractor or CEDI must verify that an ERA enrollment form is already on file for that provider or supplier. The request cannot be processed until both are submitted and issued.

The binding information in an ERA enrollment form does not expire if the person who signed that form for a provider is no longer employed by the provider or that Medicare contractor or CEDI is no longer associated with the Medicare program.

Medicare responsibility for ERA oversight and administration is simply transferred in that case to that entity that the Centers for Medicare & Medicaid Services (CMS) chooses to replace that Medicare contractor or CEDI, and the provider as an entity retains responsibility for those requirements mentioned in the form regardless of any change in personnel on staff.

Contractors may require a wet signature to be submitted in conjunction with the electronic enrollment.

(**Note**: A wet signature is an original signature on a document that is then scanned and sent by e-mail.)

The document will become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to the Medicare contractor, CEDI, or other contractor if designated by CMS. Either party may terminate the arrangement by giving the other party thirty (30) days written notice of its intent to terminate.

In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

Additional information

The official instruction, CR 8223, issued to your FI, carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1235OTN.pdf*.

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

MLN Matters® Number: MM8223
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Related CR Release Date: May 10, 2013
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Related CR Transmittal #: R1235OTN
Implementation Date: October 7, 2013

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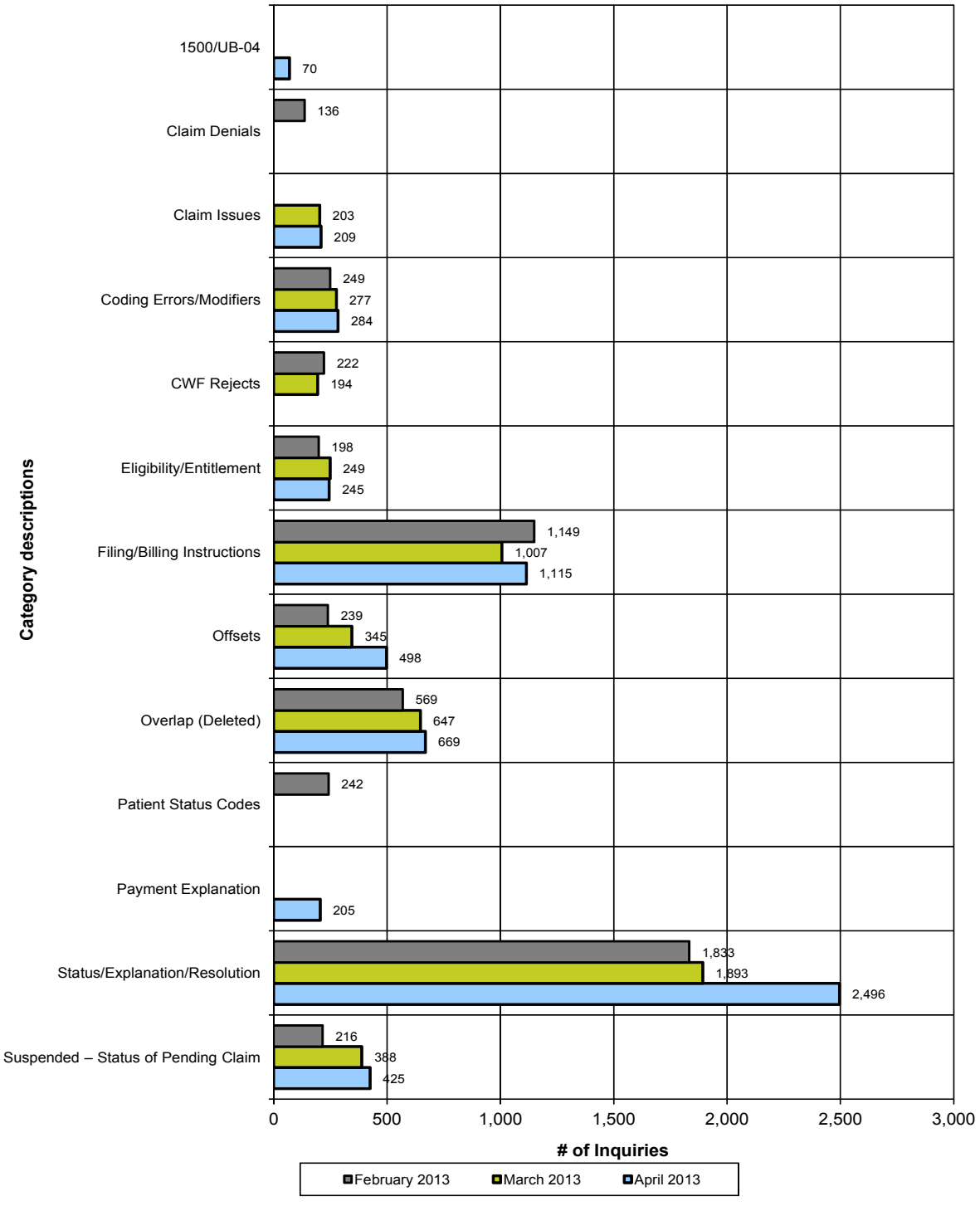
Top inquiries, rejects, and return to provider claims February 2013 - April 2013

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 February 2013 through April 2013.

