Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

January 2014

In this issue

Registration for ICD-10 testing week – March 3-7, 2014

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. To help you prepare for this transition, the Centers for Medicare & Medicaid Services (CMS) announces a national testing week for current direct submitters (providers and clearinghouses) from March 3 through 7, 2014.

This testing week will give trading partners access to the Medicare administrative contractors' (MAC) and the common electronic data interchange (CEDI) for testing with real-time help desk support. The event will be conducted virtually. Registration is required.

What you can expect during testing

- Test claims with ICD-10 codes must be submitted with current dates of service (i.e., October 1, 2013, through March 3, 2014), since testing does not support future dated claims.
- Test claims will receive the 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected in the system.
- Testing will not confirm claim payment or produce remittance advice.
- MACs and CEDI will be staffed to handle increased call volume during this week.

More information is available in *MLN Matters® article MM8465, ICD-10 Testing with Providers through the Common Edits and Enhancements Module (CEM) and Common Electronic Data Interchange (CEDI)*.

Register now

Registration information is available at *http://medicare.fcso.com/ICD-10/265463.pdf*.

Source: *CR 8465*

Contents

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

Documentation requirements for home health prospective payment system face-to-face encounter

Provider types affected

This *MLN Matters*® special edition article is intended for physicians who refer patients to home health, order home health services, and/or certify patients' eligibility for the Medicare home health benefit, home health agencies, and non-physician practitioners (NPPs).

What providers need to know

Effective January 1, 2011, the Affordable Care Act mandates that prior to certifying a beneficiary's eligibility for the HH benefit, the certifying physician must document that he or she or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the beneficiary.

Background

The regulation governing the face-to-face encounter requires that as a condition for payment, the encounter occur within 90 days prior to the start of care or up to 30 days after the start of care and the documentation of the encounter includes "…an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services…."

Improper payments by type of error

The majority of home health prospective payment system (HH PPS) improper payments are due to "insufficient documentation" errors. "Insufficient documentation" errors occur when the medical documentation submitted is inadequate to support payment for the services billed or when a specific documentation element that is required is missing.

Most "insufficient documentation" errors for HH PPS result from claims where the narrative portion of the face-to-face encounter document does not sufficiently describe how the clinical findings from the encounter support the beneficiary's homebound status and the need for skilled services.

Note: **The homebound status of the patient and their need for skilled services must be written in a brief narrative, signed by the physician, titled "Home Health Face to Face Encounter", and dated.**

Some of the records reviewed contained very little clinical information beyond simple lists of diagnoses, recent injuries, or procedures. For example, "insufficient documentation" includes instances where the need for skilled nursing is justified with only a listed diagnosis, such as chronic obstructive pulmonary disease (COPD), osteoarthritis, or fracture of the humerus; and the beneficiary's homebound status is documented only by a notation such as "gait abnormality" or "taxing effort."

As described in the regulation (42 CFR 424.22(a)(1)(v)), such information is not sufficient. The face-to-face encounter documentation must explain why the findings from the encounter support the medical necessity of the services ordered and the beneficiary's homebound status.

Also, the *Medicare Benefit Policy Manual* states that the documentation must include a brief narrative that "describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services."

Narrative requirements

The two elements of the **required brief narrative** for documenting a home health face-to-face encounter are:

1. Confined to the home – Describe why the patient is homebound. An individual shall be considered "confined to the home" (homebound) if both of the following two criteria are met:

A. The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence, OR
- Have a condition such that leaving his or her home is medically contraindicated.

Examples:

a. Ambulates limited distance of 125' with assistance of a walker due to acute stroke;

b. Poor endurance, shortness of breath with minimal ambulation due to congestive heart failure (CHF) and needs assistance to leave the home.

B. There must exist:

- A normal inability to leave home; AND
- Leaving home must require a considerable and taxing effort.

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Home *(continued)*

Examples:

a. Deteriorating mental status, unable to leave home unsupervised;

b. Frequent seizure activity, requires supervision/ assistance of another person

2. Need for skilled services - To qualify for home health services, the beneficiary must need intermittent skilled nursing services, physical therapy (PT), or speech language pathology (SLP) services.

Describe what the RN, PT, or SLP and other services will be doing in the home. For example, "skilled nursing required to assess and manage new COPD regimen."

- Skilled nursing services must be reasonable and necessary for the treatment of the patient's illness or injury. Skilled nursing services can be, but are not limited to:
  - Teaching/training
  - Observe/assess
  - Complex care plan management
  - Administration of certain medications
  - Tube feedings
  - Wound care, catheters and ostomy care
  - NG and Tracheostomy aspiration/care
  - Psychiatric evaluation and therapy
  - Rehabilitation nursing

- PT, OT, SLP services must be reasonable and necessary for the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of his or her unique medical condition. Assuming all other eligibility and coverage requirements have been met, one of the following three conditions must be met for therapy services to be covered :

  a. The skills of a qualified therapist are needed to restore patient function. Therapy services must be provided with the expectation that, based on the assessment made by the physician of the patient's restorative potential, the condition of the patient will improve materially in a reasonable and generally predictable period of time.

  b. The skills of a qualified therapist are needed to design or establish a maintenance program.

  - The clinical condition of the patient requires the specialized skill, knowledge and judgment of a qualified therapist to design or establish a maintenance program, related to the patient's illness or injury, in order to ensure the safety of the patient and the effectiveness of the program.

  c. The skills of a qualified therapist (not an assistant) are needed to perform maintenance therapy.

  - The clinical condition of the patient is such that the complexity of the therapy services required to maintain function involves the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant) or the clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist themself (and not an assistant) in order to ensure the patient's safety and to provide an effective maintenance program.

Example: Ms. Jane Doe is a 99-year old female hospitalized with congestive heart failure (CHF) exacerbation (she has co-morbid asthma and low vision). She is going home and needs skilled nursing due to a new medication regimen and high potential for hospital readmission. She also needs in-home PT for strength training due to deconditioning during CHF exacerbation and safety assessment because she is at risk for falls. She is unable to leave the house without a walker.

Element 1:"Confined to the Home" Status due to deconditioning, CHF, and low vision.

Element 2: Skilled nursing is required due to medication changes. PT is required for strength training and home assessment due to fall risk.

Additional information

Attached to this article are documents that you may want to review showing correct and incorrect examples of documentation.

A list of frequently asked questions is available at *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html*.

MLN Matters® article SE1038 provides guidance for the original face-to-face implementation, is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1038.pdf*.

You may also want to review *MLN Matters*® article MM8444 which provides clarification of the definition

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Home *(continued)*

of "confined to the home" as stated in the revised Section 30.1.1 of Chapter 7 of the *Medicare Benefit Policy Manual*. The article may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8444.pdf*.

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

MLN Matters® Number: SE1405
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Prompt payment interest rate revision.

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt.

The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2013, must be paid before the end of business on March 31, 2013.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1.

Providers may access the Treasury Department Web page *http://fms.treas.gov/prompt/rates.html* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 2.125 percent is in effect through June 30, 2014. Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor

- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

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

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

Reassigning benefits to a Part A provider

Any individual who wants to reassign their benefits to an eligible entity, or terminates an existing reassignment, must complete the form CMS-855R. If the individual is not enrolled in Medicare, they will also need to enroll via the form CMS-855I.

If the individual wants to reassign benefits to a Part A provider, the entity receiving the reassigned benefits must enroll with the contractor utilizing the form CMS-855B, and the physician reassigning benefits must complete and submit form CMS-855R and form CMS-855I if not previously enrolled

For additional information, refer the change request *(CR) 7864* or the related *MLN Matters*® article *MM7864*.

CMS updates EFT authorization agreement: CMS 588

The Office of Management and Budget recently approved changes to the *CMS 588*, Electronic Funds Transfer (EFT) Authorization Agreement. The revised CMS 588 is available on the CMS *forms list*.

Medicare administrative contractors (MACs) will continue to accept the 05/10 version of the CMS 588 through October 31, 2014. After October 31, 2014, the MACs will return any newly submitted 05/10 versions of the CMS 588 applications with a letter explaining the CMS 588 application has been updated and the provider/supplier must submit a current version (09/13) of the CMS 588 application.

Revised liability and denial messages for services furnished to incarcerated beneficiaries

Note: This article was revised January 15, 2014, to reflect the revised change request (CR) 8488 issued December 27, 2013. In the article, the effective and implementation dates are changed and the CARC and RARC descriptions are changed to reflect the revised CR 8488 descriptions. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. This information was previously published in the December 2013 *Medicare A Connection*, Pages 14-15.

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administration contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs) for services provided to Medicare beneficiaries while they are in federal, state, or local custody.

Provider action needed

This article is based on CR 8488 which instructs Medicare claims administration contractors to use an updated claim adjustment reason code (CARC), remittance advice remark code (RARC), and group code when denying claims for services furnished to incarcerated Medicare beneficiaries. See the *Background* and *Additional information* sections of this article for further details regarding these changes. Make sure that your billing staffs are aware of these changes.

Background

According to federal regulations at *42 CFR 411.4*, Medicare does not pay for services furnished to a beneficiary who has no legal obligation to pay for the service, and no other person or organization has a legal obligation to provide or pay for the service. Refer to the *Electronic Code of Federal Regulations* (*e-CFR*) at *http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=1270613eb7cae1ed8c62899034b0eca2&rgn=div8&view=text&node=42:2.0.1.2.11.1.35.3&idno=42*. This exclusion presumptively applies to individuals who are incarcerated.

Under 42 CFR 411.6, Medicare does not pay for services furnished by a federal provider of services or by a federal agency. Also, under *42 CFR 411.8*, Medicare does not pay for services that are paid for directly or indirectly by a governmental entity.

