

C Medicare A CONNECTION

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A Newsletter for MAC Jurisdiction 9 Providers

November 2013



In this issue

| | |
|--|----|
| Information on incarcerated beneficiary claims | 5 |
| Medicare deductibles and premium rates for 2014 | 16 |
| Suspension of 'two midnight rule' reviews | 18 |
| CMS provides MS-DRGs for ICD-10 planning | 23 |
| Physician payment rates and policies for 2014 | 35 |
| Outpatient facility policy and payment changes | 36 |
| Upcoming educational events | 41 |

Functional reporting requirements for outpatient therapy services

First Coast Service Options (First Coast) has seen an increase in the number of unpaid claims billed by providers for outpatient therapy services due to functional reporting errors.

Providers billing outpatient therapy services for Medicare beneficiaries must submit functional limitation data (non-payable G-codes) to report the status of a beneficiary's functional limitations.

For each non-payable G-code submitted, a modifier must be appended to the G-code to report the severity/complexity for that functional measure. All practice settings that provide outpatient therapy services must include this information on the claim form for the claim to be processed.

The G-codes and severity modifiers are required:

- On the same date of service as an evaluative procedure, including a re-evaluation, or
- At the outset of a therapy episode of care (initial therapy service)
 - Report current status and project goal status of the mobility functional limitation

- Once every 10 treatment days
 - The date of service when the progress report services are furnished report the current status and projected goal status and the mobility functional limitation
 - This step is repeated as clinically appropriate
- At the time of discharge from the therapy episode of care (if data is available)
 - Report the projected goal and discharge status of the mobility functional limitation
- The same date of service the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary

Each reported functional G-code must contain essential line of service information:

- Functional severity modifier

(continued on Page 3)



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

General Information

| | |
|---|---|
| Updates to the Medicare Claims Processing Internet-Only Manual (IOM)..... | 3 |
| Implementation of the award for the jurisdiction K A/B MAC..... | 4 |
| CMS updates information on incarcerated beneficiary claims..... | 5 |
| Further details on the revalidation of provider enrollment information..... | 6 |
| DMEPOS contract suppliers announced..... | 8 |

General Coverage

| | |
|--|----|
| Full implementation of phase 2 edits for ordered/referred services..... | 9 |
| Update to Medicare deductible, coinsurance, and premium rates for 2014 | 16 |
| Mandatory reporting of an eight digit clinical trial number on claims | 17 |
| Suspension of 'two midnight rule' reviews of hospital admissions | 18 |

Local Coverage Determinations

| | |
|-------------------|----|
| LCD contents..... | 19 |
|-------------------|----|

Electronic Data Interchange

| | |
|---|----|
| Termination of the common working file Part A provider queries..... | 22 |
| Changes to the laboratory national coverage determination software for ICD-10 codes | 23 |
| CMS provides MS-DRGs and other new resources for ICD-10 planning | 23 |
| ICD-10 testing EDI common edits and enhancements module..... | 24 |
| New influenza virus and hepatitis B virus vaccine codes | 25 |
| MREP and PC Print updates for phase III 360 rule compliance..... | 26 |
| Annual update of skilled nursing healthcare common procedure coding system codes | 27 |
| EDI enrollment tips | 28 |
| Coding guidelines for 3D mammography | 28 |
| Identify how ICD-10 will affect your practice..... | 29 |
| 2014 HCPCS update and release of final HCPCS coding decision letters | 29 |

Claim and Inquiry Summary Data

| | |
|------------------------------|----|
| Top inquiries | 30 |
| Top rejects | 31 |
| Top return to provider | 32 |

Reimbursement

| | |
|---|----|
| FISS claims processing update for ambulance services..... | 33 |
| Denial of inpatient service claims related to a hospice terminal diagnosis..... | 33 |
| CMS finalizes physician payment rates and policies for 2014..... | 35 |
| CMS makes outpatient facility policy and payment changes | 36 |
| Overpayment recoupment of services for procedure Agriflu® | 36 |

Hospitals

| | |
|---|----|
| Reassignment to Part A critical access hospitals billing under method II..... | 37 |
| Skilled nursing facility consolidated billing for ambulance services | 38 |

Educational Resources

| | |
|--|----|
| Upcoming provider outreach and educational events – January 2014 | 41 |
|--|----|

Other Educational Resources

| | |
|--|----|
| CMS MLN Connects™ Provider eNews | 42 |
|--|----|

Contact Information

| | |
|---|----|
| Florida and USVI Contact Information..... | 43 |
| Puerto Rico Contact Information | 44 |

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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Updates to the Medicare Claims Processing Internet-Only Manual (IOM)

Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs) and other providers 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

Change request (CR) 8490, on which this article is based, advises Medicare contractors of revisions to Chapters 1 and 6 of the *Medicare Claims Processing Manual*. Make sure that your billing staffs are aware of these updates.

Background

CR 8490 updates Chapter 1 of the manual to correct the wording for value codes 19 and 79. The corrected wording is as follows:

- 19 – The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement.
This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.
- 79 – The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

Chapter 6, sections 30.6.3, 40.6.4 and 40.8 are revised for clarification as follows:

- Section 30.6.3 is modified slightly just to show that certain calculations related to labor and non-labor percentages are rounded.

- Section 40.6.4 is modified to show that when occurrence span code 77 is used, if the beneficiary is receiving a skilled level of care during a period of provider liability, the provider should submit these days as covered.
- Section 40.8 is amended to show that no-payment bills are only required for beneficiaries that have previously received skilled care and subsequently dropped to non-covered care and continue to reside in the certified area of the facility.

Additional information

The official instruction, CR 8490 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2815CP.pdf>.

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>.

MLN Matters® Number: MM8490
Related Change Request (CR) #: CR 8490
Related CR Release Date: November 15, 2013
Effective Date: March 18, 2014
Related CR Transmittal #: R2815CP
Implementation Date: March 18, 2014

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.



Therapy (continued)

- Therapy modifier indicating the discipline of the plan of care
- Date of corresponding billable service
- Nominal charge for service line
 - Penny for institutional claims
 - Zero for professional claims (If billing software requires a nominal charge, add a penny)

For additional guidance on functional reporting requirements for outpatient therapy services, refer to *MLN Matters*® [MM8005](#) in the related items box under news on the [rehabilitation services specialty page](#).

Implementation of the award for the jurisdiction K A/B MAC

Effective date: October 1, 2013

Implementation: date: October 7, 2013

Background

The Centers for Medicare & Medicaid Services (CMS) is required to compete each Part A and Part B Medicare administrative contractor (A/B MAC) workload at least once every five years. It recently did so for the jurisdiction K A/B MAC workload formerly known as jurisdiction 13 and jurisdiction 14.

Jurisdiction 13 is comprised of Part A and Part B for Connecticut and New York.

Jurisdiction 14 is comprised of Part A and Part B for Maine, Massachusetts, New Hampshire, Rhode Island and Vermont as well as the home health and hospice (HH+H) region A states of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.

The HH+H workload was formerly known as the regional home health intermediary (RHII) workload.

CMS awarded this JK workload to National Government Services (NGS). NGS is the incumbent for the current J13 portion of the workload. The address for NGS is as follows:

National Government Services
8115 Knue Road
Indianapolis, IN 46250

NHIC, Corp. (NHIC) is the outgoing contractor for the current J14 portion of the workload. The address for NHIC, Corp. is as follows:

NHIC, Corp
75 Sgt. William B. Terry Drive
Hingham, MA 02043

CMS has determined that it will not need to change the current jurisdiction 13 Part A and Part B Connecticut and New York Part A workload numbers when this new contract is implemented on June 1, 2013.

CMS will, however, need to change the workload numbers for the J14 Part A and Part B Maine, Massachusetts, New Hampshire, Rhode Island, Vermont and home health and hospice region A workloads.

This change is being made because CMS needs to differentiate between the workload processed by the outgoing contractor (OGC) and the incoming contractor.

The workload numbers shall be changed and the workloads shall be transitioned to the JK A/B MAC as indicated below:

Part A (effective October 18, 2013)

| Workload | JK workload number | Current workload number | Outgoing contractor |
|----------------------------------|--------------------|-------------------------|---------------------|
| Rhode Island | 14411 | 14401 | NHIC |
| Massachusetts | 14211 | 14201 | NHIC |
| New Hampshire | 14311 | 14301 | NHIC |
| Vermont | 14511 | 14501 | NHIC |
| Maine | 14111 | 14101 | NHIC |
| Home health and hospice region A | 14014 | 14004 | NHIC |

Part B (effective October 25, 2013)

| Workload | JK workload number | Current workload number | Outgoing contractor |
|---------------|--------------------|-------------------------|---------------------|
| Maine | 14112 | 14102 | NHIC |
| Massachusetts | 14212 | 14202 | NHIC |
| New Hampshire | 14312 | 14302 | NHIC |
| Vermont | 14512 | 14502 | NHIC |
| Rhode Island | 14412 | 14402 | NHIC |

The following applications or business owners shall continue to accept the current J13 A/B workload numbers for the J13 portion (Connecticut and New York) of the JK workload.

The following applications or business owners shall accept the new JK A/B workload numbers for the J14 portion of the JK workload once the above cited workload is transitioned to the JK A/B MAC.

1. Administrative qualified independent contractor (AdQIC)
2. CMS analysis reporting and tracking system (CMS ARTS)
3. Contractor administrative, budget and financial management (CAFM)
4. Comprehensive error rate testing system (CERT)
5. Contractor management information system (CMIS)
6. CMS Baltimore data center
7. Coordination of benefits agreement program (COBA)

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Award (*continued*)

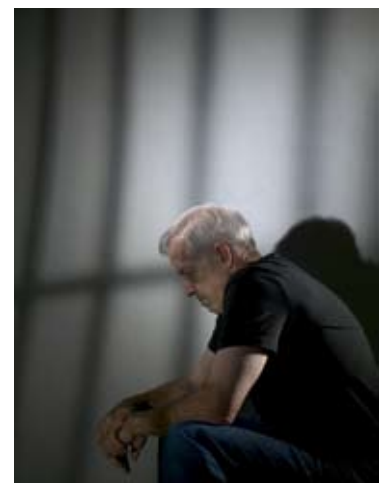
8. Coordination of benefits contractor (COBC)
9. Contractor reporting of operational workload data system (CROWD)
10. Common working file (CWF)
11. Customer service assessment and management system (CSAMS)
12. Electronic correspondence referral system (ECRS)
13. Electronic health records incentive program (EHR)
14. Electronic prescribing (eRx)
15. Enterprise data centers (EDCs)
16. Expert claims processing system (ECPS)
17. Fiscal intermediary shared system (FISS)
18. Fraud prevention system (FPS)
19. Health care information system (HCIS)
20. Healthcare integrated general ledger accounting system (HIGLAS)
21. Health insurance master record (HIMR)
22. Integrated data repository (IDR)
23. Intern and resident information system (IRIS)
24. Local coverage determination database (LCD)
25. Medicare appeals system (MAS)
26. Medicare coverage data base (MCD)
27. Medicare secondary payer recovery contractor (MSPRC)
28. Multi-carrier system (MCS)
29. National data warehouse (NDW)
30. National level repository (NLR)
31. National Part B pricing files
32. National provider identifier crosswalk (NPI)
33. Next generation desktop (NGD)
34. Part B analytics reporting system (PBAR)
35. Production performance monitoring system (PULSE)
36. Provider enrollment, chain, and ownership system (PECOS)
37. Provider customer service program contractor information database (PCID)
38. Provider inquiry evaluation system (PIES)
39. Program safeguard contractor (PSC)
40. Provider statistical and reimbursement system (PS and R)
41. Qualified independent contractor (QIC)
42. Quality improvement evaluation system (QIES)
43. Recovery auditors (RA)
44. Recover management and accounting system (REMAS)
45. Renal management information system (REMIS)
46. Strategic work information transfer system (SWIFT)
47. System tracking for audit and reimbursement (STAR)
48. ZIP code file
49. Zone program integrity contractors (ZPICs)

Source: Change request 8303

CMS updates information on incarcerated beneficiary claims

The Centers for Medicare & Medicaid Services (CMS) has a new [Web page](#) focused on the 2013 claims denials associated with a beneficiary's incarceration status.