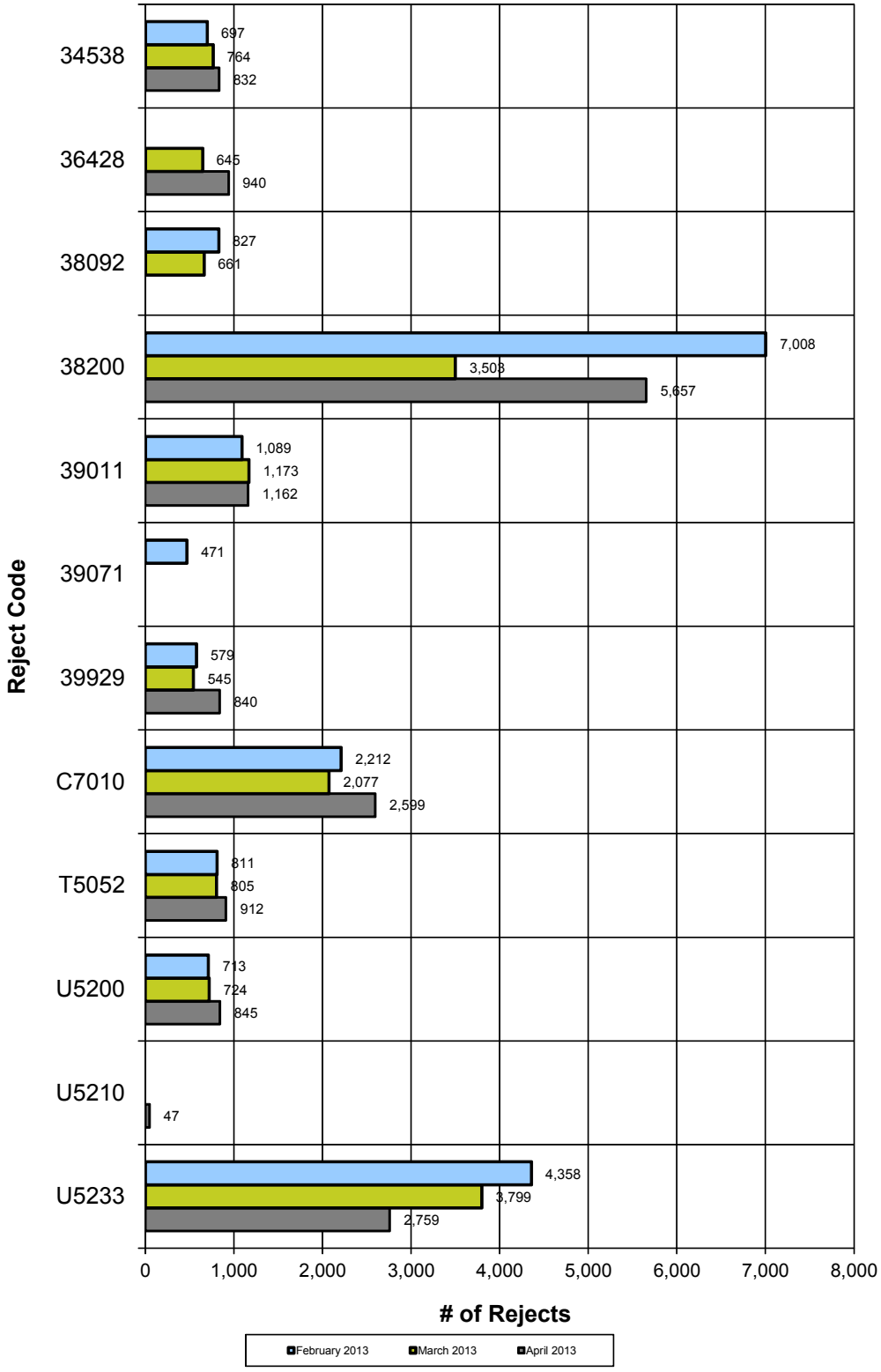
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Top inquiries for February-April 2013