As such, when claims for services furnished to beneficiaries who are incarcerated are submitted to Medicare, the claims are rejected by the common working file (CWF) and denied by the claims processing contractors. Per previously issued instructions (most recently, CR 7678, Transmittal 1054, issued March 7, 2012; see related *MLN Matters*® article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7678.pdf*), MACs use the following remittance advice messages and group code when denying such claims:

- CARC: 96 – "Non-covered charges."
- RARC: N103 – "Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a federal facility, or while he or she is in state or local custody under a penal authority, unless under state or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the state or local government pursues such debt in the same way and with the same vigor as any other debt."
- Group code: PR – patient responsibility

CR 8488 revises the remittance advice messages and group code used for denials of claims for services furnished to incarcerated beneficiaries.

MACs will begin using the following new CARC code when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody:

- CARC: 258 – Claim/service is not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover this claim/service.

In addition, MACs will begin using the following revised RARC N103 language when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody:

- RARC: N103 – "Records indicate this patient was a prisoner or in custody of a federal, state, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under state or local law, the individual is personally liable for the cost of his or her health care while in custody and the state or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the federal/state/local authority as appropriate. "

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Incarcerated *(continued)*

MACs will begin using the following group code to assign proper liability when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody so that the provider or supplier should seek repayment for the cost of its services provided from the authority that was in custody of the beneficiary on the date of service:

- Group code: OA – other adjustment

Other than the above, MACs will continue to use existing remittance advice codes and messages and MSN language already in place when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody.

Additional information

The official instruction, CR 8488 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1330OTN.pdf*.

If you have any questions, please contact your 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: MM8488 Revised
Related Change Request (CR) #: CR 8488
Related CR Release Date: December 27, 2013
Effective Date: April 1, 2014
Related CR Transmittal #: R1330OTN
Implementation Date: April 7, 2014

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With *Jimmo v. Sebelius* settlement, CMS clarifies skilled services policy

Note: This article was revised January 15, 2014, to reflect the revised change request (CR) 8458 issued January 14. In the article, the CR release date, transmittal number, and the Web address are revised. This article was previously published in the December 2013 edition of *Medicare A Connection,* Pages 10-12. All other information remains the same.

Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs); inpatient rehabilitation facilities (IRFs); home health agencies (HHAs); providers and suppliers of therapy services under the outpatient therapy (OPT) benefit– including critical access hospitals (CAHs), hospitals, rehabilitation agencies, SNFs, HHAs, physicians, certain non-physician practitioners, and therapists in private practice– submitting claims to Medicare contractors (Parts A/B Medicare administrative contractors (MACs) and Medicare advantage organizations) for services to Medicare beneficiaries, including physical therapy, occupational therapy, and speech-language pathology services.

What you need to know

This article is based on change request (CR) 8458, which updates portions of the *Medicare Benefit Policy Manual* (MBPM) to clarify key components of SNF, IRF, HH, and OPT coverage requirements pursuant to the settlement agreement in the case of *Jimmo v. Sebelius*. Nothing in this settlement agreement modifies, contracts, or expands the existing eligibility requirements for Medicare coverage.

In accordance with the *Jimmo v. Sebelius* settlement agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant program manuals used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The following are some significant aspects of the manual clarifications now being issued: • No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims in which skilled care is required. Medicare has long recognized that even in situations where no improvement is expected, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition). For example, the longstanding SNF level of care regulations, specify that the ". . restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a

patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need . .. skilled services . . . ." [42 CFR 409.32(c)] (This regulation is available at *http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec409-32.pdf*.)

While the example included in this provision pertains specifically to skilled nursing services, the concept of skilled therapy services can similarly involve not only services that are restorative in nature (or "rehabilitative" therapy in the OPT setting) but, if certain standards are met, maintenance therapy as well:

- **Restorative/rehabilitative therapy**. In evaluating a claim for skilled therapy that is restorative/ rehabilitative (i.e., whose goal and/or purpose is to reverse, in whole or in part, a previous loss of function), it would be entirely appropriate to consider the beneficiary's potential for improvement from the services. We note that such a consideration must always be made in the IRF setting, where skilled therapy must be reasonably expected to improve the patient's functional capacity or adaptation to impairments in order to be covered.
- **Maintenance therapy**. Even if no improvement is expected, under the SNF, HH, and OPT coverage standards, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration. Skilled maintenance therapy may be covered when the particular patient's special medical complications or the complexity of the therapy procedures require skilled care.

Accordingly, these revisions to the MBPM clarify that a beneficiary's lack of restoration potential cannot serve as the basis for denying coverage in this

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Settlement *(continued)*

context. Rather, such coverage depends upon an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Moreover, when the individualized assessment demonstrates that skilled care is, in fact, needed in order to safely and effectively maintain the beneficiary at his or her maximum practicable level of function, such care is covered (assuming all other applicable requirements are met).

Conversely, coverage in this context would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of non-skilled personnel.

Medicare has never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. The manual revisions now being issued will serve to reflect and articulate this basic principle more clearly.

Therefore, denial notices should contain an accurate summary of the reason for denial, which should be based on the beneficiary's need for skilled care and not be based on lack of improvement for a beneficiary who requires skilled maintenance nursing services or therapy services as part of a maintenance program in the SNF, HH, or OPT settings.

In the *MBPM* (the *Manual* within which all revisions were made by CR 8458), the revised Chapter 15, Section 220 specifically discusses Part B coverage under the OPT benefit. In that chapter, both rehabilitative and maintenance therapy are addressed.

Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. A "maintenance program" (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness." No mention of improving the patient's condition is noted within the MP definition.

Enhanced guidance on appropriate documentation. Portions of the revised manual provisions now include additional material on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the means by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case. Thus, even though the terms of the *Jimmo* settlement do not include an explicit reference to documentation requirements as such, CMS has nevertheless decided to use this opportunity to introduce additional guidance in this area, both generally and as it relates to particular clinical scenarios. An example of this material appears in a new Section 30.2.2.1 of the MBPM's revised Chapter 8, in the guidelines for SNF coverage under Part A.

We note that this material on documentation does not serve to require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although it does identify certain vague phrases like "patient tolerated treatment well," "continue with POC," and "patient remains stable" as being insufficiently explanatory to establish coverage). Rather, as indicated previously, coverage determinations must consider the entirety of the clinical evidence in the file, and our enhanced guidance on documentation is intended simply to assist providers in their efforts to identify and include the kind of clinical information that can most effectively serve to support a finding that skilled care is needed and received—which, in turn, will help to ensure more accurate and appropriate claims adjudication.

Further, as noted in the discussion of OPT coverage under Part B in Section 220.3.D of the *MBPM*, Chapter 15, care must be taken to assure that documentation justifies the necessity of the skilled services provided. Justification for treatment would include, for example, objective evidence or a clinically supportable statement of expectation that:

- In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and, there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- In the case of maintenance therapy, the skills of a therapist are necessary to maintain, prevent, or

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Settlement *(continued)*

slow further deterioration of the patient's functional status, and the services cannot be safely and effectively carried out by the beneficiary personally or with the assistance of non-therapists, including unskilled caregivers.

The Settlement agreement.

The *Jimmo v. Sebelius* settlement includes language specifying that **"Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."** Rather, the intent is to clarify Medicare's longstanding policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration.

As such, the revised manual material now being issued does not represent an expansion of coverage, but rather, provides clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the existing policy.

Additional information

The official instruction, CR 8458 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf*. All of the revised portions of the *Medicare Benefit Policy Manual* are a part of CR 8458. If you have 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*.

> "Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition." *-MM8458*

MLN Matters® Number: MM8458
Related Change Request (CR) #: CR 8458
Related CR Release Date: January 14, 2014
Effective Date: January 7, 2014
Related CR Transmittal #: R179BP
Implementation Date: January 7, 2014

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Therapy cap values for 2014

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8407, which informs Medicare contractors about changes to the policy for outpatient therapy caps for 2014. For physical therapy and speech-language pathology combined, the therapy cap for 2014 will be $1,920. For occupational therapy, the cap for 2014 will be $1,920. Make sure that your billing staffs are aware of these changes.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B. These limitations are commonly referred to as "therapy caps." The therapy caps are updated each year based on the Medicare economic index.

The Deficit Reduction Act of 2005 directed the Secretary to implement a process for exceptions to therapy caps for medically necessary services. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, Section 603(a) of the American Taxpayer Relief Act of 2012 extended the therapy caps exception process through December 31, 2013.

Additional information

The official instruction, CR 8407 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2807CP.pdf*.

If you have any questions, please contact your 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: MM8407
Related Change Request (CR) #: CR 8407
Related CR Release Date: November 6, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2807CP
Implementation Date: January 6, 2014

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2014 annual update to the therapy code lists

Provider types affected

This *MLN Matters*® article is intended for physicians, therapists, and other providers who submit claims to Medicare administrative contractors (MACs), including home health & hospice MACs for outpatient rehabilitation therapy services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8482 which updates the therapy code list for 2014 by adding four "always therapy" codes, one "sometimes therapy" code, and deletes two current codes. The update to the therapy code list reflects those made in the 2014 Healthcare Common Procedure Coding System and *Current Procedural Terminology*, Fourth Edition (HCPCS/*CPT*®-4). Please make sure your billing and coding staff are aware of these changes.

Background

The Social Security Act (Section 1834(k)(5)); (see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The HCPCS/*CPT*®-4 is the coding system used for the reporting of these services.

CR 8482, from which this article is taken, updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the 2014 HCPCS/*CPT*®-4. The therapy code listing can be found at *http://www.cms.gov/Medicare/Billing/TherapyServices/index.html*.

CR 8482 updates the therapy code list with four "always therapy" codes, one "sometimes therapy" code, and deletes two current codes for 2014 as shown in the following tables.