Source: PERL 201311-09



Further details on the revalidation of provider enrollment information

Note: This article was revised November 4 and December 9, 2013, respectively, to reflect current revalidation processes and include the 2014 application fee amount of \$542.00. This information was previously published in the December 2012 *Medicare A Connection*, Pages 20-22.

Provider types affected

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

Provider action needed

Stop – impact to you

In change request (CR) 7350, the Centers for Medicare & Medicaid Services (CMS) discussed the final rule with comment period, titled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the *Federal Register*.

A related *MLN Matters®* article is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf>. This article provides no new policy, but only provides further information regarding the revalidation requirements based on Section 6401 (a) of the Affordable Care Act.

Caution – what you need to know

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

Special note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers should continue to submit routine changes – address updates, reassignments, additions to practices, changes in authorized officials, information updates, etc – as they always have.

If you also receive a request for revalidation from the

MAC, respond separately to that request.

Go – what you need to do

When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based PECOS or complete the 855,
- Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC, and
- If applicable, pay your fee by going to <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>.

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

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011.

Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are generally not impacted. Excluded from the revalidation requirements are providers enrolled solely to order and refer items or services

to Medicare beneficiaries and practitioners who have opted out of the Medicare program.

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

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

Therefore, between now and 2015, MACs will send out revalidation notices on an intermittent, but regular basis to begin the revalidation process for

(continued on next page)



Provider (continued)

each – provider and supplier.

Providers and suppliers must submit the revalidation application only after being asked by their MAC to do so. Please note that 42 CFR 424.515(d) provides CMS the authority to conduct these off-cycle revalidations.

CMS asks all providers who receive a request for revalidation to respond to that request.

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

CMS will provide the MACs with a list of providers/suppliers requiring revalidation every 60 days beginning October 2013. Within 60 days of receiving the CMS list, MACs will mail the revalidation notices.

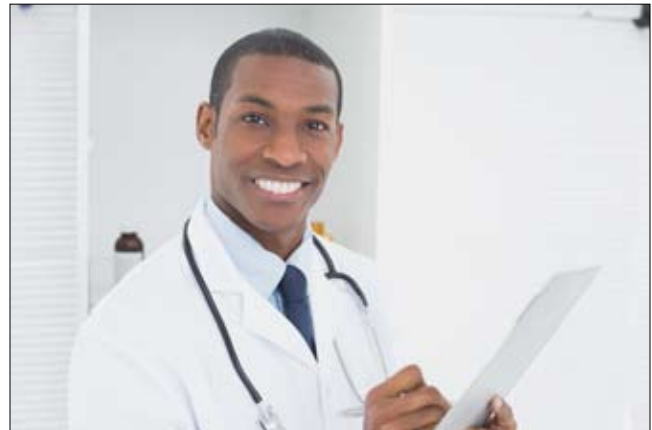
Large groups (200+ members) accepting reassigned benefits from providers identified on the CMS list will receive a letter from their MACs informing them that providers linked to their group have been selected to revalidate.

A spreadsheet detailing the applicable provider's name, national provider identifier (NPI), and specialty will also be provided. The letter and spreadsheet will be mailed to the group's correspondence address within 15 days of the MAC receiving the CMS list. This is informational only. Groups should not take any action to revalidate their providers until asked by their MAC to do so.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize Internet-based PECOS or the CMS list available on CMS.gov to determine if their providers have been mailed a revalidation notice.

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

To revalidate via the Internet-based PECOS, go to <https://pecos.cms.hhs.gov/pecos/login.do>. PECOS allows you to review information currently on file, update and submit your revalidation via the Internet. Once completed, you must electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required



supporting documentation to your appropriate MAC immediately.

Section 6401(a) of the Affordable Care Act also requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The application fee is \$532 for 2013. The fee for 2014 is \$542. CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

All institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit an enrollment fee (reference 42 CFR 424.514) with their revalidation. You may submit your fee by ACH debit, or credit card. Revalidations are processed only when fees have cleared. To pay your application fee, go to <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do> and submit payment as directed.

A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you mail this receipt to the MAC along with the certification statement for the enrollment application. CMS will notify the MAC that the application fee has been paid.

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

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

(continued on next page)

Provider (continued)

A 60-day extension is available if more time is needed to complete the revalidation process. Extension requests should be coordinated with your MAC and requested in writing (fax/email permissible) or via phone. The individual provider, the authorized or delegated official of the group or the enrollment contact person can request the extension.

A group may request an extension on behalf of individuals reassigned to their group. Group extensions shall also be coordinated through your MACs and must meet the following requirements.

- Only permitted if the provider reassigns all benefits to the group requesting the extension,
- The extension is requested by the authorized or delegated official of the group or the enrollment contact person, and
- The providers' name, national provider identifier (NPI) and justification as to why an extension is needed is provided. The extension can be requested in writing (fax/email permissible) or via phone.

Additional Information

To find out whether a provider/supplier has been mailed a revalidation notice go to <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

A sample revalidation letter is available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf>.

A revalidation checklist is available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

For more information about the enrollment process and required fees, refer to *MLN Matters*® article MM7350, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf>.

For more information about the application fee



payment process, refer to *MLN Matters*® article SE1130, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf>.

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

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DMEPOS contract suppliers announced

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for the round one re-compete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

A list of round one re-compete contract supplier locations for each product category and competitive bidding area is now available at www.dmecompetitivebid.com/cs. This list is current as of October 31, 2013. Contract suppliers may add or change locations.

Updates will be posted on the Medicare supplier directory website at www.medicare.gov/supplier in mid-December 2013.

CMS is required by law to re-compete contracts under the DMEPOS competitive bidding program at least once every three years. The round one rebid contracts will expire on December 31, 2013, and the round one re-compete contracts and prices are scheduled to go into effect on January 1, 2014.

For more information, view the [fact sheet](#)

Source: CMS PERL 201311-01

Full implementation of phase 2 edits for ordered/referred services

Note: This article was revised November 6, 2013, to provide updated information regarding the effective date of the edits (January 6, 2014). Additional clarifying information regarding the advance beneficiary notice, claim adjustment reason codes (CARC) and durable medical equipment (DME) rental equipment has also been updated. Please review the article carefully for these changes. All other information remains the same. This article was previously published in the April 2013 *Medicare A Connection*, Pages 16-21.

Note: This article was previously revised April 19, 2013, to add references to the CMS-1450 form and to add question h. on under "Effect of edits on providers."

Previously, it was revised April 3, 2013, to advise providers to not include middle names and suffixes of ordering/referring providers on paper claims. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer.

If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first letter of the first name and the first four letters of the last name.

When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html>.

Provider types affected

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

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



Provider action needed

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

What you need to know

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

Phase 2: Effective January 6, 2014, CMS will turn on the edits to deny Part B clinical laboratory and imaging, DME, and Part A HHA claims that fail the ordering/referring provider edits.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing will continue to be rejected. Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit will not expose a Medicare beneficiary to liability.

Therefore, an advance beneficiary notice is not appropriate in this situation. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services, including home health, DMEPOS, imaging and clinical laboratory.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare
(continued on next page)

Ordering (continued)

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

When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found on <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html>.

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

All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application. Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the implementation date of the ordering/referring phase 2 provider edits.

Background

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program.

Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the NPI. The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from clinical laboratories for ordered tests
- Claims from imaging centers for ordered imaging procedures



- Claims from suppliers of DMEPOS for ordered DMEPOS
- Claims from Part A HHA

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

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-ray services payable under Medicare Part B.)
- Physician assistants
- Clinical nurse specialists
- Nurse practitioners
- Clinical psychologists
- Interns, residents, and fellows
- Certified nurse midwives
- Clinical social workers

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

CMS would like to highlight the following limitations:

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

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Ordering (continued)

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

- Optometrists may only order and refer DMEPOS products/services, and laboratory and X-ray services payable under Medicare Part B.

Questions and answers relating to the edits

1. What are the ordering and referring edits?

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

2. Why did Medicare implement these edits?

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

3. How and when will these edits be implemented?

These edits were implemented in two phases:

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

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

- N264** Missing/incomplete/invalid ordering provider name
- N265** Missing/incomplete/invalid ordering provider primary identifier

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

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

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

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

- N272** Missing/incomplete/invalid other payer attending provider identifier

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

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

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs. 1 (add this footer “1 NPIs were added only when the matching criteria verified the NPI.”)

On January 28, 2010, CMS made available to the public, via the *Downloads* section of the “Ordering Referring Report” page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering/Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the report twice a week. At any given time, only one report (the most current) will be available for downloading. To learn more about the report and to download it, go to <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>; click on “Ordering & Referring Information” (on the left). Information about the report will be displayed.

Phase 2: Effective January 6, 2014, CMS will turn on the phase 2 edits. In phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

Below are the denial edits for Part B providers and suppliers who submit claims to Part A/B MACs, including DME MACs:

- 254D or 001L** Referring/Ordering Provider Not Allowed To Refer/Order
- 255D or 002L** Referring/Ordering Provider Mismatch

CARC code 16 or 183 and/or the RARC code N264, N574, N575 and MA13 shall be used for denied or adjusted claims.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing (edit 289D) will continue to be rejected. CARC code 16 and/or the RARC code N265, N276 and MA13 shall be used for rejected claims due to the missing required matching NPI.