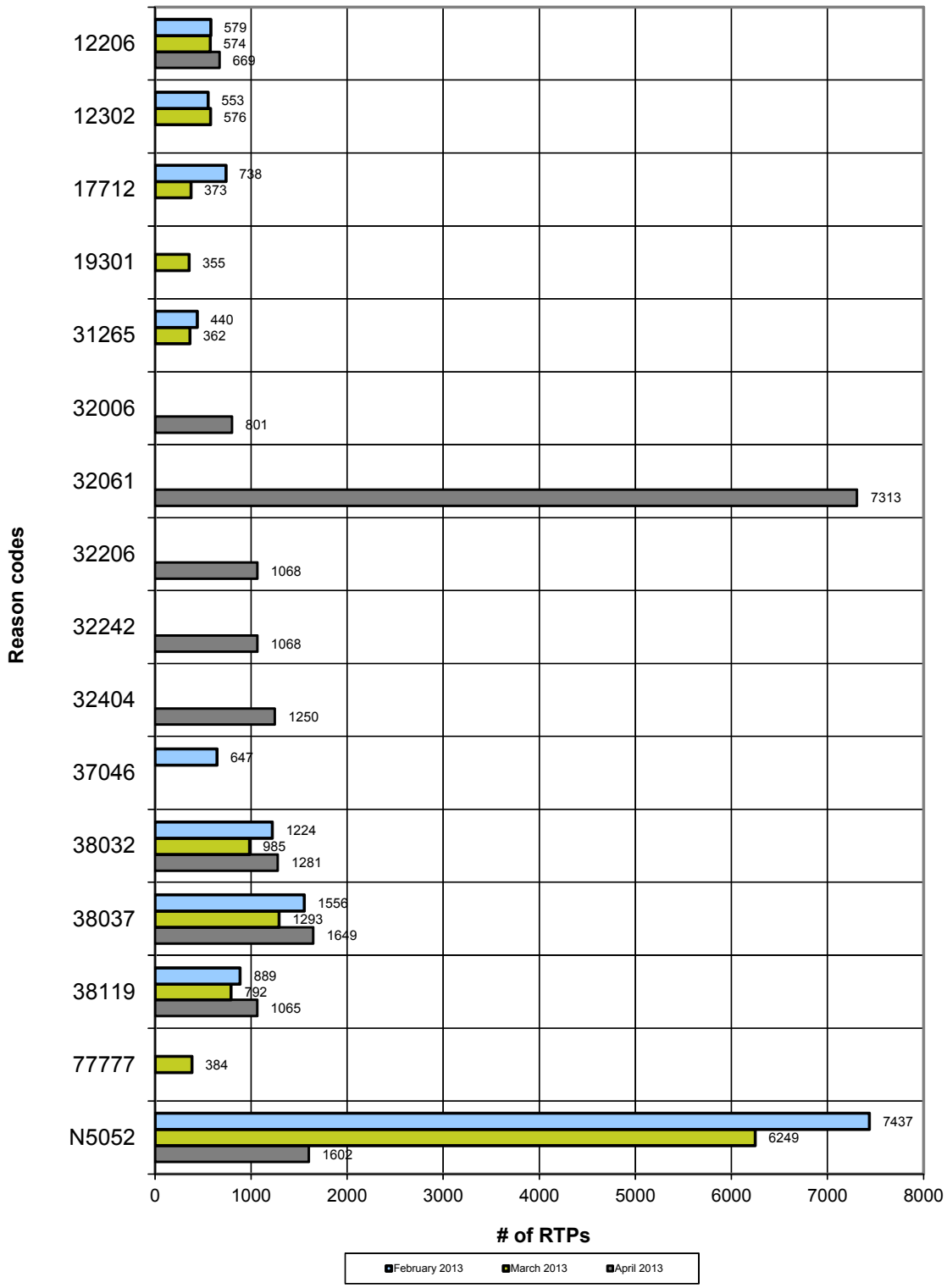
Part A top rejects for February 2013 through April 2013

Top rejects for February-April 2013



Part A top return to providers (RTPs) for February 2013 through April 2013

Top RTPs for February-April 2013



OIG cites questionable billing by suppliers of lower limb prostheses

Note: This article was revised April 11, 2013, to remove a note box that had appeared in the *Key points* section of the article. All other information is the same. It was previously published in the June 2012 issue of *Medicare A Connection*, Pages 36-39.

Provider types affected

This *MLN Matters*® special edition article is intended for providers who bill Medicare for lower limb prostheses. No new policies are contained in this article.

What you need to know

This article highlights the August 2011 report from the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) study titled *Questionable Billing By Suppliers of Lower Limb Prostheses*. It also discusses Medicare policy regarding the coverage of lower limb prostheses under its Part B durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) benefit. The study was designed to meet the following objectives:

1. Identify payments for lower limb prostheses in 2009 that did not meet certain Medicare requirements;
2. Identify Medicare payments for lower limb prostheses in 2009 for beneficiaries with no claims from their referring physicians;
3. Identify suppliers of lower limb prostheses that had questionable billing in 2009; and
4. Describe the program safeguards in place in 2009 and the first half of 2010 to prevent inappropriate payments for lower limb prostheses.

Background

Between 2005 and 2009, Medicare spending for lower prostheses increased 27 percent, from $517 million to $655 million. The number of Medicare beneficiaries receiving lower limb prostheses decreased by 2.5 percent, from almost 76,000 to about 74,000.

Medicare policy requires that a supplier have an order from the referring physician before providing prostheses to the beneficiary. Upon receipt of the referring physician's order, the supplier can move forward with the prostheses fitting for the beneficiary with the applicable prostheses.

Medicare policy also requires that suppliers follow local coverage determination policies. These policies provide guidelines for determining the beneficiary's potential functional level and specify how suppliers must submit claims for certain types and combinations

of prostheses.