Always therapy codes added for 2014

Code	Descriptor
92521	*Evaluation of speech fluency (eg, stuttering, cluttering)*
92522	*Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)*
92523	*Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (eg, receptive and expressive language*
92524	*Behavioral and qualitative analysis of voice and resonance*

Always therapy coded deleted for 2014

Code	Descriptor
92506	*Evaluation of speech, language, voice, communication, and/or auditory processing disorder, and/or aural rehabilitation status.*

Sometimes therapy code added for 2014

Code	Descriptor
*97610**	*Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*

Sometimes therapy code deleted for 2014

Code	Descriptor
*0183T**	*Low frequency, non-contact, non-thermal ultrasound, including topical applications(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*

**97610* replaces current code *0183T* effective January 1, 2014

Additional information

The official instruction, CR 8482, issued to MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2844CP.pdf*.

If you have any questions, please contact your 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: MM8482
Related Change Request (CR) #: CR 8482
Related CR Release Date: December 27, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2844CP
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.

Summary of policies in the 2014 Medicare physician fee schedule final rule and telehealth originating site facility fee payment

Provider types affected

This *MLN Matters*® article is intended for physicians and non-physician practitioners (NPPs) submitting claims to Medicare administrative contractors (MAC) for services to Medicare beneficiaries.

Provider action needed

This article, based on change request (CR) 8533, provides a summary of the policies in the 2014 Medicare physician fee schedule (MPFS) final rule and announces the telehealth originating site facility fee payment. Please see the *Background* and Policy section of this article for details of the changes. Make sure that your billing staffs are aware of these updates for 2014.

Background

CR 8533 provides a summary of the policies in the 2014 MPFS. Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period November 27, 2013, that updates payment policies and Medicare payment rates for services furnished by physicians and nonphysician practitioners (NPPs) that are paid under the MPFS in 2014.

The final rule addresses Medicare public comments on payment policies that were described in the proposed rule earlier this year, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for 2014," (displayed July 8, 2013, and published in the *Federal Register* July 19, 2013).

The final rule also addresses interim final values established in the 2013 MPFS final rule with comment period, which was displayed November 1, 2012, and published in the *Federal Register* November 16, 2012. The final rule assigns interim final values for new and revised codes for 2014 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until January 27, 2014.

Key provisions of the MPFS final rule

Sustainable growth rate (SGR) and MPFS conversion factor for 2014

Without a change in the law, the conversion factor will be reduced by 20.1 percent for services in 2014. The President's budget calls for averting these cuts and finding a permanent solution to this problem. The 2014 conversion factor is $27.2006, which reflects a smaller reduction in the conversion factor than the 24.4 percent reduction that CMS projected in March 2013.

The smaller reduction is due in part to a 4.72 percent adjustment to the conversion factor to offset the decrease in Medicare physician payments that would otherwise have occurred due to the 2014 rescaling of the relative value units (RVUs) so that the proportions of total payments for the work, practice expense (PE), and malpractice RVUs match the proportions in the final revised Medicare economic index (MEI) for 2014. This issue is discussed further below. The overall 2014 reduction in physician fee schedule payments required under the SGR methodology is unchanged by this rescaling.

On December 20, 2013, after the MPFS final rule was issued, Congress passed the "Pathway for SGR Reform Act of 2013." This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect January 1, 2014. The new law provides a 0.5 percent update through March 31, 2014. The 2014 conversion factor under this new law is $35.8228.

Medicare economic index

CMS finalized the proposed revisions to the calculation of the MEI, which is the price index used to update physician payments for inflation. The changes are in response to recommendations by a technical advisory panel that met during 2012. The MEI is one of the factors used in determining the MPFS conversion factor. The final rule includes changes in the MPFS RVUs assigned to the work and practice expense categories so that the weights used in the MPFS payment calculation will continue to mirror those in the MEI. As a result, some payment is being redistributed to work from PE.

Telehealth services

CMS modified the regulations establishing the geographic criteria for eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of urban areas as determined by the Office of Rural Health Policy. This change will more appropriately allow sites located

(continued on next page)

Physician *(continued)*

within HPSAs in metropolitan statistical areas (MSAs) that have rural characteristics to qualify as originating sites and improve access to telehealth services in shortage areas. In this rule, CMS also finalizes a policy that determines an originating site's geographic eligibility based on the areas as of December 31 of the preceding year for the entire calendar year.

This change will avoid mid-year changes to geographic designations (sometimes without advance notice to Medicare beneficiaries and providers) that could result in unexpected disruptions to established telehealth originating sites and avoid the need to make mid-year Medicare telehealth payment policy changes.

In addition, we are adding transitional care management services (*CPT*® codes *99495-99496*) to the list of eligible Medicare telehealth services).

Telehealth originating site facility fee payment amount update

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

The MEI increase for 2014 is 0.8 percent. Therefore, for 2014, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $24.63. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

Revisions to the practice expense geographic adjustment

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect the local cost of operating a medical practice as compared to the national average. CMS calculates separate GPCIs to adjust the work, PE, and malpractice cost components of each payment. The law requires that we review the GPCIs every three years and adjust them as appropriate with a two-year phase-in of the new GPCIs. We are finalizing new GPCIs using updated data. The updated GPCIs will be phased in over 2014 and 2015. Additionally, we will apply the statutorily mandated 1.5 work GPCI floor in Alaska and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming).

Misvalued codes

Consistent with amendments made by the Affordable Care Act, CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes and make adjustments, where appropriate. We finalized the values for around 200 codes in the 2014 final rule. In addition, we assigned interim final values for approximately 200 services, including hip and knee replacements, mental health services, and GI endoscopy services. These interim final rates are open for public comment until January 27, 2014.

CMS is not finalizing its proposal to adjust relative values under the MPFS to effectively cap the physician PE payment for procedures furnished in a non-facility setting at the total payment rate for the service when furnished in an ambulatory surgical center or hospital outpatient setting. Instead, CMS will take additional time to consider issues raised by the public commenters and plans to address this issue in future rulemaking. In addition, for 2014, we are finalizing 18 codes that we identified and proposed as potentially mis-valued services in consultation with MAC medical directors.

Application of therapy caps to critical access hospitals (CAHs)

The law applies annual limitations or "therapy caps" one per beneficiary incurred expenses for outpatient therapy services – one for physical therapy and speech-language pathology services combined and another for occupational therapy services. CMS finalized its proposal to apply the therapy caps and related policies to outpatient therapy services furnished by a CAH beginning January 1, 2014, in order to properly apply the law that established the therapy caps.

Compliance with state law for incident-to services

CMS is requiring as a condition of Medicare payment that "incident to" services be furnished in compliance with applicable state law. This policy strengthens program integrity by allowing Medicare to deny or recoup payments when services are furnished not in compliance with state law. We also eliminated redundant regulations for each type of practitioner by consolidating the "incident to" requirements for all practitioners that are permitted to bill Medicare directly for their services, reducing the regulatory burden and making it less difficult for practitioners to determine what is required in order to bill Medicare for "incident to" services. This portion of the final rule with comment period is effective on January 27, 2014.

(continued on next page)

Physician *(continued)*

The outpatient mental health treatment limitation

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends Section 1833(c) of the Social Security Act to phase out the outpatient mental health treatment limitation over a five-year period, from 2010-2014. The limitation had resulted in Medicare paying approved lower percentage of the allowed amount under the MPFS for outpatient mental health treatment rather than the 80 percent that is paid for most other services. This limitation expires January 1, 2014. In 2014, Medicare will pay the same percentage of the MPFS amount for outpatient mental health services as other Part B services (i.e. 80 percent of the MPFS amount).

Primary care and chronic care management

As part of its ongoing efforts to appropriately value primary care services, Medicare will begin making a separate payment for chronic care management services beginning in 2015.

Chronic care management services include the development, revision, and implementation of a plan of care; communication with the patient, caregivers, and other treating health professionals; and medication management.

Medicare beneficiaries with multiple chronic conditions who wish to receive these services can choose a physician or other eligible practitioner from a qualified practice to furnish these necessary to support payment for furnishing care management services through the 2015 MPFS.

Additional information

The final rule will appear in the December 10, 2013, *Federal Register*. For more information, see *https://www.federalregister.gov/articles/2013/12/10/2013-28696/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory*.

The official instruction, CR 8533, issued to your MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2840CP.pdf*.

If you have any questions, please contact your 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: MM8533
Related Change Request (CR) #: CR 8533
Related CR Release Date: December 20, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2840CP
Implementation Date: January 6, 2014

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Expansion of Medicare telehealth services for 2014

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

Stop – impact to you

This article is based on change request (CR) 8553, which updates Medicare telehealth services in the *Medicare Benefit Policy Manual* and the *Medicare Claims Processing Manual*.

Caution – what you need to know

In the 2014 physician fee schedule final rule with comment period, the Centers for Medicare & Medicaid Services (CMS) added two codes to the list of Medicare telehealth services. Additionally, CMS modified regulations describing eligible telehealth originating sites to include health professional shortage areas (HPSAs) located in rural census tracts of metropolitan statistical areas effective January 1, 2014. This definition is consistent with the determinations made by the Office of Rural Health Policy (ORHP) in the Health Resources and Services Administration (HRSA). Finally, CMS modified regulations in order to establish geographic eligibility for Medicare telehealth originating sites for each calendar year based upon the status of the area as of December 31st of the prior calendar year.

Go – what you need to do

Make sure that your billing staffs are aware of these changes.

Background

CMS is adding the following services to the list of Medicare telehealth services for 2014:

- *CPT® 99495*: *Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge*.

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Telehealth *(continued)*

- *CPT® 99496*: *Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge*.

This policy will allow the required face-to-face visit component of both services to be furnished through telehealth.