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Ordering (continued)

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

| Reason code | This reason code will assign when: |
|--------------|--|
| 37236 | <ul style="list-style-type: none"> The statement “From” date on the claim is on or after the date the phase 2 edits are turned on The type of bill is ‘32’ or ‘33’ Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code. |
| 37237 | <ul style="list-style-type: none"> The statement “From” date on the claim is on or after the date the phase 2 edits are turned on The type of bill is ‘32’ or ‘33’ The type of bill frequency code is ‘7’ or ‘F-P’ Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code. |

Effect of edits on providers

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

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

- a. You have a current Medicare enrollment record.**

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

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

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

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Ordering (continued)

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

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

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

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

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

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

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the ordering referring report described earlier in this article.
- Ensure you are correctly spelling the ordering/referring provider's name.
- If you furnished items or services from an order or referral from someone on the ordering/referring report, your claim should pass the ordering/referring provider edits.
- The ordering/referring report will be replaced

twice a week to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the ordering/referring report but who may be listed on the next report.

f. Make sure your claims are properly completed.

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

could cause the claim to fail the edits.

▪ Ensure that the name and the NPI you enter for the ordering/referring provider belong to a physician or non-physician

practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral.

- Make sure that the qualifier in the electronic claim (x12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.

If there are additional questions about the informational messages, billing providers should contact their local A/B MAC, or DME MAC.

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

g. What if my claim is denied inappropriately?

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

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

-SE 1305

Ordering (continued)

standard claims appeals process or work through your A/B MAC or DME MAC.

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

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

i. Are the phase 2 edits based on date of service or date of claim receipt?

The phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

j. A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month at the time the phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled?

Claims for capped rental items will continue to be paid for up to 13 months from the implementation date of the phase 2 edits to allow coverage for the duration of the capped rental period.

Additional guidance

- 1. Terminology:** Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically

correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

- 2. Orders or referrals by interns or residents:** The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)).

The final rule states that state-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching

physician. However, if states provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with state law.

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

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

services they furnish to Medicare beneficiaries.

- 4. Orders or referrals by dentists:** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional information

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

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Ordering (continued)

for each state can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf.

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

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

To obtain an NPI, you may apply online at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. For more information about NPI enumeration, visit <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProviderStand/index.html>.

Additional article updates

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

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

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

MLN Matters® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf>.



MLN Matters® article MM6856, "Expansion of the Current Scope for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) Claims processed by Medicare Regional Home Health Intermediaries (RHHIs)," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf>.

MLN Matters® article SE1311, "Opting out of Medicare and/or Electing to Order and Refer Services" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf> informs ordering and referring providers about the information they must provide in a written affidavit to their Medicare contractor when they opt-out of Medicare.

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

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Update to Medicare deductible, coinsurance, and premium rates for 2014

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) 8527 which details the 2014 Medicare premium, coinsurance, and deductible amounts. Make sure that your billing staffs are aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per day for days 61–90 spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after day 90 in a spell of illness. The coinsurance amount for these days is equal to one half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for days 21–100 of skilled nursing facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for health insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for two years for every year they could have enrolled and failed to enroll in Part A.

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

The updated rates are as follows:

2014 Part A – hospital insurance (HI) rates

Deductible

- \$1,216.00

Coinsurance

- \$304.00 a day for days 61-90
- \$608.00 a day - days 91-150 (lifetime reserve days)
- \$152.00 a day for days 21-100 (skilled nursing facility coinsurance)

Base premium (BP)

- \$426.00 a month BP with 10 percent surcharge
- \$468.60 a month BP with 45 percent reduction
- \$234.00 a month (for those who have 30-39 quarters of coverage) BP with 45 percent reduction and 10 percent surcharge
- \$257.40 a month

2014 Part B – supplementary medical insurance (SMI) rates standard premium

- \$104.90 a month

Deductible

- \$147.00 a year

Pro rata data amount

- \$114.99 1st month
- \$32.01 2nd month

Coinsurance

- 20 percent

Additional information

The official instruction, CR 8527, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R82GI.pdf>.

If you have questions, contact your 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: MM8527

Related Change Request (CR) #: CR 8527

Related CR Release Date: November 15, 2013

Effective Date: January 1, 2014

Related CR Transmittal #: R82GI

Implementation Date: January 6, 2014

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Mandatory reporting of an eight-digit clinical trial number on claims

Note: This article was revised November 6, 2013, due to a revised change request (CR). The transmittal number, CR release date and link to the CR were also changed. All other information remains the same. This information was previously published in the August 2013 *Medicare A Connection*, Pages 18-19.

Provider types affected

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

Provider action needed

This article is based on CR 8401, which informs you that, effective January 1, 2014, it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the *Medicare National Coverage Determination (NCD) Manual*, Section 310.1.

The clinical trial number to be reported is the same number that has been reported voluntarily since the implementation of CR 5790, dated January 18, 2008. That is the number assigned by the National Library of Medicine (NLM) <http://clinicaltrials.gov/> website when a new study appears in the NLM clinical trials data base. Make sure that your billing staffs are aware of this requirement.

Background

CR 5790, Transmittal 310, dated January 18, 2008, titled "Requirements for Including an 8-Digit Clinical Trial Number on Claims" is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R310OTN.pdf>. The *MLN Matters*® article for CR 5790 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5790.pdf>.

This number is listed prominently on each specific study's page and is always preceded by the letters "NCT."

The Centers for Medicare & Medicaid Services (CMS) uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry. Furthermore, this identifier permits CMS to better track Medicare

payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by consulting CMS's clinical trials/registry website at <http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/index.html>.

For institutional paper or direct data entry (DDE) claims, the eight digit clinical trial number is to be placed in the value amount for paper only value code D4/DDE claim UB-04 (For Locators 39-41) when a clinical trial claim includes:

- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions), and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For institutional claims that are submitted on the electronic claim 837I, the eight digit number should be placed in loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- Condition code 30
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions), and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For professional claims, the eight digit clinical trial number preceded by the two alpha characters of CT must be placed in field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in loop 2300 REF02(REF01=P4) when a clinical trial claim includes:

- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions), and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an eight digit clinical trial number will be returned as unprocessable to the provider for inclusion of the trial number using the messages listed below.

- **Claim adjustment reason 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 National

(continued on next page)



Suspension of ‘two midnight rule’ post-payment patient status reviews of inpatient hospital admissions

The Centers for Medicare & Medicaid Services (CMS) recently issued instructions for Medicare administrative contractors (MACs), recovery auditors, and the supplemental medical review contractor to suspend post-payment patient status reviews for inpatient claims with dates of admission October 1, 2013, through December 31, 2013.

According to CMS, claims with evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to surpass the two midnight presumption

could warrant medical review at any time.

MACs, recovery auditors, and the supplemental medical review contractor may continue other types of inpatient hospital review for purposes other than determining the appropriateness of the inpatient admission versus treatment as an outpatient.

Here is the link to the [change request 8508](#) which provides more detail regarding the status review suspension.

Source: CR 8508



Clinical (continued)

Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)”

- **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.”
- **Group code:** Contractual obligation (CO).

Note: This is a reminder/clarification that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

Additional information

The official instruction, CR 8401, issued to your

Medicare contractor regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2805CP.pdf>.

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>.

MLN Matters® Number: MM8401 **Revised**
 Related Change Request (CR) #: CR 8401
 Related CR Release Date: October 30, 2013
 Effective Date: January 1, 2014
 Related CR Transmittal #: R2805CP
 Implementation Date: January 6, 2014

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

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

Effective and notice dates

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

Contents

Revised LCDs

| | |
|--|----|
| Polysomnography and sleep testing..... | 20 |
| Psychological and neuropsychological tests | 20 |
| Hyperbaric oxygen therapy (HBO therapy) | 21 |
| Therapy and rehabilitation services..... | 21 |

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**.

Revision to LCDs

Polysomnography and sleep testing – revision to the Part A LCD

LCD ID number: L29905 (Florida)

LCD ID number: L29907 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for polysomnography and sleep testing was most recently revised January 1, 2013.

Since that time, the LCD has been revised in the “Documentation/Credentialing Requirements” section of the LCD under “Technologist/Technician Credentials/Training” to clarify the credentialing between a technologist and a technician.

The LCD is revised to read as follows: “All technologists and technicians conducting sleep testing who are not registered by the BRPT, ABRET, ABSM, NBRC or other accepted certification body, must be affiliated with an AASM accredited sleep facility or Joint Commissions accredited sleep facility (a Joint Commission accredited sleep laboratory). Unregistered technologists and technicians must maintain appropriate training and supervision, and, be

supervised by a registered and licensed technologist, where license is required by state law.

Technologist staffing must be adequate to address the workload of the sleep facility and assure the safety of patients.” Additionally, the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD under “Accreditation” has also been revised.

Effective date

This LCD revision is effective for claims processed **on or after October 29, 2013**. First Coast LCDs are available through the CMS Medicare coverage databases 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, please [click here](#).

Psychological and neuropsychological tests – revision to Part A/B LCD

LCD ID number: L33688 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for psychological and neuropsychological tests was effective October 14, 2013. Since that time, the LCD was revised to remove *Current Procedural Terminology (CPT®)* code 96125 and add it to the therapy and rehabilitation services LCD. In addition, the *Coding Guidelines* attachment was also revised.

Effective date

This LCD revision is effective for claims processed **on**

or after November 27, 2013, for services rendered **on or after October 14, 2013**. First Coast LCDs are available through the CMS Medicare coverage databases 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, please [click here](#).

First Coast Service Options Inc provides current and draft local coverage determinations (LCDs), when they exist, for Medicare-covered procedure codes.

Not every procedure code is covered by an LCD.
[Click here](#) to look up current LCDs



Hyperbaric oxygen therapy (HBO therapy) – revision to the Part A LCD

LCD ID number: L28887 (Florida)

LCD ID number: L28909 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for hyperbaric oxygen therapy (HBO therapy) was most recently revised January 1, 2013. Since that time, the LCD has been revised based on a reconsideration request to require a dual diagnosis for the treatment of arterial insufficiency ulcers if they persist after reconstructive surgery has restored large vessel function.

The “ICD-9 Codes that Support Medical Necessity” section of the LCD and the “Coding Guidelines” attachment have been updated to add ICD-9-CM code V58.73 (aftercare following surgery of the circulatory system, NEC) as a secondary diagnosis code with ICD-9-CM code 444.21, 444.22, or 444.81



(arterial embolism and thrombosis) when billed in the outpatient setting following hospitalization.

Effective date

This LCD revision is effective for services rendered **on or after December 30, 2013**. First Coast LCDs are available through the CMS Medicare coverage databases 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, please [click here](#).

Therapy and rehabilitation services – revision to the Part A LCD

LCD ID number: L28992 (Florida)

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

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

Since that time, the LCD was revised to add *Current Procedural Terminology (CPT®)* codes 96125 and 97532 specific to speech-language therapy services under the “CPT®/HCPCS Codes” section of the LCD.

CPT® code 96125 was also added specific to physical and/or occupational therapy services under the “CPT®/HCPCS Codes” section of the LCD. In addition, the “Sources of Information and Basis for Decision”

section of the LCD was also revised.

Effective date

This LCD revision is effective for claims processed **on or after November 8, 2013**. First Coast LCDs are available through the CMS Medicare coverage databases 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, please [click here](#).

Your feedback matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs.

Discover the results of your feedback on our Website highlights page at <http://medicare.fcso.com/Feedback/201743.asp>.