The study completed by the OIG was based on an analysis of Medicare Part B claims for lower limb prostheses from 2009 and Part A and Part B claims from 2004 to 2009 for beneficiaries who received lower limb prostheses in 2009.

OIG staff also completed interviews with the four DME Medicare administrative contractors (MACs), three zone program integrity contractors (ZPICs), and two DME program safeguard contractors (PSCs). The OIG considered a paid claim did not meet the requirements if the supplier:

- Did not indicate whether the prosthesis was for the right or left limb;
- Billed for a prosthesis for both limbs on the same date using two claims;
- Did not meet potential functional level requirements;
- Billed for a higher number of units of a prosthesis than allowed on a claim;
- Billed for combinations of prostheses that were not allowed; or
- Billed for prostheses that were not covered.

Claims data was an additional component of the OIG's analysis to determine the number of claims for beneficiaries with no claims from their referring physicians during the last five years and the Medicare payments for these claims. The following elements were analyzed to identify suppliers that had questionable billing:

- Suppliers that had at least 10 beneficiaries, and
- Suppliers that were paid at least $100,000 for lower limb prostheses in 2009.

This sample included 1,632 of the 4,575 Medicare suppliers who had a paid claim for lower limb prostheses in 2009, which accounted for 92 percent of the $655 million who billed for lower limb prostheses.

Findings

In 2009, the study found that: :

1. In 2009, Medicare inappropriately paid $43 million for lower limb prostheses that did not meet certain requirements. These payments could have been prevented by using claims processing edits.
2. Medicare paid an additional $61 million for beneficiaries with no claims from their referring

(continued on next page)

Prostheses *(continued)*

physicians.

3. In 2009, 267 suppliers of lower limb prostheses had questionable billing. Approximately 136 suppliers frequently submitted claims that did not meet certain Medicare requirements or were for beneficiaries with no claims from their referring physicians. An additional 131 suppliers had other questionable billing. This included billing for a high percentage of beneficiaries with no history of an amputation or missing limb or a high percentage of beneficiaries with unusual combinations of prostheses.
4. Medicare contractors conducted varying degrees of program safeguard activities related to lower limb prostheses.
   - The four DME MACs had varying claims processing edits in place, but none had edits for all requirements.
   - None of the DME MACs conducted medical reviews, and not all had conducted data analyses or provided education related to lower limb prostheses.
   - All ZPICs and DME PSCs conducted data analyses and opened investigations related to lower limb prostheses.

The OIG made six recommendations based upon their findings. The Centers for Medicare & Medicaid Services (CMS) concurred with five of the six recommendations made by the OIG. The recommendations and CMS actions are as follows:

Recommendations

OIG recommendation 1: Implement additional claims processing edits to prevent inappropriate payments. CMS should instruct the four DME MACs to implement claims processing edits based on all of the local coverage determination requirements.

CMS response: CMS concurred and stated it would instruct the DME MACs to implement consistent claims processing edits based on local coverage determination requirements.

OIG recommendation 2: Strengthen monitoring of billing for lower limb prostheses. CMS should instruct the DME MACs, ZPICs, and DME PSCs to monitor billing for lower limb prostheses using the measures discussed in this report. CMS should develop thresholds for these measures and instruct its contractors to conduct additional reviews of suppliers that exceed the thresholds.

CMS response: CMS concurred and stated it would issue guidance to the DME MACs and instruct them to consider the measures used in the OIG report as supplemental criteria for detecting high-risk suppliers.

OIG recommendation 3: **Implement requirements for a face-to-face encounter to establish the beneficiary's need for prostheses.** We recommend that CMS implement requirements that the referring physician document that a face-to-face encounter occurred. This would help ensure that lower limb prostheses provided to beneficiaries are medically necessary.

CMS response: CMS concurred and stated it is exploring its current authorities to implement such requirements. CMS also stated that it would issue an educational article to further explain policy requirements for lower limb prostheses and to providers and suppliers.

OIG recommendation 4: **Revise the requirements in the local coverage determination.** CMS should work with the DME MACs to clarify several aspects of the local coverage determination. First, CMS should clarify the definitions of beneficiaries' functional levels.

Second, CMS should revise the local coverage determination or take other steps to require that licensed/certified medical professionals, such as physical therapists, evaluate beneficiaries to determine their potential functional levels. Finally, CMS should consider denying as medically unnecessary certain combinations of prostheses.

CMS response: CMS concurred and stated it would review the definitions for the functional levels and develop refinements as appropriate. CMS also stated it would consider adapting an algorithm to guide determination of the functional status of the beneficiary.

OIG recommendation 5: **Enhance screening for currently enrolled suppliers of lower limb prostheses.** Federal regulations place new DMEPOS suppliers at the high-risk level and currently enrolled DMEPOS suppliers at the moderate-risk level. CMS should consider placing current suppliers of lower limb prostheses at the high-risk level, thus subjecting them to the more rigorous screening procedures.