CMS is finalizing the regulatory definition of "rural HPSA" for purposes of determining eligibility for Medicare telehealth originating sites to include HPSAs located in rural census tracts, consistent with ORHP's definition of "rural." HRSA has developed a tool that will help providers determine geographic eligibility for Medicare telehealth services. This tool, the "Medicare Telehealth Payment Eligibility Analyzer," is available at *http://datawarehouse.hrsa.gov/telehealthAdvisor/telehealthEligibility.aspx*.

CMS is also finalizing a change in policy so that geographic eligibility for an originating site is established and maintained on an annual basis, consistent with other telehealth payment policies. Absent this proposed change, the status of a geographic area's eligibility for telehealth originating site payment is effective at the same time as the effective date for changes in designations that are made outside of CMS. Accordingly, CMS is revising regulations at 42 Code of Federal Regulations (CFR) section 410.78(b)(4) to conform to both of these policies.

For dates of service on or after January 1, 2014, MACs will accept *CPT® 99495* and *99496* submitted on professional claims. In addition, for dates of service on or after January 1, 2014, MACs will accept and pay *CPT® 99495* and *99496* when submitted with a GQ or GT modifier. For critical access hospitals (CAHs), MACs will accept and pay according to the appropriate physician or practitioner fee schedule amount when electing method II on type of bill 85x.

Additional information

Further information regarding telehealth services is available at *http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html*.

The official instruction, CR 8553, issued to your MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2848CP.pdf*.

If you have any questions, please contact your 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: MM8553
Related Change Request (CR) #: CR8553
Related CR Release Date: December 30, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2848CP
Implementation Date: January 6, 2014

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Puzzled about your enrollment status?

Put the pieces together using the enrollment status lookup. View all active applications, specific applications, and confirm if you have been sent a revalidation request at *http://medicare.fcso.com/Enrollment/PEStatus.asp*

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

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

Effective and notice dates

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

Contents

Advance beneficiary notice

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

2014 HCPCS local coverage determination changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2014 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

LCD title	Changes
Allergy Testing	**Deleted** *Current Procedural Terminology* (*CPT*®) code *88342* **Added** HCPCS code G0461 **Removed** asterisk (*) from *CPT*® code *86628* that indicated this services is also listed in the Noncovered Services LCD (Not related to 2014 HCPCS Update)
Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications	**Deleted** HCPCS code Q2051 **Added** HCPCS code J3489
Botulinum Toxins **(Coding Guidelines only**)	**Deleted** *CPT*® codes *64613* and *64614* **Added** *CPT*® codes *64616, 64617, 64642, 64643, 64644, 64645, 64646*, and *64647* **Descriptor change** for *CPT*® codes *43201* and *43236*
Diagnostic and Therapeutic Esophagogastroduodenoscopy	**Deleted** *CPT*® code *43258* **Added** *CPT*® codes *43233, 43253, 43254*, *43266*, and *43270* **Descriptor change** for *CPT*® codes *43235-43239, 43241, 43243-43251*, and *43255*
Dialysis (AV fistula and graft) Vascular Access Maintenance	**Deleted** *CPT*® codes *37205, 37206, 37207*, and *75960* **Added** *CPT*® codes *37236, 37237, 37238*, and *37239*
G-CSF (Filgrastim, Neupogen®)	**Deleted** HCPCS codes J1440 and J1441 **Added** HCPCS codes J1442 and J1446 **Changed** "LCD Title" from "G-CSF (Filgrastim, Neupogen®)" to " G-CSF (Neupogen®, Granix™)"
Hemophilia Clotting Factors	**Added** HCPCS code C9133
Intensity Modulated Radiation Therapy (IMRT)	**Added** *CPT*® code *77293* **Descriptor change** for *CPT*® code *77295*
Intravenous Immune Globulin	**Deleted** HCPCS code C9130 **Added** HCPCS code J1556
Mohs Micrographic Surgery (MMS) **(Coding Guidelines only)**	**Deleted** *CPT*® code *88342* **Added** HCPCS code G0461
Molecular Pathology Procedures	**Added** *CPT*® code *81287*

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HCPCS *(continued)*

LCD title	Changes
Molecular Pathology Procedures for Human Leukocyte Antigen (HLA) Typing	**Descriptor change** for *CPT®* codes *81371, 81376*, and *81382*
Noncovered Procedures – Endoscopic Treatment of Gastroesophageal Reflux Disease (GERD)	**Descriptor change** for *CPT®* codes *43201*, *43236, 43241*, and *43257*
Noncovered services	**Deleted** *CPT®* codes *0183T* (replaced with *CPT®* code *97610*), *0185T* (changed to *CPT®* code *99199*), and *0186T* (changed to *CPT®* code *67299*) **Descriptor change** for *CPT®* codes *43206* and *43252* **The following change is not related to the 2014 HCPCS update**. Based on CR 8572 the following verbiage was added under the "Local Noncoverage Decisions-Laboratory Procedures" section of the LCD: "Beginning in 2014, payment for most laboratory tests (except for molecular pathology tests) will be packaged under the OPPS, therefore the clinical laboratory tests listed below, for TOB 13x (outpatient hospital), are packaged in this setting."
Plerixafor (Mozobil®)	**Deleted** HCPCS codes J1440 and J1441 **Added** HCPCS codes J1442 and J1446
Renal angiography	**Deleted** HCPCS code G0275
Therapy and rehabilitation Services	**Deleted** *CPT®* code *92506* **Added** *CPT®* codes *92521, 92522, 92523*, and *92524*

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**

RARC, CARC and MREP and PC Print update

Provider types affected

This MLN Matters® article is intended for physicians, other providers, and suppliers who submit claims to Medicare claims administration contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8561 which updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists that are effective on April 1, 2014. CR 8561 also instructs fiscal intermediary standard system (FISS) and VIPs Medicare system (VMS) maintainers to update PC print and Medicare Remit Easy Print (MREP) software by April 7, 2014. Make sure that your billing staffs are aware of these updates and that they obtain the updated MREP or PC Print software.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Accordingly, Medicare policy states that CARCs and appropriate RARCs must be used for:

- Transaction 835 (Health Care Claim Payment/ Advice) and standard paper remittance advice, along with group code to report payment adjustments and informational RARCs to report appeal rights, and other adjudication related information; and
- Transaction 837 (coordination of benefits (COBs)).

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

CARC and RARC code sets are updated three times a year on a regular basis. CR 8561 lists only the changes that have been approved since the last code update issued August 30, 2013, in CR 8422, Transmittal R2776CP and does not provide a complete list of codes for these two code sets.

The *MLN Matters*® article corresponding to CR 8422, MM8422, can be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8422.pdf*.

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

Changes in CARC list since CR 8422

The following tables list the changes in the CARC database since the last code update CR 8422. The full CARC list may be downloaded from the WPC website, available at *http://wpc-edi.com/Reference*.

New codes – CARC

Code	Narrative	Effective date
257	The disposition of the claim/ service is pending during the premium payment grace period, per health insurance exchange requirements. (Use only with Group Code OA)	11/01/2013
258	Claim/service not covered when patient is in custody/ incarcerated. Applicable federal, state or local authority may cover the claim/service.	11/01/2013
P1	State-mandated requirement for property and casualty, see claim payment remarks code for specific explanation. to be used for property and casualty only.	11/01/2013
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 insurance policy number segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF). To be used for workers' compensation only.	11/01/2013
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)	11/01/2013

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RARC *(continued)*

Code	Narrative	Effective date
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/ treatment. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	11/01/2013
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	11/01/2013
P6	Based on entitlement to benefits. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	11/01/2013
P7	The applicable fee schedule/ fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/ fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for property and casualty only.	11/01/2013
P8	Claim is under investigation. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	11/01/2013
P9	No available or correlating *CPT*®/HCPCS code to describe this service. To be used for Property and Casualty only.	11/01/2013
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.	11/01/2013
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)	11/01/2013
P12	Workers' compensation jurisdictional fee schedule adjustment. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	11/01/2013

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RARC *(continued)*

Code	Narrative	Effective date
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	11/01/2013
P14	The Benefit for this Service is included in the payment/ allowance for another service/ procedure that has been performed on the same day. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	11/01/2013
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.	11/01/2013
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA	11/01/2013
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only	11/01/2013
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.	11/01/2013
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.	11/01/2013
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	11/01/2013
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/01/2013
P22	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/01/2013

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RARC *(continued)*

Code	Narrative	Effective date
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/01/2013

Modified codes – CARC

Code	Modified narrative	Effective date
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	11/01/2013
253	Sequestration - reduction in federal payment	11/01/2013

Deactivated codes – CARC

Code	Current narrative	Effective date
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	07/01/2014
191	Not a work related injury/ illness and thus not the liability of the workers' compensation carrier **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF)	07/01/2014
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/ service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	07/01/2014
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/ treatment. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	07/01/2014
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (**Note**: To be used for property and casualty only)	07/01/2014

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RARC *(continued)*

Code	Current narrative	Effective date
218	Based on entitlement to benefits. **Note**: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 insurance policy number segment (Loop 2100 other claim related information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF). To be used for workers' compensation only	07/01/2014
220	The applicable fee schedule/ fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/ fee database code(s) that best describe the service(s) provided and supporting documentation if required. (**Note**: To be used for Property and Casualty only)	07/01/2014
221	Claim is under investigation. **Note**: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (**Note**: To be used by property & casualty only)	07/01/2014
230	No available or correlating CPT/HCPCS code to describe this service. **Note**: Used only by property and casualty.	07/01/2014
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for property & casualty only.	07/01/2014
255	The disposition of the related property & casualty claim (injury or illness) is pending due to litigation. (Use only with group code OA)	07/01/2014
W1	Workers' compensation jurisdictional fee schedule adjustment. **Note**: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 class of contract code identification segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF) if the regulations apply.	07/01/2014
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	07/01/2014

(continued on next page)

RARC *(continued)*

Code	Current narrative	Effective date
W3	The Benefit for this Service is included in the payment/ allowance for another service/ procedure that has been performed on the same day. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.	07/01/2014
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	07/01/2014
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)	07/01/2014
W6	Referral not authorized by attending physician per regulatory requirement.	07/01/2014
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	07/01/2014
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	07/01/2014
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	07/01/2014
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	07/01/2014
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	07/01/2014
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. **Note**: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	07/01/2014

Changes in RARC list since CR 8422

The following are changes in the RARC database since the last code update CR 8422.