You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.



Termination of the common working file Part A provider queries

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8248 which informs Medicare contractors and providers that the Centers for Medicare & Medicaid Services (CMS) needs to eliminate the ELGA, ELGH, HIQA, HIQH, HUQA Part A queries since CMS can no longer support the approach of allowing providers online access to queries that are not HIPAA compliant. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Effective April 1, 2013, CMS terminated the common working file (CWF) Part B provider query with CR 8086 (Termination of the Common Working File ELGB Provider Query). With CR 8248, ELGA, ELGH, HIQA, HIQH, HUQA Part A queries will be terminated in April 2014.

When the CWF ELGA, ELGH, HIQA, HIQH, HUQA Part A queries are eliminated, providers will need to use other query capabilities, such as the HIPAA eligibility transaction system (HETS).

In May 2005, CMS implemented the HETS transaction to provide HIPAA compliant eligibility queries and replies. Currently, many providers use HETS to obtain Medicare beneficiary information.

Even though the CWF queries address the same business need, they are not HIPAA compliant and do not contain the same audit and security features as HETS. In addition, due to timing of updates to the databases used for these two query mechanisms, and due to differences in the way data is displayed, the responses could be different or appear different.

As a result, CMS is eliminating the CWF ELGA, ELGH, HIQA, HIQH, HUQA Part A queries. CWF queries will no longer be supported after April 7, 2014



Additional information

The official instruction, CR 8248 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1313OTN.pdf>.

For questions or more information about HETS, please visit the HETS Help Web Page at <http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html>. If you experience any problems while using the HETS application, you can contact the Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk at 1-866-324-7315 or email them at mcare@cms.hhs.gov.

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>.

MLN Matters® Number: MM8248
 Related Change Request (CR) #: CR 8248
 Related CR Release Date: November 7, 2013
 Effective Date: April 7, 2014
 Related CR Transmittal #: R1313OTN
 Implementation Date: April 7, 2014

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Learn the secrets to billing Medicare correctly

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



Changes to the laboratory national coverage determination software for ICD-10 codes

Provider types affected

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

Provider action needed

Change request (CR) 8494, from which this article is taken, provides that the laboratory national coverage determination (NCD) edit software will be updated to accommodate the processing of the International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes.

This is a follow-up to CR 8202 (Changes to the Laboratory National Coverage Determination (NCD) Software for ICD-10), dated February 1, 2013, that extended the ICD-9 to ICD-10 implementation date to October 1, 2014. You can find this CR at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1174OTN.pdf>.

Background

In accordance with the *Medicare Claims Processing Manual*, Chapter 16 (Laboratory Services), Section 120.2 (Implementation and Updates of Negotiated National Coverage Determinations (NCDs) for Clinical Diagnostic Laboratory Services), the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

The changes are a result of coding analysis decisions developed under the procedures for maintaining codes

in the negotiated NCDs and for biannual updates of the ICD-9-CM codes.



CR 8494, from which this article is taken, instructs the Medicare shared systems maintainers to update the laboratory NCD edit software to accommodate the processing of the ICD-10 diagnosis codes. There are no updates to the laboratory NCD code lists for this quarter.

Additional information

The official instruction, CR 8494 issued to your A/B MAC regarding this

change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2806CP.pdf>.

If you have any questions, please contact your 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: MM8494

Related Change Request (CR) #: CR 8494

Related CR Release Date: November 1, 2013

Effective Date: October 1, 2014

Related CR Transmittal #: R2806CP

Implementation Date: January 6, 2014

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CMS provides MS-DRGs and other new resources for ICD-10 planning

The Centers for Medicare & Medicaid Services recently published the International Classification of Diseases (ICD), tenth edition (ICD-10) Medicare severity diagnosis related groups (MS-DRGs), version 31, on the [ICD-10 conversion project Web page](#).

This is the ICD-10 version of the currently used fiscal year 2014 MS-DRGs. CMS developed the file and other resources to help the health care industry transition to ICD-10 by October 1, 2014.

The release of the ICD-10 MS-DRGs includes the *ICD-10 MS-DRGs v31 Definitions Manual*, Medicare code

editor, and ICD-10 MS-DRGs v30 and v31 comparison file.

In addition to making the MS-DRG files available, CMS updated [ICD-10 fact sheet](#) for Medicare billing and payment.

This fact sheet informs Medicare providers on the ICD-10 clinical modification and procedure coding system. It includes compliance date information and billing and payment frequently asked questions.

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

ICD-10 testing with providers through the common edits and enhancements module and common electronic data interchange

Provider types affected

This *MLN Matters*® article is intended for Medicare providers and suppliers submitting claims to Medicare contractors (A/B Medicare administrative contractors (A/B MACs), home health and hospice MACs (HHH MACs) and the durable medical equipment MACs (DME MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8465, which announces plans for front-end ICD-10 testing between MACs and their trading partners.

For dates of service of October 1, 2014, and after, providers are required to submit ICD-10 codes on their claims. MACs must provide the opportunity for providers and suppliers to submit test claims through the CEM or the DME common electronic data interchange (CEDI) during the designated testing week. Make sure that your billing staff is aware of these upcoming testing periods for ICD-10.

Background

CMS is in the process of implementing ICD-10. All covered entities have to be fully compliant on October 1, 2014. CR 8465 instructs all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the HIPAA 5010 implementation. The ICD-10 testing week has been created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

This testing week will give trading partners access to the MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on each MAC's and the CEDI website as well as the CMS website. The testing week will be March 3 through March 7, 2014.

Information about the testing week:

- Your MAC will announce and actively promote the testing week via listserv messages and will post the testing week announcement on their website.
- Your MAC will host a registration site for the testing week, or provide an email address for the

trading partners to provide registration information. The registration site or email address information will be available and publicized to trading partners at least four weeks prior to the testing week.

- During the testing week, EDI help desk support will be available, at a minimum, from 9:00 a.m. to 4:00 p.m. local contractor time, with enough support to handle any increased call volume.
- Providers and suppliers participating during the testing week will receive electronic acknowledgement confirming that the submitted test claims were accepted or rejected.
- On or before March 18, 2014, your contractor will report the following to CMS:
 - Number of trading partners conducting testing during the testing week.

- Percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract.

- Percent of test claims accepted versus rejected.

- Report of any significant issues found during testing.



Additional information

The official instruction, CR 8465 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1303OTN.pdf>.

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>.

MLN Matters® Number: MM8465
 Related Change Request (CR) #: CR 8465
 Related CR Release Date: November 1, 2013
 Effective Date: December 3, 2013
 Related CR Transmittal #: R1303OTN
 Implementation Date: March 3, 2014

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New influenza virus and hepatitis B virus vaccine codes

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

Provider action needed

This article is based on change request (CR) 8249, which provides instructions for payment and common working file (CWF) edits to be updated to include influenza virus vaccine codes 90653, 90672, 90685, 90686, 90687, 90688, and Q2033; and hepatitis B virus vaccine code 90739 for claims with dates of service on or after January 1, 2013, but processed on or after October 7, 2013.

The CR also provides instructions for payment and Medicare common working file (CWF) edits to be updated to include influenza virus vaccine code 90661 for claims with dates of service on or after November 20, 2012, processed on or after October 7, 2013. Make sure that your billing staffs are aware of these updates.

Background

Vaccines that are described by codes 90653, 90685, 90687, 90688, and 90739 are currently pending Food and Drug Administration (FDA) approval. Vaccines that are described by codes 90661, 90672, 90686, and Q2033 have already been approved.

The Centers for Medicare & Medicaid Services (CMS) will notify Medicare contractors once FDA approval is obtained for the vaccines that are described by codes 90653, 90685, 90687, 90688, and 90739. In addition, Medicare contractors are adding Q2033 as an acceptable influenza vaccine code. As a result of CR 8249:

- Effective for claims with dates of service on or after January 1, 2013, vaccine codes 90653, 90672, 90685, 90686, 90687, 90688, 90739, and Q2033 will be payable by Medicare.
- Effective for claims with dates of service on or after November 20, 2012, code 90661 will be payable by Medicare.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination must take assignment on the claim for the vaccine.

On professional claims, for dates of service between January 1, 2013, and September 30, 2013, Medicare contractors shall use local pricing guidelines to determine payment rates for influenza virus vaccine codes 90653, 90672, 90685, 90686, 90687, 90688,



and Q2033; and hepatitis B virus vaccine code 90739. For dates of service on or after October 1, 2013, Medicare contractors will use Medicare Part B payment limits for these codes. Effective for dates of service between November 20, 2012, and September 30, 2013, contractors shall use local pricing guidelines to determine payment rates for influenza virus vaccine code 90661.

On institutional claims, hospitals (type of bill (TOB) 12X and 13X), skilled nursing facilities (TOB 22X and 23X), home health agencies (TOB 34X), hospital-based renal dialysis facilities (72X), and critical access hospitals (85X), payment will be based on reasonable cost for codes 90653, 90672, 90685, 90686, 90687, 90688, 90739, and Q2033 with dates on service on or after January 1, 2013. For the same facilities billing code 90661 on or after November 20, 2012, the payment is also based on reasonable cost.

For Indian Health Services (IHS) facilities (including IHS critical access hospitals), comprehensive outpatient rehabilitation facilities, and independent renal dialysis facilities, payment will be based on the lower of the actual charge or 95 percent of the average wholesale price (AWP).

Medicare contractors shall deny claims for vaccines containing codes 90653, 90685, 90687, 90688, and 90739 if vaccines described by these codes have not obtained approval from the FDA by October 1, 2013. In doing so, they will use:

Claims adjustment reason code (CARC) 114:
Procedure/product not approved by the Food and Drug Administration.

- Remittance advice remark code (RARC) M51:
Missing/incomplete/invalid procedure code.
- Group code: CO

Contractors shall also deny claims containing vaccine codes 90653, 90685, 90687, 90688, and 90739 if no product is located as a result of utilizing local pricing guidelines.

(continued on next page)

MREP and PC Print updates for phase III 360 rule compliance

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.

What providers need to know

This article is based on change request (CR) 8479 which informs Medicare standard system maintainers about changes to documentation requirements for electronic transactions. Make sure that your billing staffs are aware of these changes.

Background

Section 1104 of the Patient Protection and Affordable Care Act (ACA) 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 transactions.

Key points in CR 8479

Medicare contractor's systems will publish text describing the group code/CARC/RARC/CAGC reject codes included in the remittance advice to trading partners using MREP, PC Print, or PCACE software to view/print all V5010 x12 835 transactions. All published text will contain corresponding code descriptions or definitions specified in the code lists without changing the meaning and intent of the descriptions.

Medicare contractor's systems will publish text describing the corresponding CORE-defined claim adjustment/denial business scenario on all V5010 x12 835 transactions for trading partners using MREP, PC Print, or PCACE software to view/print v5010 x12 835 transactions.



Additional information

The official instruction, CR 8479 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1380OTN.pdf>.

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>.