CMS response: CMS did not concur and stated that it has in place sufficient tools that allow for increased scrutiny of existing DMEPOS suppliers. CMS noted that if an existing supplier meets one of several triggering events, that supplier automatically is elevated to the high-risk level.

OIG recommendation 6: Take appropriate action on suppliers with questionable billing. In a separate memorandum, we will refer the suppliers that we identified to CMS for appropriate action.

CMS response: CMS concurred and stated it would share the information with the DME MACs and the recovery audit contractors (RAC). RACs review Medicare claims on a post payment basis to identify inappropriate payments. The following section reviews Medicare policy for coverage of lower limb prostheses.

(continued on next page)

Prostheses *(continued)*

Key points

Medicare requirements for lower limb prostheses

Provisions of the Social Security Act (the Act) govern Medicare payment for all items or services, including lower limb prostheses. The Act states that Medicare will cover only services and items considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

In addition, Medicare requires that a supplier have an order from a physician before providing prostheses to the beneficiary. This physician is known as the referring physician.

Upon receiving the order, the supplier consults with the referring physician, as needed, to confirm the order and recommend any necessary changes and evaluates the beneficiary. The supplier fits the beneficiary with the most appropriate prostheses. The supplier then determines the group of codes that best describes the prostheses provided, choosing from 178 Healthcare Common Procedure Coding System (HCPCS) codes that are specific to lower limb prostheses.

Further, local coverage determination policies provide additional Medicare requirements for lower limb prostheses. These policies, consistent with policies for other DMEPOS, are identical across the country. The local coverage determination specifies how suppliers must submit claims for certain types and combinations of prostheses.

In particular, it states that each claim must include a modifier to indicate whether the prosthesis is for the right or left limb. When a supplier provides prosthesis for each limb on the same date, the supplier must submit only one claim and include both the right and left modifiers on the claim.

The local coverage determination also has guidelines for determining the beneficiary's potential functional level. Specifically, it states that a beneficiary is placed at one of five potential functional levels based on the reasonable expectations of the supplier and the referring physician.

When determining the potential functional level, suppliers and the referring physicians must take into account the beneficiary's history, current overall medical condition, and desire to walk. The supplier then uses a modifier on the claim to indicate the beneficiary's potential functional level (K0 to K4). Prostheses are not considered medically necessary if the beneficiary has the lowest potential functional level (K0), which indicates that he or she does not have the ability or the potential to walk. In addition, for some prostheses, the local coverage determination specifies the minimum potential functional level that the beneficiary must have for the prosthesis to be considered medically necessary.

Further, the local coverage determination limits the number of certain items that can be billed on a claim. If the number of units of these prostheses exceeds the limit, the additional items will be denied as not medically necessary.

The local coverage determination also considers certain combinations of prostheses to be medically unnecessary. For example, certain sockets are not allowed for use with temporary base prostheses. Finally, the local coverage determination states that HCPCS L5990, a specific type of foot addition, will be denied as not medically necessary.

In addition, CMS recently established new screening procedures for provider enrollment. For example, screening may include licensure and criminal background checks. CMS created three levels of screening – limited, moderate, and high – based on the risk of fraud, waste, and abuse. New DMEPOS suppliers were placed at the high risk level, while currently enrolled DMEPOS suppliers were placed at the moderate risk level.

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

You may want to review *MLN Matters*® article SE1201 at *http://www.cms.gov/MLNMattersArticles/downloads/SE1201.pdf* for important reminders on the requirements for ordering and referring physicians.

Additional information

If you are unsure of, or have questions about, documentation requirements, contact your Medicare contractor at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The entire OIG report titled "Questionable Billing By Suppliers of Lower Limb Prostheses" is available at *http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf*.

MLN Matters® Number: SE1213 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Discontinuation of home health type of bill 33x

Provider types affected

This *MLN Matters*® article is intended for home health agencies submitting claims to Medicare contractors (regional home health intermediaries (RHHI) and Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

Provider action needed

Effective for home health episodes beginning on or after October 1, 2013, original Medicare will no longer accept institutional claims submitted with type of bill (TOB) 033x. Your RHHI or MAC will return your claims with TOB 033x; and a statement covers "From" date of on, or after, October 1, 2013.

CR 8244, from which this article is taken, updates the *Medicare Claims Processing Manual* Chapter 10 (Home Health Agency Billing), and makes system changes required to discontinue the use of TOB 033x (home health, outpatient (includes HHA visits under a Part A plan of treatment)). You should make sure that your billing staffs are aware of this TOB change.

Background

The National Uniform Billing Committee (NUBC) maintains the type of bill (TOB) code set healthcare organizations use on institutional claims. In 2012, the NUBC voted to simplify TOB codes for home health claims by using a single TOB code for all home health services provided under a home health care plan.

CR 8244 announces the NUBC's decision to discontinue the use of TOB 33x (home health, outpatient (includes HHA visits under a Part A plan of treatment)). Effective October 1, 2013, you should use TOB 032x for your claims for home health episodes. Medicare will no longer accept institutional claims submitted on, or after, that date with TOB 033x .