The full RARC list can be downloaded from the WPC website available at *http://wpc-edi.com/Reference*.

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RARC *(continued)*

New codes – RARC

Code	Narrative	Effective date
N677	Alert: films/images will not be returned.	11/1/2013
N678	Missing post-operative images/visual field results.	11/1/2013
N679	Incomplete/Invalid post-operative images/visual field results.	11/1/2013
N680	Missing/incomplete/invalid date of previous dental extractions.	11/1/2013
N681	Missing/incomplete/invalid full arch series.	11/1/2013
N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	11/1/2013
N683	Missing/incomplete/ invalid prior treatment documentation.	11/1/2013
N684	Payment denied as this is a specialty claim submitted as a general claim.	11/1/2013
N685	Missing/incomplete/invalid prosthesis, crown or inlay code.	11/1/2013
N686	Missing/incomplete/invalid questionnaire needed to complete payment determination.	11/1/2013
N687	Alert - This reversal is due to a retroactive disenrollment. (**Note**: To be used with claim/ service reversal)	11/1/2013
N688	Alert – This reversal is due to a medical or utilization review decision. (**Note**: To be used with claim/service reversal)	11/1/2013
N689	Alert –This reversal is due to a retroactive rate change. (**Note**: To be used with claim/ service reversal)	11/1/2013
N690	Alert – This reversal is due to a provider submitted appeal. (**Note**: To be used with claim/ service reversal)	11/1/2013
N691	Alert – This reversal is due to a patient submitted appeal. (**Note**: To be used with claim/ service reversal)	11/1/2013
N692	Alert – This reversal is due to an incorrect rate on the initial adjudication (**Note**: To be used with claim/service reversal)	11/1/2013
N693	Alert – This reversal is due to a cancelation of the claim by the provider.	11/1/2013
N694	Alert – This reversal is due to a resubmission/change to the claim by the provider.	11/1/2013
N695	Alert – This reversal is due to incorrect patient financial responsibility information on the initial adjudication.	11/1/2013
N696	Alert – This reversal is due to a coordination of benefits or third party liability recovery retroactive adjustment. (**Note**: To be used with claim/ service reversal)	11/1/2013
N697	Alert – This reversal is due to a payer's retroactive contract incentive program adjustment. (**Note**: To be used with claim/service reversal)	11/1/2013
N698	Alert – This reversal is due to non-payment of the health insurance exchange premiums by the end of the premium payment grace period, resulting in loss of coverage. (**Note**: To be used with claim/service reversal)	11/1/2013

Modified codes – RARC

Code	Modified narrative	Effective date
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	11/01/2013

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RARC *(continued)*

Code	Modified narrative	Effective date
N103	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under state or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the federal/state/ local authority as appropriate.	11/01/2013
N178	Missing pre-operative images/visual field results	11/01/2013
N244	Incomplete/Invalid pre-operative images/visual field results.	11/01/2013
N597	Adjusted based on a medical/dental provider's apportionment of care between related injuries and other unrelated medical/ dental conditions/injuries.	11/01/2013

Deactivated codes – RARC

Code	Current narrative	Effective date
N365	This procedure code is not payable. It is for reporting/information purposes only.	07/01/2014
N627	Service not payable per managed care contract.	07/01/2014
N632	According to the official medical fee schedule this service has a relative value of zero and therefore no payment is due.	07/01/2014

Additional information

The official instruction, CR 8561, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2855CP.pdf*.

If you have any questions, please contact your 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: MM8561
Related Change Request (CR) #: CR 8561
Related CR Release Date: January 10, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R2855CP
Implementation Date: April 7, 2014

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Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*.

This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders.

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

Provider types affected

This *MLN Matters*® special edition article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including durable medical equipment MACs (DME MACs) for items and services provided in clinical trials to Medicare beneficiaries.

Provider action needed

This article is related to change request (CR) 8401, which requires, effective January 1, 2014, the mandatory reporting of a clinical trial identifier 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 identifier 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.

Since the release of CR 8401, the Centers for Medicare & Medicaid Services (CMS) has learned that some physicians, providers, and suppliers do not have the capability at this time to submit the clinical trial identifier number associated with trial-related claims. This article presents those physicians, providers, and suppliers with an alternative means of satisfying the CR 8401 requirements until January 1, 2015. At that time, such providers must fully comply with CR 8401. Make sure that your billing staffs are aware of the requirement and the implementation changes and dates.

Background

CMS understands that implementing CR 8401 by January 1, 2014, would create an undue hardship on a number of its stakeholders. As a result, for physicians, providers, and suppliers who do not have the capacity at this time to report the clinical trials identifier number associated with trial-related claims, CMS is providing an option to submit a generic number in place of the actual national clinical trials (NCT) number.

Beginning January 1, 2014, and continuing no later than through December 31, 2014, those abovementioned physicians, providers, and suppliers may instead report an 8-digit, generic number of 99999999 using the instructions in CR 8401. This will allow trial-related claims to process appropriately if they are prepared according to instructions in CR 8401.

Keep in mind that trial-related claims will be returned if they do not contain either the actual clinical trial identifier number or the 8-digit generic number 99999999 – you may not leave those indicated fields blank. That said, CMS encourages those affected by CR 8401 to update their internal claims processing procedures as expeditiously as possible so they can begin reporting the actual clinical trial identifier number as CR 8401 instructs.

Note: This in no way precludes those already reporting and/or able to report the actual clinical trial number on clinical trial-related claims from doing so. Beginning January 1, 2015, without further notice, CR 8401 shall be fully implemented.

Note: For clarification, the clinical trial identifier number is required for all items/services provided in relation to participation in a clinical trial, clinical study, or registry that may result from coverage with evidence development (CED), the Medicare Clinical Trial Policy, or a CMS-approved investigational device exemption (IDE) study. For IDE trials, both the IDE and the clinical trial identifier number are required. Specifically, include the clinical trial identifier number if: the beneficiary is enrolled in an approved clinical trial; and, the claim is for the investigational item or service, and/or, the costs are related to the investigational item or service, and/or, the costs are related to routine care for the condition in the clinical trial.

Additional information

The official instruction, CR 8401, issued to your MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2805CP.pdf*. The *MLN Matters*® article related to CR 8401 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf*

Section 310.1 of the "Medicare National Coverage Determination (NCD) Manual" is available at on *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf*.

If you have any questions, please contact your 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: SE1344
Related Change Request (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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Medicare system project for electronic submission of medical documentation (esMD)

Provider types affected

This *MLN Matters*® special edition article is intended for all Medicare fee-for-service (FFS) providers and suppliers who submit medical documentation to Medicare review contractors.

Provider action needed

This article is based on the utilization of the electronic submission of medical documentation (esMD) via Medicare's esMD gateway to respond to review contractor's requests for medical documentation.

Background

The Centers for Medicare & Medicaid Services (CMS) uses several types of review contractors to measure, prevent, identify, and correct improper payments or identify potential fraud.

Review contractors find improper payments and potential fraud by reviewing a sample of claims. They request medical documentation from the provider or supplier and manually review the claims against the medical documentation to verify the providers' compliance with Medicare's rules.

As of September 2011, providers are able to respond to these requests for medical documentation electronically using the electronic submission of medical documentation (esMD) via Medicare's esMD gateway. Since September 2011, CMS enhanced the esMD gateway to support several new use cases, for example:

- In September 2012, CMS implemented a prior authorization (PA) process via the esMD gateway for power mobility devices (PMD) for FFS Medicare beneficiaries who reside in seven states with high populations of error prone providers (CA, IL, MI, NY, NC, FL and TX).
- In January 2013, CMS expanded the CMS esMD gateway to allow durable medical equipment (DME) suppliers and providers to send electronic PA Requests to Medicare review contractors.
- In June 2013, CMS enabled automated prior authorization review results responses from Medicare review contractors to health information handlers (HIHs) via the esMD gateway.

Medicare's esMD system provides an alternative mechanism for submitting medical documentation, PMD PA requests, and PMD result code responses to review contractors.

A list of review contractors that will accept esMD transactions, as well as receive PMD PA requests and send PMD PA review results can be found at *http://go.cms.gov/RevCon*.

The primary intent of esMD is to reduce provider costs and cycle time by minimizing paper processing and mailing of medical documentation to review contractors. The number of participants in the CMS esMD program has grown steadily since its inception. As of September 30, 2013:

- 449,460 Unique medical record transactions have been submitted;
- 30,199 Medicare providers are using esMD to respond to medical record requests;
- 55 Medicare providers use esMD to submit prior authorization requests;
- 24 HIHs are certified by CMS to offer esMD services;
- 27 Review contractors are approved by CMS to accept medical records via esMD

Medicare providers, including physicians, hospitals, and suppliers must obtain access to a CONNECT-compatible gateway in order to send medical documentation electronically to review contractors. For example:

- Larger providers, such as hospital chains, may choose to build their own gateway;
- Many providers may choose to obtain gateway services by entering into a contract or other arrangement with a HIH that offers esMD Gateway services.

HIHs contract with providers to supply them with esMD services much the same way that providers contract with claims clearinghouses to supply them with claims submission services.

A listing of the HIHs that have been approved by CMS to offer esMD services can be found at *http://go.cms.gov/esmd-HIH*. HIH's set the price of their esMD provider services. Providers are encouraged to contact one or more of the HIHs to determine what esMD services are available.