MLN Matters® Number: MM8479
Related Change Request (CR) #: CR 8479
Related CR Release Date: November 6, 2013
Effective Date: April 1, 2014
Related CR Transmittal #: R1308OTN
Implementation Date: April 7, 2014

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Influenza (continued)

Additional information

The official instruction, CR 8249 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2693CP.pdf>.

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>.

MLN Matters® Number: MM8249
Related Change Request (CR) #: CR 8249

Related CR Release Date: May 2, 2013
Effective Date: November 20, 2012 (For code 90661);
January 1, 2013 (For codes 90653, 90672, 90685,
90686, 90687, 90688, 90739, and Q2033)
Related CR Transmittal #: R2693CP
Implementation Date: October 7, 2013

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Annual update of healthcare common procedure coding system codes for skilled nursing facility consolidated billing

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), regional home health intermediaries (RHHI), and/or home health & hospice (HH&H) MACs for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

Stop – Impact to you

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in change request (CR) 8474 could impact your payments.

Caution – What you need to know

This article is based on CR 8474 which provides the 2014 annual update of HCPCS codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

By the first week in December 2013:

- Physicians and other providers who bill carriers or A/B MACs are advised that new code files (titled 2014 carrier/A/B MAC update) will be posted at <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html> on the Centers for Medicare & Medicaid Services (CMS) website; and
- Providers who bill FIs or A/B MACs are advised that new Excel and PDF files (titled 2014 FI/A/B MAC Update) will be posted to <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>.

Go – What you need to do

It is important and necessary for you to read the “General Explanation of the Major Categories” PDF file located at the bottom of each year’s FI/A/B MAC update in order to understand the major categories, including additional exclusions not driven by HCPCS codes.

Background

Medicare’s claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay.

Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and



FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing and SNF consolidated billing), Sections 20.6 (SNF CB Annual Update Process for fiscal intermediaries (FIs)/A/B MACs) and 110.4.1 (Annual Update Process). You can find this manual at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf>.

Current Procedural Terminology® (CPT®) codes 11042 (Debride skin/tissue), 11043 (Debride tissue/muscle), and 11044 (Debride tissue/muscle/bone) will be eliminated from the FI/A/B/MAC minor surgery inclusion list effective 12/31/2012. Also, note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional information

The official instruction, CR 8474 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2802CP.pdf>.

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>.

MLN Matters® Number: MM8474
Related Change Request (CR) #: CR 8474
Related CR Release Date: October 25, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2802CP
Implementation Date: January 6, 2014

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EDI enrollment tips

The following are important tips to keep in mind when completing an EDI enrollment form:

- Effective October 1, 2013, Medicare EDI does not accept EDI enrollment forms older than February 2013.
 - Effective February 1, 2014, Medicare EDI will return all EDI enrollment forms received containing a form revision date older than October 25, 2013.
 - A link to the completion instructions is at the bottom of Page 1 of the EDI enrollment form.
 - The EDI enrollment form is interactive allowing you to complete the form online, print, sign and date it.
 - All fields with an asterisk (*) are required.
 - A required fax coversheet precedes the EDI enrollment form.
 - The EDI enrollment form is a legal document and all pages must be returned with the request, otherwise, the entire application will be returned.
 - Electronic billers will automatically be enrolled for electronic remittance advice (ERA) with the submitter on the request unless otherwise indicated in the ERA section.
 - If requesting SPR (standard paper remittance) an exception form is also required. This can be obtained by contacting Medicare EDI and must be sent in with the EDI enrollment form.
- Note:** An exception form requires a business justification for requesting remittance on paper.
- If you are enrolling in PC-ACE Pro32™, you must specify the manner in which you select to receive the software. Once the form is completed and printed, you must sign the authorized official original signature field in the PC-ACE Pro32™ section and the *Signature Requirements* section.
 - Signature requirements: The authorized official original signature must be completed on all applications, signing this section confirms you have read and agree with the *Agreement*, Centers for Medicare & Medicaid Services (CMS) obligations, and *Attestation* sections on page 3 and 4.
 - It is highly recommended that you keep a copy of your completed enrollment form(s) for your records.
 - A link has been provided on the EDI fax coversheet to the Medicare A data direct entry (DDE) page for obtaining the DDE user ID request form.
 - EDI forms are processed in the order in which they are received. Notification will be sent to the contact listed on the form advising status of the form.
 - Once the form has been completed, print, sign, date and return all pages including the EDI fax cover sheet.

Coding guidelines for 3D mammography

Medicare provides coverage for a screening mammography, which includes the use of three-dimensional (3D) images (breast tomosynthesis) to detect breast cancer.

This technology produces direct digital images and should be reported using one of the three existing Healthcare Common Procedure Coding System (HCPCS) codes that describe digital mammography services. When using these codes to bill a 3D image, the two-dimensional image is included.

Breast tomosynthesis, and all other types of digital

mammography, is described using the following HCPCS codes:

- G0202 Screening mammography, producing direct digital image, bilateral, all views
- G0204 Diagnostic mammography, direct digital image, bilateral, all views
- G0206 Diagnostic mammography, producing direct digital image, unilateral, all views

Get ready for ICD-10

On October 1, 2014, the health care industry will transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures.

This transition will change how you do business—from registration and referrals to superbills and software upgrades. To help you get ready, the Centers for Medicare & Medicaid Services has the following resources to help your practice prepare for the transition:

- [Online ICD-10 guide](#)
- [ICD-10 basics for large medical practices](#)
- [ICD-10 frequently-asked questions](#)



Identify how ICD-10 will affect your practice

To be fully prepared for the October 1, 2014, International Classification of Diseases, 10th Edition (ICD-10) transition, you need to know exactly how ICD-10 will affect your practice. Many people associate coding with submitting claims; in reality, ICD codes are used in a variety of processes within clinical practices, from registration and referrals to billing and payment. The following is a list of important questions to help you think through where you use ICD codes and how ICD-10 will affect your practice. By making a plan to address these areas now, you can make sure your practice is ready for the ICD-10 transition.

- **Where do you use ICD-9 codes?** Keep a log of everywhere you see and use an ICD-9 code. If the code is on paper, you will need new forms (e.g., patient encounter form, superbill). If the code is entered or displayed in your computer, check with your electronic health record (EHR) and/or practice management system vendor to see when your system will be ready for ICD-10 codes.
- **Will you be able to submit claims?** If you use an electronic system for any or all payers, you need to know if it will be able to accommodate the ICD-10 version of diagnoses and hospital inpatient procedures codes. If your billing system has not been upgraded for the current version of HIPAA claims standards (version 5010), you will not be able to submit claims. Check with your practice management system or software vendor to make sure your claims are in the 5010 format and that your system or software can include the ICD-10 version of diagnoses and hospital inpatient procedures codes.
- **Will you be able to complete medical records?** If you use any type of EHR system in your office, you need to know if it will capture ICD-10 codes. Look at how you enter ICD-9 codes (e.g., do you type them in or select from a drop down menu) and talk to your EHR vendor about your system's capabilities for ICD-10. If your EHR system does not capture ICD-10 codes and you use another terminology (SNOMED), you will still need ICD-10 codes to submit claims.
- **How will you code your claims under ICD-10?** If you currently code by look up in ICD-9 books, purchase the ICD-10 code books in early 2014. Take a look at the codes most commonly used in your office and begin developing a list of comparable ICD-10 codes. Alternatively, check your software for an ICD-10 look up functionality.
- **Are there ways to make coding more efficient?** For example, develop a list of your most commonly used ICD-9 codes and become familiar with the ICD-10 codes you will use in the future; and invest in a software program that helps small practices with coding.

Want more information about ICD-10?

Visit the [CMS ICD-10 website](#) for the latest news and resources to help you prepare for the October 1, 2014, deadline. [Sign up for CMS ICD-10 industry email updates](#) and [follow us on Twitter](#).

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

2014 HCPCS update and release of final HCPCS coding decision letters

Although the Centers for Medicare & Medicaid Services (CMS) is still assessing the impact of the partial government shutdown on completion of the 2014 healthcare common procedure coding system (HCPCS), CMS intends to publish the 2014 HCPCS annual update file on the HCPCS website on or before November 27, 2013.

New HCPCS codes will be effective January 1, 2014, unless otherwise specified in the file.

Final HCPCS coding decision letters will be mailed to individual applicants to coincide with the publication

of the HCPCS annual update. Timing of release of the HCPCS file and decision letters is based on the timing of publication of final regulations, as posted on:

[All FFS Provider Center page](#)

[Physician center page](#)

[Hospital center page](#)

[Ambulatory surgical centers \(ASC\) page](#)

[Home health agency \(HHA\) center page](#)

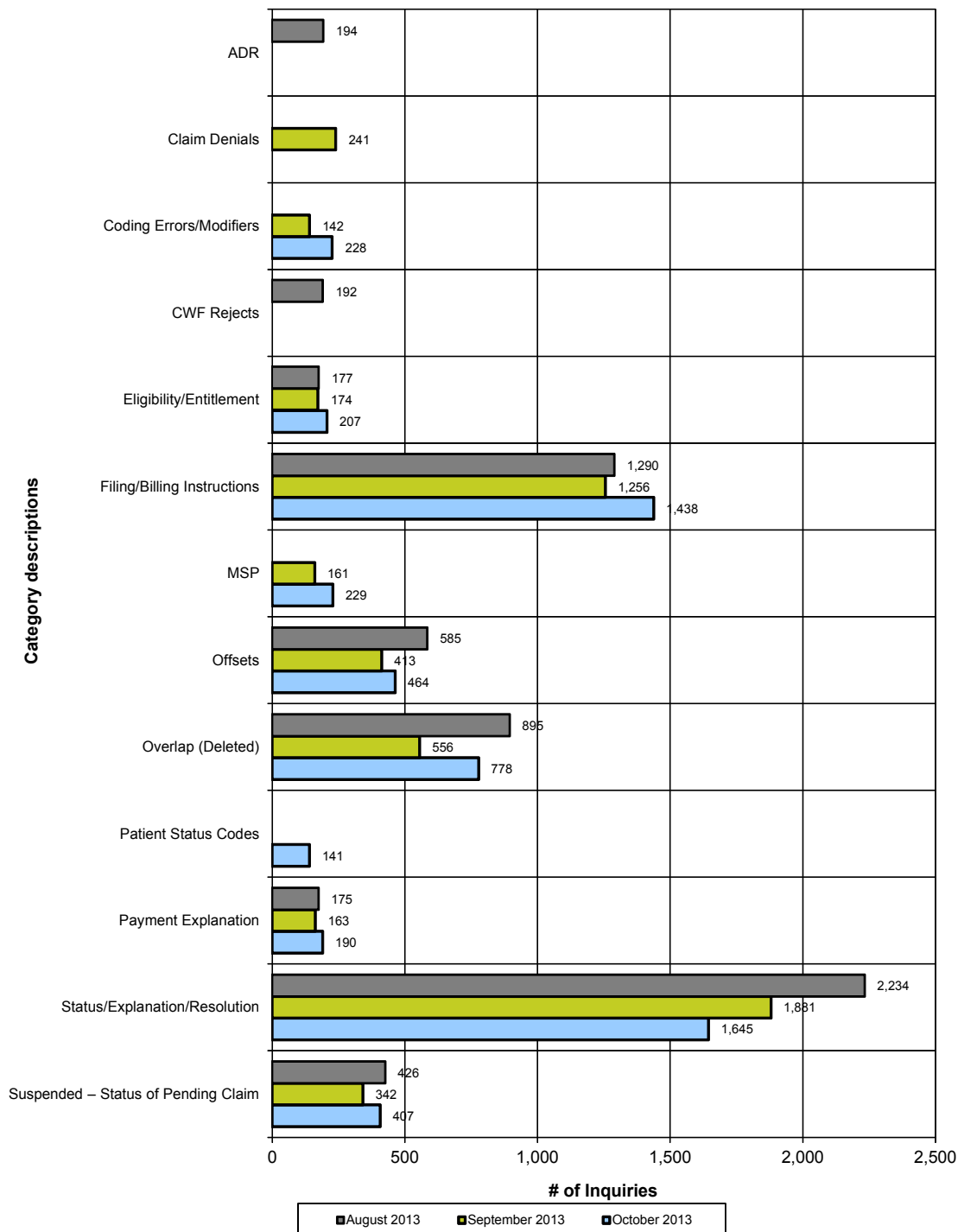
Source: CMS PERL 201311-02

Top inquiries, rejects, and return to provider claims August 2013 through October 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 August 2013 through October 2013.