Additional information

The official instruction, CR 8244 issued to your RHHI or MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2694CP.pdf*.

If you have any questions, please contact your 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*.

MLN Matters® Number: MM8244
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Related CR Release Date: May 3, 2013
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Related CR Transmittal #: R2694CP
Implementation Date: October 7, 2013

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Get ready for ICD-10 - Free webinar, June 20, 10 a.m

The Centers for Medicare & Medicaid Services (CMS) will offer a free webinar to help providers develop strategies for the transition to the International Classification of Diseases, Tenth Revision (ICD-10). The webinar is scheduled for 10-11 a.m., Thursday, June 20.

Click here for information about how to register.

Critical access hospitals use line level national provider identifier editing

Provider types affected

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

Provider action needed

This article, based on change request (CR) 8170, instructs Medicare contractors on implementing a system update to include the line level national provider identifier (NPI) field editing for sanctioned critical access hospital (CAH) providers reimbursed under the optional method. Please make sure that your billing staffs are aware of updates.

Background

With the October 2012 implementation of CR 7578, the Centers for Medicare & Medicaid Services (CMS) stored line level NPI information for CAHs. At the time of the implementation of CR 7578, NPI editing was not applied at the line level. CR 8170 instructs the fiscal intermediary shared system (FISS) to apply the same editing, conditions and sanctions for the line level NPI fields that are currently being applied at the claim level. The policy for this provision remains the same.

Additional information

The official instruction, CR 8170, 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/R1214OTN.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.

MLN Matters® Number: MM8170
Related Change Request (CR) #: CR 8170
Related CR Release Date: May 3, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1214OTN
Implementation Date: October 7, 2013

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Applying multiple procedure payment reductions to therapy cap amounts for critical access hospital claims

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8278 which revises the amount applied toward a beneficiary's therapy cap amounts when therapy services are provided in a critical access hospital (CAH). The requirements of CR 8278 ensure that the multiple procedure payment reduction is applied to these amounts. Make sure billing staff are aware of this change.

Background

The American Taxpayer Relief Act of 2012 (ATRA; Section 603; see *http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf*) contained a number of original Medicare provisions affecting the outpatient therapy caps and manual medical review threshold. These provisions became effective on January 1, 2013. One of the provisions required that outpatient therapy services provided in CAH settings should be included in the beneficiary's therapy cap and threshold total, using the amount that would be payable if the services were paid under the Medicare physician fee schedule.

This change was implemented via CR 7881.You can review the corresponding *MLN Matters*® at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7881.pdf*.

Payments for outpatient hospital therapy services include a multiple procedure payment reduction when more than one unit or procedure is provided to the same patient on the same day by the same provider. Inadvertently, Medicare's initial implementation of this provision updated the therapy cap and threshold total by the full fee schedule amount, without applying the multiple procedure payment reduction. The requirements of CR 8278 correct how CAH claims update the therapy cap and threshold total. If the results of CR 8278 are that previously denied therapy claims become payable, you may request that your FI or A/B MAC adjust such claims.

Additional information

The official instruction, CR 8278, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1216OTN.pdf*.

(continued on next page)

Billing social work and psychological services in comprehensive outpatient rehabilitation facilities

Provider types affected

This *MLN Matters*® article is intended for comprehensive outpatient rehabilitation facilities (CORFs) 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) 8257, which updates the list of Healthcare Procedure Coding System (HCPCS) codes billable in a CORF. It also manualizes billing instructions for a national coverage determination (NCD) related to CORFs that was previously omitted from the *Medicare Claims Processing Manual*. CR 8257 contains no new policy. It updates Medicare system edits and billing instructions to more accurately reflect current policy.

Background

In 2008, the Centers for Medicare & Medicaid Services (CMS) issued CR 5898, entitled "Comprehensive Outpatient Rehabilitation Facility (CORF) Billing Requirement Updates for Fiscal Year (FY) 2008."

That CR established a number of edits in Medicare claims processing systems that ensure the correct *Current Procedural Terminology*® (*CPT*®)/HCPCS code and revenue code combinations are billed on CORF claims (type of bill (TOB) 75x). One of these edits required that *CPT*® code *96152* was the only code that could be billed with medical social services or behavioral health revenue codes on CORF claims.

In September 2009, Medicare issued CR 6005, entitled comprehensive outpatient rehabilitation facility (CORF) services. CR 6005 created a new HCPCS code, G0409, for billing of social work and psychological services in the CORF setting. At that time, Medicare did not update the claims processing system to replace *CPT*® code *96152* with HCPCS code G0409 in the edit created by CR 5898. CR 8257 corrects this oversight.

On TOB 75x, G0409 can only be billed with revenue codes 0569 or 0911. Also, note that Medicare only allows revenue codes 0270, 0274, 0279, 029x, 0410, 0412, 0419, 042x, 043x, 044x, 0550, 0559, 0569, 0636, 0771, 0911, and 0942 to be billed on TOB 75x.