While esMD is not mandatory, many healthcare providers find that it reduces costs,increases efficiency, and shortens processing times for certain transactions. CMS has instructed review contractors to not target providers for medical review based on their use of esMD.

The esMD system accepts portable document format (PDF) files, which enables providers to use esMD services as long as they have the proper scanning mechanism. Some HIHs may offer scanning services in addition to their esMD services.

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Changes to the laboratory national coverage determination (NCD) edit software for April 2014 (ICD-10)

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8585, which announces the changes that will be included in the April 2014 quarterly release of the edit module for clinical diagnostic laboratory services inclusive of ICD-10 translations. Please make sure that your billing staffs are aware of these changes for 2014.

Background

CR 8585 announces the changes that will be included in the April 2014 quarterly release of the edit module for clinical diagnostic laboratory services. The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation, effective April 1, 2003.

In accordance with the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 16, Section 120.2, 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 maintenance of codes in the negotiated NCDs and biannual updates of the ICD-9-CM codes.

CR 8585 communicates requirements to shared system maintainers (SSMs) and contractors notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for April 2014. These changes are effective for services furnished on or after April 1, 2014, for ICD-9, and on or after October 1, 2014, for ICD-10. Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. They will adjust claims brought to their attention.

Additional information

The official instruction, CR 8585 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2852CP.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: MM8585
Related Change Request (CR) #: CR 8585
Related CR Release Date: January 10, 2014
Effective Date: April 1, 2014 - ICD-9 only; October 1, 2014 - ICD-10 only
Related CR Transmittal #: R2852CP
Implementation Date: April 7, 2014

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Electronic *(continued)*

Additional information

If you have any questions, please contact the review contractor to whom you wish to send esMD transactions. The review contractor toll-free numbers can be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

For more information, visit the esMD Web page at *http://www.cms.gov/esmd*, or follow esMD on Twitter *@CMSGov* (#CMS_esMD).

For more information on the Medicare Recovery Audit program, see the *MLN Matters*® article SE1024 at *http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf* on the CMS website.

Contact information for your recovery auditor is available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/RAC-Contact-Information-AbbrState-Apr2013.pdf*.

MLN Matters® Number: SE1343 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Validation of payment group codes for prospective payment systems based on patient assessments

Provider types affected

This *MLN Matters*® special edition article is intended for inpatient rehabilitation facilities (IRF) submitting claims to Medicare A/B Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

This article conveys editing requirements within the fiscal intermediary shared system (FISS) system, for inpatient rehabilitation facility prospective payment system (IRF PSS) claims and the matching process with the IRF-patient assessment instrument (PAI). Make sure billing staff are aware of these changes.

Background

Section 1886(j)(2)(D) of the Social Security Act (*http://www.socialsecurity.gov/OP_Home/ssact/title18/1886.htm*) requires IRFs to transmit sufficient patient data to allow the Centers for Medicare & Medicaid Services (CMS) to administer the IRF prospective payment system.

These data are necessary to assign beneficiaries to the appropriate case-mix groups, to monitor the effects of the IRF PPS on patient care and outcomes, and to determine whether adjustments to the case-mix groups are warranted.

To administer the PPS, CMS requires IRFs to electronically transmit a PAI for each IRF stay to CMS's national assessment collection database (database). Each IRF must report the date that it transmitted the PAI to the database on the claim that it submits to the MAC.

If an IRF transmits the PAI more than 27 calendar days from (and including) the beneficiary's discharge date, the IRF's payment rate for the applicable case-mix group should be reduced by 25 percent.

The Office of Inspector General (OIG) has recommended in various reports, that CMS consider establishing a process that would allow the FISS to interface with the CMS national assessment collection database to identify, on a prepayment basis, IRF claims with incorrect PAI transmission health insurance prospective payment system (HIPPS) codes and/or dates.

In CR 7760, Medicare systems were enhanced to allow communication with the CMS national assessment collection database for IRF-PAI. This will ensure that the HIPPS code on claims received by MACs match the payment group on the IRF-PAI received by the CMS's national assessment collection database and ensure the late assessment reduction is applied accurately.

The system changes required by this enhancement were considerable and required an extended testing period to validate the effectiveness of the communication via file transfers between FISS and the CMS national assessment collection database. Such testing is ongoing.

The first step was to ensure that the enhancements worked correctly in a test environment, then to validate that the same processes worked in production environments. We conducted a one (1) day production validation in November 2013. It was determined that an extended period of validation was needed in production to test all the aspects of the new matching process, so a two (2) week validation period was approved starting December 6, 2013.

IRF claims submitted to FISS, during the two (2) week validation period will suspend with reason code *37069*. These claims will suspend in status Location S-MFRX0 while FISS communicates with the CMS national assessment collection database requesting for a match of the claim with the assessment to be made and additional information submitted on the assessment.

Each nightly cycle the status/location changes the last digit until four nightly cycles are completed (i.e., S-MFRX1, SMFRX2, S-MFRX3, and S-MFRX4. If no return file is received after the 4th nightly cycle the claim is released to continue processing. If a return file is received by the A/B MAC, the following outcomes are possible:

- A match is found. Claim information matches the IRF-PAI HIPPS and transmission date, so the claim will continue processing;
- A match is found. Claim information matches the IRF-PAI HIPPS, but the transmission date is different causing the claims processing system to use the date documented at the CMS

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Group *(continued)*

National Assessment Collection Database for claims processing purposes. If it is determined that the IRF-PAI was transmitted late based on the information found on the CMS National Assessment Collection Database, then the 25 percent penalty will be applied;

- A match is found. Claim information does not match the IRF-PAI HIPPS information, but the transmission date matches causing the claims processing system to use the assessment HIPPS information documented at the CMS National Assessment Collection Database for claims processing purposes;
- A match is found. Claim information does not match IRF-PAI HIPPS information, and the transmission date information is different causing the claims processing system to use the assessment HIPPS information and date documented at the CMS national assessment collection database for claims processing purposes;
- A match is not found. Claim information is submitted, however no corresponding IRF-PAI match is found at the CMS National Assessment Collection Database causing the claim to Return to Provider (RTP) with reason code *37096*;

Feedback from MACs and providers during this validation process has been very positive with the exception of one (1) issue that had not been anticipated. It appears that providers are submitting claims to their MAC prior to the IRF-PAI completing processing at the CMS national assessment collection database.

This causes reason code *37096* to return the claim to the provider. It is important to remember that prior to submission of your IRF claim to FISS, you must have an IRF-PAI that has completed processing at the CMS national assessment collection database. The provider can verify this by reviewing their IRF-PAI validation report.

If a provider has inadvertently submitted their claim prior to IRF-PAI completing processing and it has RTP'd with reason code *37096*, simply resubmit claim once the IRF-PAI has completed processing at the CMS national assessment collection database.

This will require communication between the provider's billing office and their clinical staff that submits their IRF-PAI to the CMS national assessment collection database.

If you are using a provider/vendor created software to code your claims and transmitting your IRF-PAI to the CMS national assessment collection database at a later point, you are reminded that you cannot submit your claim until the IRF-PAI has completed processing at the CMS national assessment collection database. There is no need to call the QIES Technical Support Office (QTSO) help desk for such billing issues.

If a provider has submitted an IRF-PAI prior to submission of the claim with information that is different from the claim submission for any of the following information:

- Beneficiary HIC number (IRF-PAI item 2);
- Beneficiary date of birth (IRF-PAI item 6);
- Provider CCN (IRF-PAI item 1B);
- Claim statement covers through dates (IRF-PAI item 40); and
- Claim admission date (IRF-PAI item 12).

The claim or the IRF-PAI should be corrected (depending on which item had the error) prior to the claim submission. If the claim is submitted without correcting the appropriate information, the matching IRF-PAI will not be found since it does not exist and the claim will be RTP'd with reason code *37096*.

However, most cases that have been brought to our attention are showing that the claim is being submitted one (1) day prior to the finalization of the IRF-PAI at the CMS National Assessment Collection Database.

Providers may want to add an additional claim hold day(s) on their claim submission to allow IRF-PAI completing processing and to avoid claims being RTP'd with reason code *37096*. To assist providers with the appropriate contact information the attached charts have been provided.

Additional information

You may want to review the related article to CR 7760 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7760.pdf*.

If you have any questions, please contact your 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: SE1342
Related Change Request (CR) #: CR 7760
Related CR Release Date: July 18, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2495CP
Implementation Date: October 1, 2012