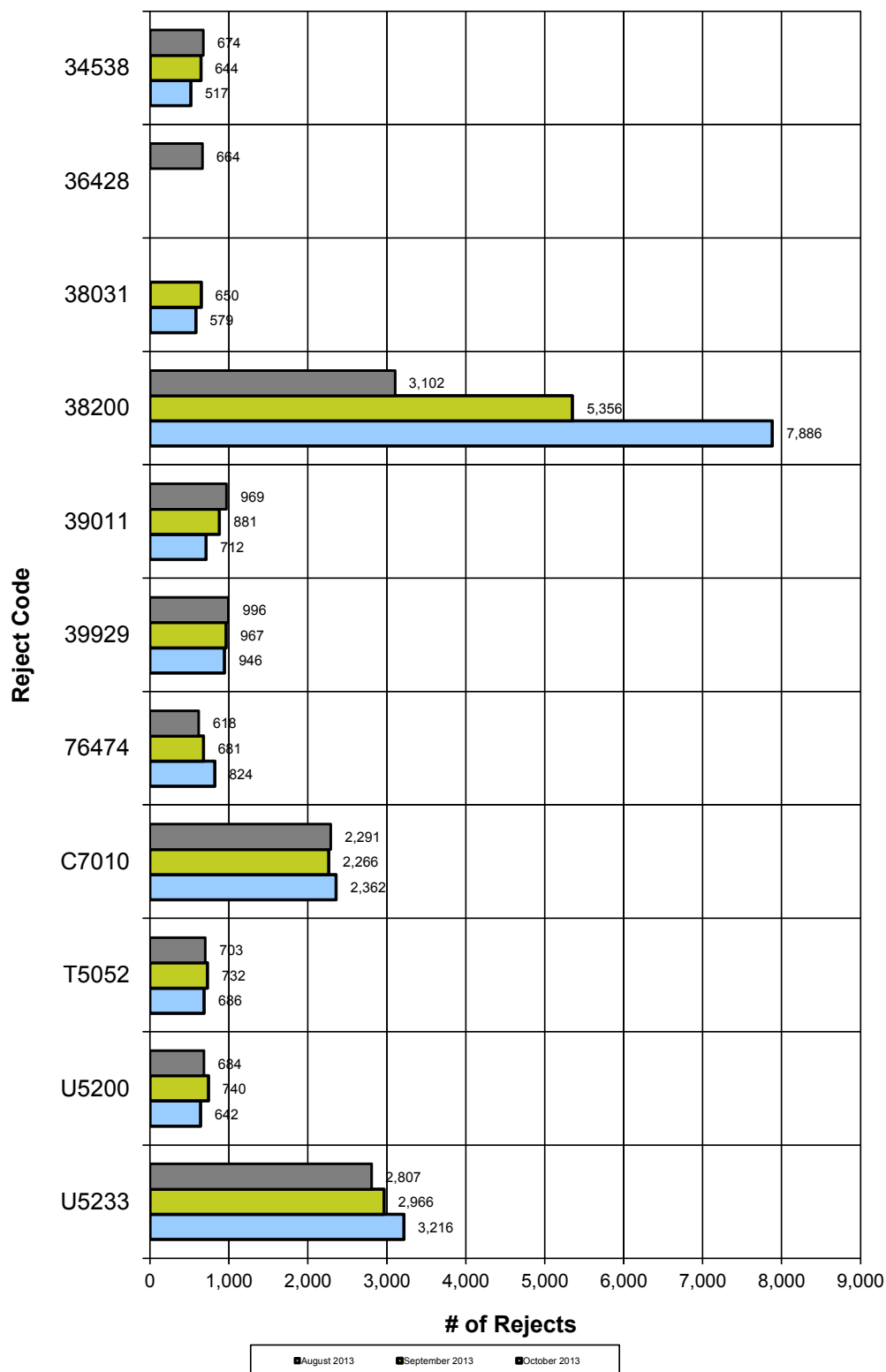
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at http://medicare.fcso.com/inquiries_and_denials/index.asp.

Top inquiries for August-October 2013



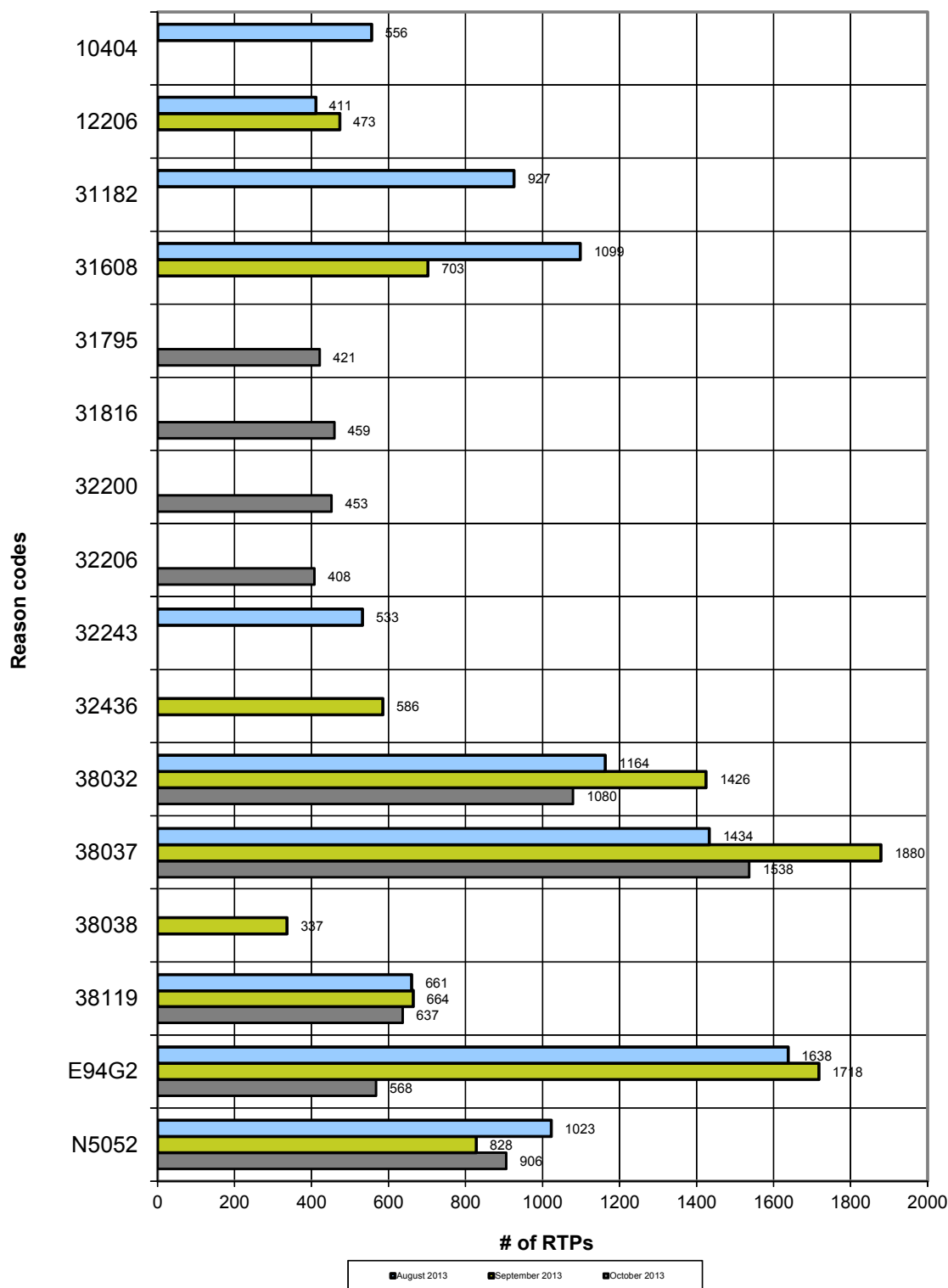
Part A top rejects for August 2013 through October 2013

Top rejects for August-October 2013



Part A top return to providers (RTPs) for August 2013 through October 2013

Top RTPs for August-October 2013



FISS claims processing update for ambulance services

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8251 which informs Medicare contractors that systems changes are being made to include HCPCS A0888 in the listing of mileage codes allowed to be billed with transport claims that do not require attending provider name and NPI. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

In CR 7557, the Centers for Medicare & Medicaid Services (CMS) implemented system edits for nonscheduled transportation services where the attending provider name and identifiers (including national provider identifier (NPI)) were not required.

When implementing those changes, CMS considered the mileage pairs that would be billed with the transport with the exception of A0888 (Non-covered ambulance mileage, per mile). CMS now needs to add the HCPCS code of A0888 to the listing of mileage codes allowed to be billed with the transport claims that do not require attending provider name and NPI.

NPI regulations stated that the attending provider name and identifiers (including NPI) are required when claim/encounter contains any services other than nonscheduled transportation services.

If the claim/encounter was for nonscheduled transportation services, the attending provider name and identifiers (including NPI) are not required.

Additional information

The official instruction, CR 8251 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1309OTN.pdf>.

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>.

MLN Matters® Number: MM8251

Related Change Request (CR) #: CR 8251

Related CR Release Date: November 6, 2013

Effective Date: April 1, 2012

Related CR Transmittal #: R1309OTN

Implementation Date: April 7, 2014

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Denial of inpatient service claims related to a hospice terminal diagnosis

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8273, which calls for changes in Medicare's claims processing systems to deny an inpatient hospital claim when the principal diagnosis on the inpatient claim matches one of the diagnosis codes on the hospice claim.