With CR 8257, Medicare is also correcting another oversight in the therapy chapter of the *Medicare Claims Processing Manual*. In 2001, Medicare issued CR 1535, which implemented an NCD regarding biofeedback training for the treatment of urinary incontinence. CR 1535 established CORF claims (type of bill 75x) as a valid type of bill for payment of biofeedback training as defined by the NCD.

Additional information

The official instruction, CR 8257 issued to your FI or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2690CP.pdf*.

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

MLN Matters® Number: MM8257
Related Change Request (CR) #: CR 8257
Related CR Release Date: May 3, 2013
Effective Date: October 1, 2012
Related CR Transmittal #: R2690CP
Implementation Date: October 7, 2013

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

Applying *(continued)*

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

A copy of the therapy cap fact sheet can be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/Therapy-Cap-Fact-Sheet_1-17.pdf*.

MLN Matters® Number: MM8278
Related Change Request (CR) #: CR 8278
Related CR Release Date: May 3, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R1216OTN
Implementation Date: October 7, 2013

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CMS issues proposed inpatient payment regulation

Policies to promote safety and program integrity among proposals

On April 26, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update fiscal year (FY) 2014 Medicare payment policies and rates for inpatient stays at general acute care and long-term care hospitals (LTCHs).

By creating the conditions for better, safer, more affordable health care, this proposed rule builds on the Obama administration's commitment to reduce the growth in health care costs while improving the quality of patient care.

The proposed rule continues CMS' commitment to payment improvements for Medicare-covered inpatient services, while increasing overall hospital payments (capital and operating) by $27 million.

It also lays out the framework for a new Affordable Care Act patient safety program to be launched in FY 2015, aimed at reducing the frequency of hospital-acquired conditions.

The rule also proposes to clarify admission and medical review criteria for hospital inpatient services.

It includes CMS' proposals for implementation of an Affordable Care Act provision that changes the methodology for calculating payments to hospitals that serve a large proportion of low-income people.

"Dedicated professionals are working day and night in hospitals to provide the care that Medicare beneficiaries need," said CMS Administrator Marilyn Tavenner. "The new policies in this proposed rule support hospitals' important work and the people with Medicare who depend on them by promoting safety and care improvement."

FY 2014 payment update

The proposed rule would increase inpatient prospective payment system (IPPS) operating rates by 0.8 percent after accounting for inflation and other adjustments required by the law.

This proposed increase also reflects a proposed temporary reduction of 0.8 percent to implement the American Taxpayer Relief Act's requirement to recoup overpayments from prior years as a result of a new patient classification system that better recognizes patient severity of illness.

CMS is also proposing an additional 0.2 percent reduction to offset projected spending increases associated with proposals regarding admission and medical review criteria for inpatient services.

CMS projects that LTCH PPS payments would increase by 1.1 percent, or approximately $62 million, in FY 2014.

Provisions promoting improved patient care

New hospital-acquired condition reduction program

The Affordable Care Act directs CMS to implement a program aimed at improving patient safety in hospitals. Beginning in FY 2015, hospitals that rank among the lowest-performing 25 percent with regard to hospital-acquired conditions will be paid 99 percent of what they would otherwise be paid under the IPPS. The proposed rule proposes the criteria and methodology CMS would use to rank hospitals with a high rate of hospital-acquired conditions.

Value-based purchasing program

The Affordable Care Act adjusts payments to hospitals according to the quality of care they delivery. For FY 2014, CMS is increasing the applicable percent reduction, the portion of Medicare payments available to fund the Value-Based Purchasing Program's value-based incentive payments, to 1.25 percent.

CMS estimates that the total amount available for performance-based incentive payments for FY 2014 would be approximately $1.1 billion, and will update this estimate for the final rule. The rule also proposes to add new measures to the program. Details about these proposed new measures are included in *FY 2014 IPPS proposed rule quality fact sheets*.

Hospital readmissions reduction program

The maximum reduction in payments under the Hospital Readmissions Reduction Program will increase from one to two percent as required by law. CMS also proposes to add two new readmission measures which could be used to calculate readmission penalties for FY 2015.

Quality reporting programs

The proposed rule would update the measures in the Hospital Inpatient Quality Reporting (IQR) program, Inpatient Psychiatric Facility Quality Reporting program, Long-Term Care Hospital (LTCH) Quality Reporting program, and the PPS-exempt cancer

(continued on next page)

Inpatient *(continued)*

hospital quality reporting program. It proposes to reduce providers' reporting burden by aligning the quality measure reporting requirement with Medicare Electronic Health Record (EHR) Incentive Program policies with certain measures in the Hospital IQR Program.

Admission and medical review criteria for inpatient services

CMS proposes to clarify its medical review criteria to presume that hospital inpatient status is appropriate for payment under Medicare Part A if the beneficiary is admitted to the hospital pursuant to a physician order and receives care for at least two midnights. This proposed policy is intended to address longstanding concerns from hospitals that they need more guidance on when a patient is appropriately treated and paid by Medicare as an inpatient. At the same time, the proposed change would help beneficiaries who in recent years have been staying in the hospital longer as outpatients because of the hospital's uncertainty about Medicare payment if they admit the patient to the hospital.