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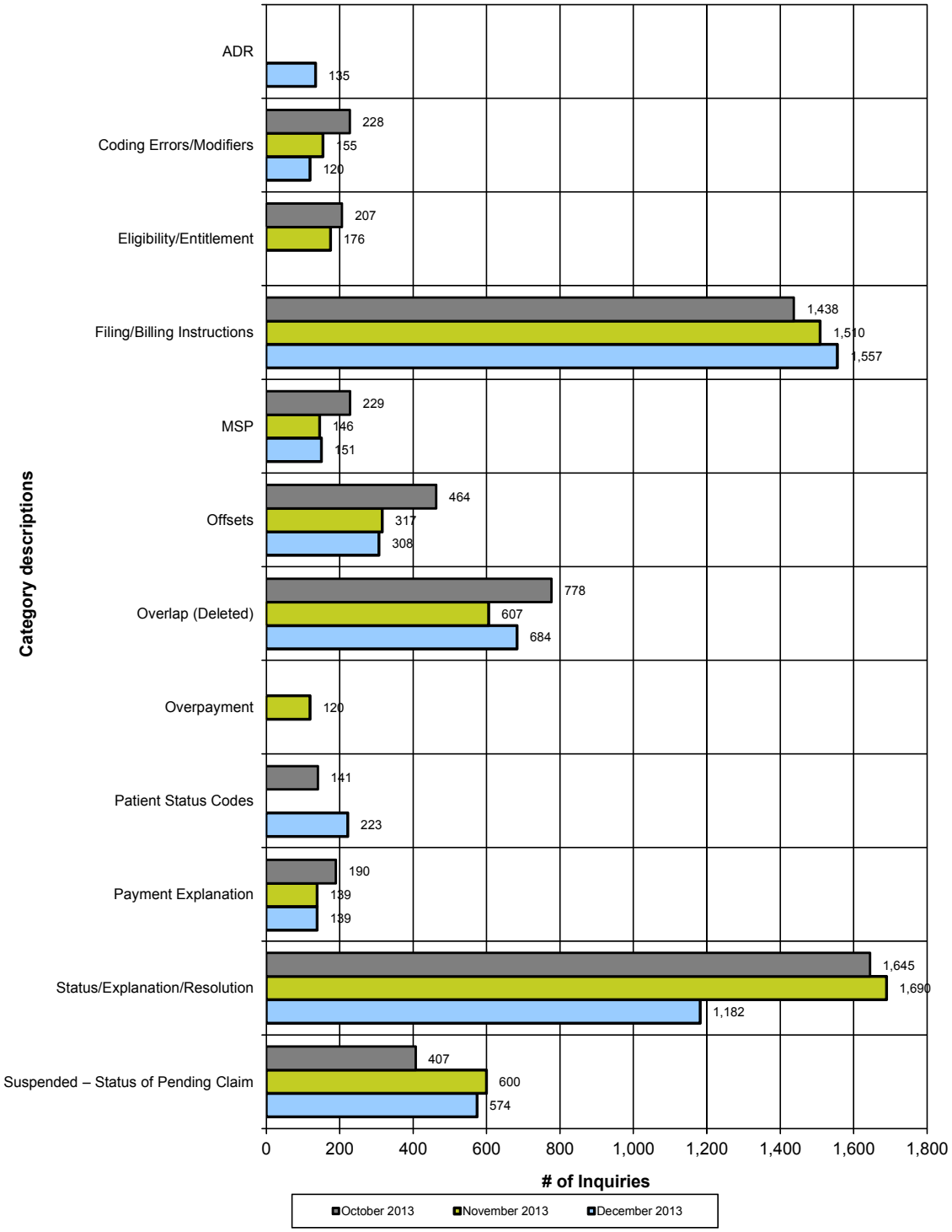
Top inquiries, rejects, and return to provider claims October 2013 through December 2013

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 October 2013 through December 2013.

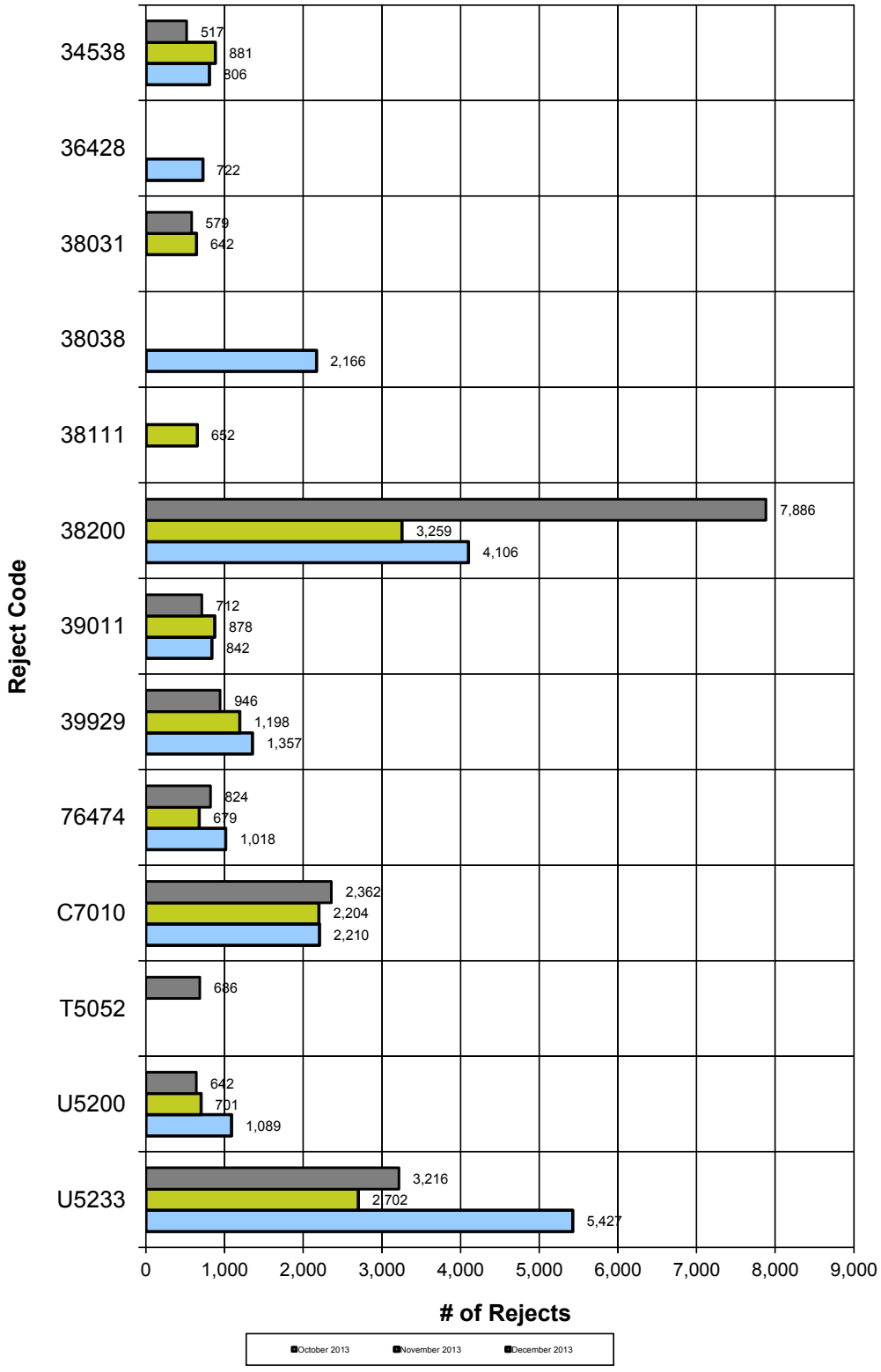
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Top inquiries for October-December 2013



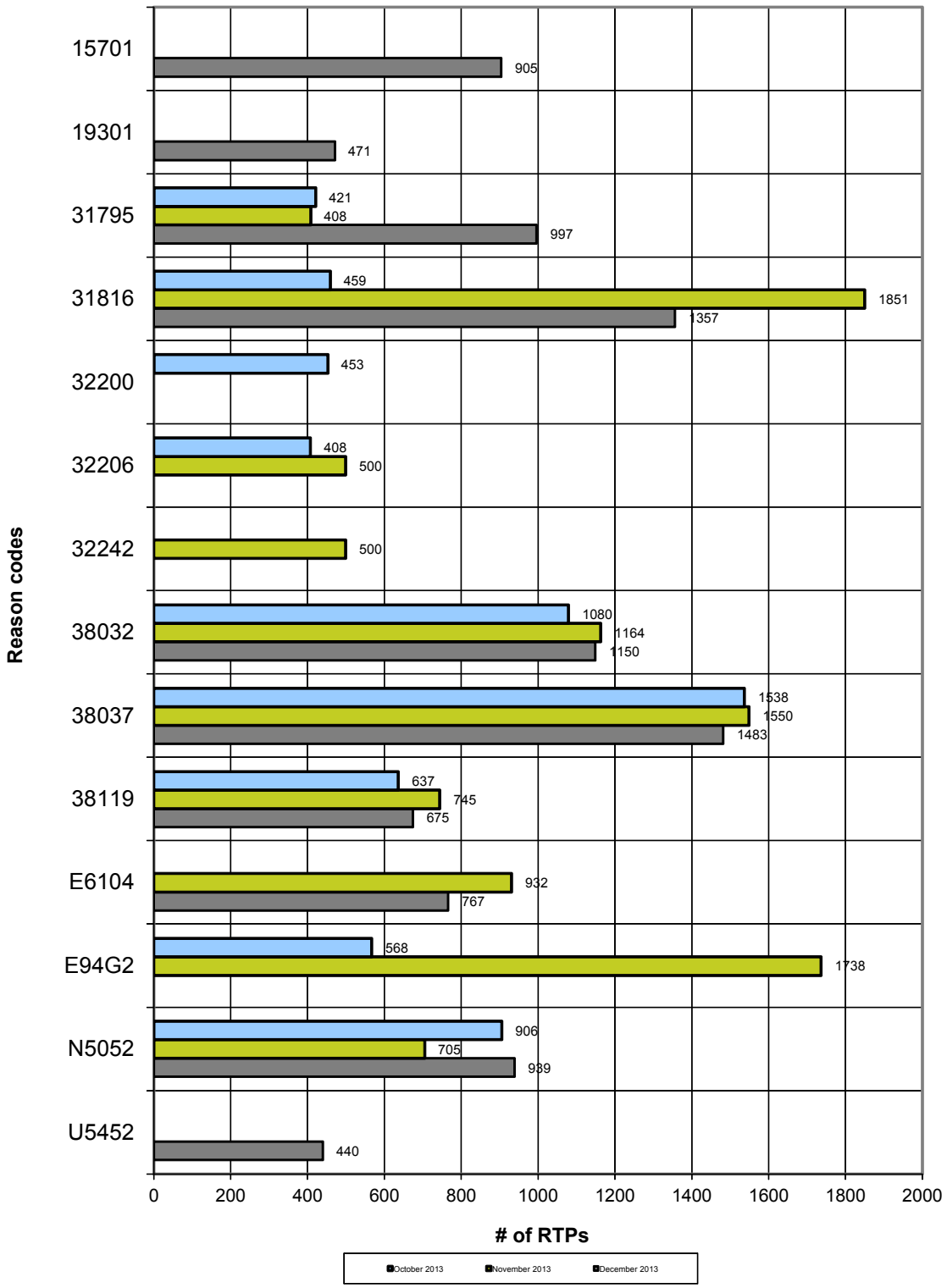
Part A top rejects for October 2013 through December 2013

Top rejects for October-December 2013



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

Top RTPs for October-December 2013



January 2014 outpatient prospective payment system update

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare A administrative contractors (MACs) for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed

This article is based on change request (CR) 8572 which describes changes to the OPPS to be implemented in the January 2014 update. Make sure your billing staff is aware of these changes.