Services related to a hospice diagnosis for the terminal illness or related conditions provided during a hospice benefit period are included in the hospice payment and are not paid separately.

An inpatient hospital claim will be denied when providers bill with a condition code 07 (Treatment of Non-terminal Condition for Hospice) on an inpatient claim and the principal diagnosis on the inpatient claim is found to match one of the diagnosis codes on the hospice claim.

When denying such claims, your MAC will provide a claim adjustment reason code of B9 (Patient is enrolled in a Hospice), remittance advice remarks code MA63 (Missing/incomplete/invalid principal

(continued on next page)

Hospice (*continued*)

diagnosis) and a group code of CO.

Note that your MAC may override the denial for a claim upon first appeal and the MAC determines that the claim should have been paid. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) recovery auditors are responsible for identifying and correcting improper payments in the Medicare fee-for-service payment process. They have identified inpatient hospital claims where the principal diagnosis listed was one of the patient's listed hospice terminal diagnoses during the hospice period, yet providers were billing the principal diagnosis with a condition code 07 "Treatment of Non-terminal Condition for Hospice."

The payments associated with these claims are considered overpayments because CMS does not pay separately for an inpatient hospital stay when a hospice diagnosis for the terminal illness or related conditions is listed as a principal hospital diagnosis.

The *Medicare Benefit Policy Manual*, Chapter 9, Section 10- Requirements- General, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf>, provides the following information on hospice election.

Hospices obtain elections from the individual and forward them to the MAC, which transmits them to Medicare's common working file (CWF) in electronic format.

Once the initial election is processed, CWF maintains the beneficiary in hospice status until death or until an election termination is received.

An individual must waive all rights to Medicare payments for the duration of the election of hospice care for the following services:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and
- Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or services that are equivalent to hospice care, except for services provided by:
 1. The designated hospice (either directly or under arrangement);
 2. Another hospice under arrangements made by the designated hospice; or
 3. The individual's attending physician, who may

be a nurse practitioner (NP) if that physician or nurse practitioner is not an employee of the designated hospice or receiving compensation from the hospice for those services.

Medicare services for a condition completely unrelated to the terminal illness and related conditions for which hospice was elected remain available to the patient if he or she is eligible for such care.

The *Medicare Claims Processing Manual*, Chapter 11, Section 50 - Billing and Payment for Services Unrelated to Terminal Illness, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf>, provides the following billing information on beneficiaries with hospice election.

Any covered Medicare services not related to the treatment of the terminal conditions for which hospice care was elected and which are furnished during a hospice election period may be billed by the rendering provider using professional or institutional claims for non-hospice Medicare payment.

On professional claims, these services are coded with the GW modifier "Service not related to the hospice patient's terminal condition."

On institutional claims, these services are coded with condition code 07 "Treatment of Non-terminal Condition for Hospice." MACs process services coded with the GW modifier or condition code 07 in the normal manner for coverage and payment determinations.

Additional information

The official instruction, CR 8273 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1312OTN.pdf>.

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>.

MLN Matters® Number: MM8273

Related Change Request (CR) #: CR 8273

Related CR Release Date: November 7, 2013

Effective Date: April 1, 2014

Related CR Transmittal #: R1312OTN

Implementation Date: April 7, 2014

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CMS finalizes physician payment rates and policies for 2014

Final rule focuses on improved care coordination

On November 27, the Centers for Medicare & Medicaid Services (CMS) finalized payment rates and policies for 2014, including a major proposal to support care management outside the routine office interaction as well as other policies to promote high quality care and efficiency in Medicare. CMS' care coordination policy is a milestone, and demonstrates Medicare's recognition of the importance of care that occurs outside of a face-to-face visit for a wide range of beneficiaries beginning in 2015. The final rule sets payment rates for physicians and non-physician practitioners paid under the Medicare physician fee schedule for 2014 and addresses the policies included in the proposed rule issued in July. CMS projects that total payments under the fee schedule in 2014 will be approximately \$87 billion.



As part of CMS' continuing effort to recognize the critical role primary care plays in providing care to beneficiaries with multiple chronic conditions, beginning in 2015, the agency is establishing separate payments for managing a patient's care outside of a face-to-face visit for practices equipped to provide these services.

The 2014 payment rates increase payments for many medical specialties with some of the greatest increases going to providers of mental health services including psychiatry, clinical psychologists and clinical social workers.

CMS is finalizing a process to adjust payment rates for test codes on the clinical laboratory fee schedule (CLFS) based on technological changes. Currently, the payment rates for test codes on the CLFS do not change once they have been set (except for changes due to inflation and other statutory adjustments). This review process will enable CMS to pay more accurately for laboratory tests on the CLFS.

The final rule also includes several provisions regarding physician quality programs and the physician value-based payment modifier (value modifier). As CMS continues to phase-in the physician value-based payment modifier, for 2016 CMS is finalizing its proposals to apply the physician value modifier to groups of physicians with 10 or more eligible professionals, and to apply upward

and downward payment adjustments based on performance to groups of physicians with 100 or more eligible professionals. However, only upward adjustments based on performance (not downward adjustments) will be applied to groups of physicians with between 10 and 99 eligible professionals.

CMS also is finalizing several related proposals to the Physician Quality Reporting System (PQRS) for 2014, including a new option for individual eligible professionals to report quality measures

through qualified clinical data registries. In 2014, quality measures will be aligned across quality reporting programs so that physicians and other eligible professionals may report a measure once to receive credit in all quality reporting programs in which that measure is used. Additionally, CMS is better aligning PQRS measures with the national quality strategy and meaningful use requirements, and transitioning away from process measures in favor

of performance and outcome measures. Finally, certain data collected in 2012 for groups reporting certain PQRS measures under the group practice reporting option (GPRO) will be publicly reported on the CMS Physician Compare website in 2014.

"Aligning measures across quality programs focuses providers on the most important measures and makes it easier to participate in programs like PQRS, which are designed to emphasize quality for Medicare beneficiaries," said Dr. Patrick Conway, CMS Deputy Administrator for Innovation and Quality and CMS Chief Medical Officer.

Full text of this excerpted [CMS press release](#) (issued November 27).

- [Final rule](#)
- [Fact Sheet: Final Policy and Payment Changes to the Medicare Physician Fee Schedule for CY 2014](#)
- [Fact Sheet: Changes for CY 2014 Physician Quality Programs and the Value-Based Payment Modifier](#)
- [Physician Fee Schedule](#)
- [Physician Value-Based Payment Modifier](#)
- [PQRS](#)

Source: CMS PERL 201311-09

CMS makes outpatient facility policy and payment changes

Rule would give hospitals and ASCs flexibility to lower per-case costs

On November 27, the Centers for Medicare & Medicaid Services (CMS) released a final 2014 hospital outpatient and ambulatory surgical center (ASC) payment rule [CMS-1601-FC] that will give hospitals and ASCs new flexibility to lower outpatient facility costs and strengthen the long-term financial stability of Medicare. In addition, CMS will replace the current five levels of hospital clinic visit codes for both new and established patients with a single code describing all outpatient clinic visits. A single code and payment for clinic visits is more administratively simple for hospitals and better reflects hospital resources involved in supporting an outpatient visit. The current five levels of outpatient visit codes are designed to distinguish differences in physician work.

Provisions in the final hospital outpatient prospective payment system (OPPS) rule encourage more efficient delivery of outpatient facility services by packaging the payment for multiple supporting items and services into a single payment for a primary service similar to the way Medicare pays for hospital inpatient care. Supporting items and services that will be included in a single payment for a primary service to the hospital and not paid separately includes:

- Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure
- Drugs and biologicals that function as supplies when used in a surgical procedure, including skin substitutes
- Certain clinical diagnostic laboratory services
- Certain procedures that are never done without a primary procedure (add-ons), and
- Device-removal procedures.



The CY 2014 final rule with comment period increases overall payments for hospital outpatient departments by an estimated 1.7 percent. The increase is based on the projected hospital market basket – an inflation rate for goods and services used by hospitals – of 2.5 percent, minus both a 0.5 percent adjustment for economy-wide productivity and a 0.3 percentage point adjustment required by statute. The rule also updates partial hospitalization payment rates for hospitals and community mental health centers.

As part of this broader proposal to consolidate payment for larger groups of services, the final rule with comment period also establishes an encounter-based or “comprehensive” payment for certain device-related procedures like cardiac stents and defibrillators, but in a change from the proposed rule, delays its effective date to 2015.

Full text of this excerpted [CMS press release](#) (issued November 27).

- [Final rule](#)
- [Fact sheet](#)

Source: CMS PERL 201311-09

Overpayment recoupment of services for procedure Agriflu®

Change request 8047 implemented the payment allowances for the seasonal influenza virus vaccines for the 2012-2013 flu season. Included in this change request was procedure Q2034 for Agriflu®.

The Food and Drug Administration (FDA) has approved this drug for three batches (lots) of the vaccine. However, the manufacturer of this drug indicates that they have neither imported nor sold Agriflu® in the United States during the 2012-2013 influenza season.

For this reason, refunds of any payments that First Coast Service Options (First Coast) has made for this drug and the administration of this drug will be requested and future claims for this drug and the administration will be denied as “not FDA-approved.”



Reassignment to Part A critical access hospitals billing under method II

Note: This article was revised November 7, 2013, to reflect an updated change request (CR). The CR removed federally qualified health centers (FQHCs) and rural health clinics (RHCs) as entities eligible to accept reassignments and clarifies that Part A reassignments only apply to CAHs II hospitals. This article was previously published in the September 2013 edition of *Medicare A Connection*, Page 58. All other information remains the same.

Provider types affected

This *MLN Matters*® article is intended for critical access hospitals billing under method II (CAH II) who submit claims to Medicare A/B Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8387, which clarifies that individual physicians and non-physician practitioners can reassign benefits directly to a Part A CAH II through their Form CMS-855A enrollment. CAH IIs are no longer required to submit a separate Form CMS-855B in order to receive reassigned benefits. The distinction between CAHs billing method I vs. method II only applies to outpatient services. It does not apply to inpatient services.

Under method I:

- The CAH bills for facility services.
- The physicians/practitioners bill separately for their professional services.

Under method II:

- The CAH bills for facility services.
- If a physician/practitioner has reassigned his/her benefits to the CAH, the CAH bills for that particular physician's/practitioner's professional service.
- If a CAH has elected method II, the physician/practitioner is not required to reassign his or her benefits to the CAH. For those physicians/practitioners who do not reassign their benefits to the CAH, the CAH only bills for facility services and the physicians/practitioners separately bill for their professional services (similar to Method I).

Although physicians or non-physician practitioners are not required to reassign their benefits to a CAH that bills Method II, doing so allows them to participate in the electronic health records (EHR) incentive program for eligible professionals (EPs).