Documentation and coding offsets

Medicare adopted a new patient classification system in FY 2008 that better recognized severity of illness but also led to increases in Medicare spending as a result of changes in documentation and coding. The American Taxpayer Relief Act requires CMS to reduce future rates over the next four years to offset $11 billion in increased payments from prior years. For FY 2014, CMS is proposing a negative 0.8 percent recoupment adjustment as the first step in the recovery process. CMS expects to make similar adjustments in FYs 2015, 2016, and 2017 in order to recover the full $11 billion required by the law.

Medicare disproportionate share hospitals

Medicare pays an additional amount to hospitals that serve a disproportionate share of low- income patients. While these disproportionate share hospital (DSH) payments will continue, they will be reduced to 25 percent of the amount Medicare would pay under the current policy. The remaining 75 percent will be adjusted for decreases in the rate of uninsured individuals nationally and distributed to hospitals that receive DSH payments based on each hospital's share of uncompensated care relative to all Medicare DSH hospitals. The proposal rule requests comments on how these additional payments will be distributed.

Long-term care hospitals

Twenty-five percent patient threshold rule: Under current regulation, if an LTCH that admits more than 25 percent of its patients from a single acute care hospital Medicare will pay for those patients above the 25 percent threshold at a comparable (lower) IPPS rate.

A statutory moratorium on application of the 25-percent rule was in place December 2007-December 2012. CMS further extended this statutory moratorium through rulemaking, but the proposed regulation would allow the 25-percent patient threshold rule to go into effect in FY 2014.

Chronically ill/medically complex criteria: CMS is soliciting feedback on preliminary findings from research on criteria to identify patients that are chronically critically ill and medically complex (CCI/MC) as CMS believes those are the most appropriate core population for LTCH care and also for full payment under the LTCH PPS. Although the research is not yet completed, CMS is describing the current findings in the FY 2014 IPPS proposed rule and soliciting comments on this approach, with the expectation of proposing changes to the LTCH PPS in FY 2015.

Get *more information on the payment and quality provisions* in the proposed IPPS/LTCH PPS rule.

CMS will accept comments on the proposed rule until June 25, 2013, and will respond to comments in a final rule to be issued by August 1, 2013. The proposed rule will appear in the May 10, 2013, *Federal Register* can be downloaded from the *Federal Register*.

Source: CMS PERL 201304-11

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New modifier for reporting end-stage renal disease drugs administered through the dialysate solution

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8256 which instructs ESRD facilities to append the new modifier, JE (Administered via Dialysate), to all ESRD claims where drugs and biologicals are furnished to ESRD beneficiaries via the dialysate solution on claims with dates of service on or after July 1, 2013. Make sure that your billing staffs are aware of this change.

Background

Change request (CR) 8256 instructs ESRD facilities to append the new JE modifier to all ESRD claim line items reporting drugs and biologicals that are furnished to ESRD beneficiaries via the dialysate solution for dates of service on or after July 1, 2013.

Dialysate can be compounded with injectable drugs and biologicals as a way to administer the drug or biological. All drugs and biologicals that are furnished to ESRD beneficiaries for the treatment of ESRD are paid under the ESRD prospective payment system (PPS) base rate regardless of the method of administration.

ESRD facilities will continue to have the ability to append the AY modifier (Item or service furnished to an ESRD patient that is not for the treatment of ESRD) when the drug or biological is furnished for reasons other than the treatment of ESRD with the exception of those drugs that are considered to always be ESRD-related.

The list of drugs and biologicals that are included in the ESRD PPS consolidated billing requirements can be reviewed at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html*.

The Centers for Medicare & Medicaid Services (CMS) believes that the JE modifier will prevent inappropriate application of the AY modifier, because CMS believes that there is confusion whether a drug or biological is considered ESRD-related when it is added to the dialysate.

Additional information

The official instruction, CR 8256 issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2688CP.pdf*.

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

MLN Matters® Number: MM8256
Related Change Request (CR) #: CR 8256
Related CR Release Date: April 26, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2688CP
Implementation Date: July 1, 2013

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

Take the time to 'chat' with the website team

Save valuable time by asking your website-related questions online – with First Coast's new Live Chat service.
Monday - Friday, 10 a.m. - 2 p.m. EDT

Educational Events

Provider outreach and educational events – June/July 2013

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

Medifest 2013 - Tallahassee

When: July 24-25
Location: Four Points By Sheraton Tallahassee Downtown
Time: All Day **Delivery language:** English
Type of Event: Educational Seminar **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

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': May 2, 2013, – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-02-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': May 9, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-09-enews.pdf*
- 'CMS Medicare FFS Provider e-News': May 16, 2013 –*http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-16-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': May 23, 2013 –*https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-23-Enews.pdf*

Source: CMS PERL 201305-01, 201305-02, 201305-03, 201305-04

Register for free, hands-on Internet-based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment.

Click on the date for any of the following sessions: June 27, July 11, July 18, or August 15, 2013.

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

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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