Background

The Centers for Medicare & Medicaid Services (CMS) previously released guidance regarding reassignments to Part A entities in CR 7864, "Revision to of the

Medicare Program Integrity Manual (PIM), Chapter 15, Section 15.5.20, consistent with 42 *Code of Federal Regulations* (CFR), Section 424.80(b)(1) and (b)(2) and the *Medicare Claims Processing Manual*, Chapter 1, Sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7."

Medicare may pay: (1) a physician or other supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services; or (2) an entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other supplier under a contractual arrangement with that entity.

CR 7864 allowed for reassignments to occur to all Part A entities via the CMS-855B Medicare enrollment application.

CR 8387 clarifies that all Part A entities may obtain reassignments via Part B, except for CAH IIs. Part A entities may only obtain reassignments through the Medicare Part A CMS 855A enrollment process. Physicians and non-physician practitioners have the option to reassign their benefits to a CAH II.

However, if the physician or non-physician practitioner wants to participate in the Medicare electronic health records (EHR) incentive program as an eligible professional (EP) and wishes to have their EHR payments sent to a CAH II, a reassignment to that entity needs to be established with Medicare.

The entity receiving the reassigned benefits must enroll with the Part A MAC via a Form CMS-855A, and the physician or non-physician practitioner reassigning benefits must enroll with the Part B MAC via a Form CMS-855I and Form CMS-855R.

If the physician or non-physician practitioner is currently enrolled with the Part B MAC via a Form CMS-855I and wishes to solely establish a new reassignment to a CAH II, only a Form CMS-855R is required. The Part A CAH II, may only receive reassigned benefits, assuming that the requirements for a reassignment exception are met and that the re-assignee meets all enrollment requirements.

Note that Medicare will verify that the national provider identifier (NPI) reported for physicians in the rendering or attending physician fields on CAH method II claims for payment, matches physician enrollment data in Medicare's files.

Additional information

The official instruction, CR 8387 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R490PI.pdf>.

The official instruction, CR 7864, issued to your Medicare contractor may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R445PI.pdf>.

(continued on next page)

Skilled nursing facility consolidated billing for ambulance services

Note: This article was revised November 14, 2013, to add clarifying language in the *Transfers between Two SNFs* section. All other information remains the same. This information was previously published in the January 2009 *Medicare A Connection*, Pages 45-47.

Provider types affected

Skilled nursing facilities (SNFs), physicians, ambulance suppliers, and providers submitting claims to Medicare administrative contractors (MACs) should review this article.

Provider action needed

This special edition article describes SNF consolidated billing (CB) as it applies to ambulance services for SNF residents.

Clarification: The SNF CB requirement makes the SNF responsible for including on the Part A bill that it submits to its MAC almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their MAC, as well as practitioners and suppliers who would generally submit their bills to a MAC. (Bills for certain types of items or equipment would be submitted by the supplier to their DME MAC.

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF residents receive during the course of a covered Part A stay. Payment for this full range of service is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service.

See *MLN Matters*® article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This instruction can be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0431.pdf>.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations (i.e. based on the reason the ambulance service is needed). This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or “bundling” requirement since 1983. Since the law describes CB in terms of services that are furnished to a “resident” of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary’s SNF “resident” status. The events are as follows:

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.);
- A trip to the beneficiary’s home to receive services from a Medicare-participating home health agency under a plan of care;

(continued on next page)

Method II (continued)

MLN Matters® article 7864, “Revision to Chapter 15 (Section 15.5.20) of the ‘Medicare Program Integrity Manual’ (PIM) Revision to of the Medicare Program Integrity Manual is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7864.pdf>.

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>.

MLN Matters® Number: MM8387 **Revised**
Related Change Request (CR) #: CR 8387
Related CR Release Date: November 6, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R490PI
Implementation Date: January 6, 2014

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.

Skilled (*continued*)

- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below); or
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

Ambulance trips to receive excluded outpatient hospital services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- Cardiac catheterization
- Computerized axial tomography imaging (CT) scans
- Magnetic resonance imaging (MRI) services
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite)
- Emergency room services
- Radiation therapy
- Angiography
- Lymphatic and venous procedures

Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB purposes with respect to those services, any associated ambulance trips are, themselves, excluded from CB as well.

Therefore, an ambulance trip from the SNF to the hospital for the receipt of such services should be billed separately under Part B by the outside supplier.

Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

Other ambulance trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers between two SNFs

When an individual leaves a SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

However, a beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if they are readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)).

Therefore, when a beneficiary travels directly from SNF 1 and is admitted to SNF two by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, a medically necessary ambulance trip that conveys the beneficiary would be bundled back to SNF one since, under 42 CFR 411.15(p)(3), the beneficiary would continue to be considered a resident of SNF one (for CB purposes) up until the actual point of admission to SNF two.

However, it should be noted that in addition to the "medical necessity" criterion in the regulations at 42 CFR 409.27(c) pertaining specifically to ambulance transports under the SNF benefit (i.e., the patient's medical condition is such that transportation by any means other than ambulance would be contraindicated), coverage in this context also involves the underlying requirement of being reasonable and necessary for diagnosing or treating the patient's condition. For example, a transfer between two SNFs would be considered reasonable and necessary in a situation where needed care is unavailable at the originating SNF, thus necessitating a transfer to the receiving SNF in order to obtain that care. By contrast, an SNF-to-SNF transfer that is prompted by non-medical considerations (such as a patient's personal preference to be placed in the receiving SNF) is not considered reasonable and necessary for diagnosing or treating the patient's condition and, thus, would not be bundled back to the originating SNF.

(continued on next page)

Skilled (*continued*)**Roundtrip to a physician's office**

If a SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate. The preamble to the July 30, 1999 final rule (64 *Federal Register* 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

Note: Confusion sometimes arises over the issue of an ambulance roundtrip that transports an SNF resident to the physician's office, as the separate Part B ambulance benefit does not normally cover transportation to this particular setting.

However, the regulations at 42 CFR 409.27(c), which describe the Part A SNF benefit's scope of coverage for ambulance transportation, incorporate by reference only the Part B ambulance benefit's general medical necessity requirement at 42 CFR 410.40(d)(1) (i.e., that transportation by any other means would be medically contraindicated), and not any of the more detailed coverage restrictions that apply under the separate Part B benefit, such as the limitation of coverage to only certain specified destinations (42 CFR 410.40(e)). Thus, if an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance, that ambulance roundtrip would be the responsibility of the SNF.

Noncoverage of transportation by any means other than ambulance

In contrast to the ambulance coverage described previously, Medicare simply does not provide any coverage at all under Part A or Part B for any non-ambulance forms of transportation, such as ambulette, wheelchair van, or litter van.

Further, as noted in the preceding section, in order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be medically necessary – that is, that the patient's condition is such that transportation by any other means would be medically contraindicated.

This means that in a situation where it is medically feasible to transport an SNF resident by means other than an ambulance – for example, via wheelchair van – the wheelchair van would not be covered (because Medicare does not cover any non-ambulance forms of transportation), and an ambulance also would not be covered (because the use of an ambulance in such a

situation would not be medically necessary). As with any non-covered service for which a resident may be financially liable, the SNF must provide appropriate notification to the resident under the regulations at 42 CFR 483.10(b)(6), which require Medicare-participating SNFs to "... inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate."

Additional information

See *MLN Matters*® special edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0431.pdf>.

The CMS *MLN*® CB website is at <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the MAC (i.e., services not included in CB)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions

The SNF PPS CB website is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNPPPS/index.html>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices)

MLN Matters® Number: SE0433 **Revised**
 Related Change Request (CR) #: NA
 Related CR Release Date: NA
 Effective Date: NA
 Related CR Transmittal #: NA
 Implementation Date: NA

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Educational Events

Provider outreach and educational events – January 2014

Medicare Part A changes and regulations

When: Tuesday, January 7

Time: 10 a.m. - 11:30 a.m. ET – Delivery language: English

Type of Event: Webcast

Medicare “Ask-the-Contractor” teleconference (ACT): 935 recoupment process

When: Tuesday, January 28

Time: 10 a.m. - 11:30 a.m. ET – Delivery language: English

Type of Event: Webcast

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.



CMS MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) MLN Connects™ Provider eNews 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 MLN Connects™ Provider eNews: October 31, 2013, – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-10-31-eneews.pdf>
- CMS MLN Connects™ Provider eNews: November 7, 2013 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-07-eneews.pdf>
- CMS MLN Connects™ Provider eNews: November 14, 2013– <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-14-eNews.pdf>
- CMS MLN Connects™ Provider eNews: November 21, 2013– <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-21-eNews.pdf>

Source: CMS PERL 201310-05, 201311-04, 201311-05, 201311-06

Medicare Speaks 2014 Orlando

February 18-19, 2014
The Florida Hotel & Conference Center
1500 Sand Lake Road, Orlando, FL 32809

Learn what's trending now in Medicare. Join First Coast Service Options (First Coast) for our new educational event, Medicare Speaks 2014, in Orlando, FL on February 18-19. The event features 20 classes focused on reducing documentation and claim errors, minimizing payment delays and promoting Centers for Medicare & Medicaid Services (CMS) initiatives such as the physician quality reporting system (PQRS) program. First Coast is also offering a bonus seminar on February 17 on PC-ACE Pro32™, Medicare's free billing software.

Participants will benefit from data-driven content based on the latest Medicare changes that you need to know to bill Medicare the right way, the first time. Best of all, providers can interact with their peers as well as Medicare experts from First Coast.

Highlights

- 20 Part A and B classes chosen by your peers – [view agenda](#)
- Participation from First Coast's medical director and leaders from Medical Review, Provider Enrollment, Customer Service and Provider Outreach and Education departments
- Bonus seminar on February 17 regarding PC-ACE Pro32™
- Participants can select 4 classes per day, or tailor the schedule to meet your needs
- Medicare experts available to answer your questions at "Ask the Contractor" tables
- Continuing education credits offered

For additional information regarding the event, including logistics and registration, view our Medicare Speaks 2013 Orlando brochure.

[Register now](#)

Note: If you do not have a training account, please [click here](#) to learn how to create one.



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

Contact CMS

The Region 4 office of the Centers for Medicare & Medicaid Services is located in Atlanta. The feedback email address is:

ROATLFM@CMS.HHS.GOV

Addresses

Claims

Additional documentation

General mailing

Congressmen mailing

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

Redeterminations

Redeterminations on overpayments

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

Debt recovery (except for MSP)

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

Post-payment medical exams

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

Freedom of Information Act (FOIA*) related requests

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

Medicare fraud and abuse

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

Provider enrollment

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

Electronic Data Interchange (EDI*)

First Coast Service Options Inc.
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 Government Benefit
Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare

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

Phone Numbers

Providers

Customer service – free of charge

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

For the hearing and speech impaired (TDD)

1-888-216-8261

Interactive voice response (IVR)

1-877-602-8816

Beneficiary

Customer service – free of charge

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

For the hearing and speech impaired (TDD)

1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number

1-904-361-0407

Audit And Reimbursement Department

Fax number
1-904-361-0407

Websites

Providers

First Coast – MAC J9

medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services

www.medicare.gov