Background

CR 8572 describes changes to and billing instructions for various payment policies implemented in the January 2014 OPPS update. Most of these policies are also outlined in the 2014 OPPS/ASC final rule. The January 2014 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 8572.

The January 2014 revisions to I/OCE data files, instructions, and specifications are provided in CR 8548. The *MLN Matters*® *Article* related to CR 8548 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8548.pdf*. Key changes to and billing instructions for various payment policies implemented in the January 2013 OPPS update are as follows:

Changes to device edits for January 2014

The most current list of device edits can be found under "Device and Procedure Edits" at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/*. Failure to pass these edits will result in the claim being returned to the provider.

No cost/ full credit and partial credit devices

Effective January 1, 2014, CMS will no longer recognize in the OPPS the FB or FC modifiers to identify a device that is furnished without cost or with a full or partial credit. Also effective January 1, 2014, for claims with APCs that require implantable devices and have significant device offsets (greater than 40 percent), the amount of the device credit will be specified in the amount portion for value code "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) and will be deducted from the APC payment for the applicable procedure.

The OPPS payment deduction for the applicable APCs referenced above will be limited to the total amount of the device offset when the FD value code appears on a claim. The offset amounts for the above referenced APCs are available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/*.

New Services

One new service listed in Table 1 below is assigned for payment under the OPPS, effective Jan. 1, 2014.

Table 1 – New services payable under OPPS effective January 1, 2014

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9737	1/01/2014	T	0174	Lap esoph augmentation	Laparoscopy, surgical, esophageal sphincter augmentation with device (e.g., magnetic band)	See Addendum B of 2014 final rule	See Addendum B of 2014 final rule

Clinic visits

Effective January 1, 2014, CMS will recognize HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) for payment under the OPPS for outpatient hospital clinic visits.

Effective January 1, 2014, *CPT*® codes *99201-99205* and *99211-99215* will no longer be recognized for payment under the OPPS.

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Outpatient *(continued)*

Extended assessment and management (EAM) composite APC (8009)

Effective January 1, 2014, CMS will provide payment for all qualifying extended assessment and management encounters through newly created composite APC 8009 (Extended Assessment and Management (EAM) Composite). A clinic visit (G0463), a Level 4 (*99284*) or Level 5 Type A ED visit (*99285*), or Level 5 Type B ED visit (G0384) furnished by a hospital in conjunction with observation services of eight or more hours will qualify for payment through APC 8009. Effective January 1, 2014, CMS will no longer provide payment for extended assessment and management encounters through APCs 8002 (Level I Extended Assessment and Management Composite) and 8003 (Level I Extended Assessment and Management Composite), which have been deleted.

Billing for stereotactic radiosurgery (SRS) planning and delivery

Effective January 1, 2014, hospitals must report SRS planning and delivery services using only the *CPT*® codes that accurately describe the service furnished. For the delivery services, hospitals must report *CPT*® code *77371, 77372, or 77373*, as described in the following table.

Table 2 – *CPT*® Codes that are reportable for SRS Delivery services effective January 1, 2014

CPT® code	Long descriptor
77371	*Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source cobalt 60 based*
77372	*Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based*
77373	*Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions*

As instructed in the 2014 OPPS/ASC final rule, *CPT*® code *77371* is to be used only for single session cranial SRS cases performed with a Cobalt-60 device, and *CPT*® code *77372* is to be used only for single session cranial SRS cases performed with a linac-based device. The term “cranial” means the pathological lesion(s) that are the target of the radiation is located in the patient’s cranium or head. The term “single session” means that the entire intracranial lesion(s) that comprise the patient’s diagnosis are treated in their entirety during a single treatment session on a single day. *CPT*® code *77372* is never to be used for the first fraction or any other fraction of a fractionated SRS treatment. *CPT*® code *77372* is to be used only for single session cranial linac-based SRS treatment.

Fractionated SRS treatment is any SRS delivery service requiring more than a single session of SRS treatment for a cranial lesion, up to a total of no more than five fractions, and one to five sessions (but no more than five) for non-cranial lesions. *CPT*® code *77373* is to be used for any fraction (including the first fraction) in any series of fractionated treatments, regardless of the anatomical location of the lesion or lesions being radiated. Fractionated cranial SRS is any cranial SRS that exceeds one treatment session. Fractionated non-cranial SRS is any non-cranial SRS, regardless of the number of fractions but never more than five.

Therefore, *CPT*® code *77373* is the exclusive code (and the use of no other SRS treatment delivery code is permitted) for any and all fractionated SRS treatment services delivered anywhere in the body, including, but not limited to, the cranium or head. *77372* is not to be used for the first fraction of a fractionated cranial SRS treatment series and must only be used in cranial SRS when there is a single treatment session to treat the patient’s entire condition.

In addition, for the planning services, hospitals must report the specific *CPT*® code that accurately describes the service provided. The planning services may include but are not limited to *CPT*® code *77290, 77295, 77300, 77334*, or *77370*, listed in Table 3 on the next page.

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Outpatient *(continued)*

Table 3 – *CPT*® codes that are reportable for SRS planning services
Effective January 1, 2014

CPT® code	Long descriptor
77290	*Therapeutic radiology simulation-aided field setting; complex*
77295	*Therapeutic radiology simulation-aided field setting; 3-dimensional*
77300	*Basic radiation dosimetry calculation, central axis depth dose calculation, tdf, nsd, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician*
77334	*Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)*
77370	*Special medical radiation physics consultation*

CMS notes that the APC assignment, OPPS status indicators, and payment rates for these SRS planning and delivery services can be found in Addendum B of the January 2014 OPPS Update that is posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Drugs, biologicals, and radiopharmaceuticals

a. New 2014 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For 2014, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 4.

Table 4 — New 2014 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

2014 HCPCS code	2014 Long descriptor	2014 SI	2014 APC
A9575	Injection, Gadoterate Meglumine, 0.1 mL	N	
A9586	Florbetapir f18, diagnostic, per study dose, up to 10 millicuries	N	
A9599	Radiopharmaceutical, Diagnostic, For Beta-amyloid Positron Emission Tomography (PET) Imaging, Per Study Dose	N	
C9133	Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.	G	1467
C9441	Injection, ferric carboxymaltose, 1 mg	G	9441
C9497	Lozapine, inhalation powder, 10 mg	G	9497
J0401	Injection, Aripiprazole, Extended Release, 1 mg	K	1468
J1446	Injection, TBO-Filgrastim, 5 micrograms	E	
J1602	Injection, golimumab, 1 mg, for intravenous use	K	1474
J7508	Tacrolimus, Extended Release, Oral, 0.1 mg	G	1465
J9371	Injection, Vincristine Sulfate Liposome, 1 mg	G	1466
Q4137	Amnioexcel or Biodexcel, Per Square Centimeter	N	
Q4138	BioDfence DryFlex, Per Square Centimeter	N	
Q4139	AmnioMatrix or BioDMatrix, injectable, 1 cc	N	
Q4140	Biodfence, Per Square Centimeter	N	
Q4141	Alloskin AC, Per Square Centimeter	N	
Q4142	XCM Biologic Tissue Matrix, Per Square Centimeter	N	

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Outpatient *(continued)*

2014 HCPCS code	2014 Long descriptor	2014 SI	2014 APC
Q4143	Repriza, Per Square Centimeter	N	
Q4145	Epifix, Injectable, 1mg	N	
Q4146	Tensix, Per Square Centimeter	N	
Q4147	Architect Extracellular Matrix, Per Square Centimeter	N	
Q4148	Neox 1k, Per Square Centimeter	N	
Q4149	Excellagen, 0.1 cc	N	

b. Other changes to 2014 HCPCS and *CPT*® codes for certain drugs, biologicals, and radiopharmaceuticals

Many HCPCS and *CPT*® codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and *CPT*® code descriptors that will be effective in 2014. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2013 and replaced with permanent HCPCS codes in 2014. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active 2014 HCPCS and *CPT*® codes.

Table 5 shown below, notes those drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS/*CPT*® code, their long descriptor, or both. Each product's 2013 HCPCS/*CPT*® code and long descriptor are noted in the two left hand columns and the 2014 HCPCS/*CPT*® code and long descriptor are noted in the adjacent right hand columns.

Table 5 — Other 2014 HCPCS and *CPT*® code changes for certain drugs, biologicals, and radiopharmaceuticals

2013 HCPCS/ *CPT*® code	2013 Long descriptor	2014 HCPCS/ *CPT*® code	2014 Long descriptor
C1204	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	A9520	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries
J0152	Injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds)	J0151	Injection, Adenosine For Diagnostic Use, 1 mg (not to be used to report any Adenosine Phosphate Compounds, Instead use A9270)
J0718	Injection, certolizumab pegol, 1 mg	J0717	Injection, certolizumab pegol , 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1440	Injection, filgrastim (g-csf), 300 mcg	J1442	Injection, Filgrastim (G-CSF), 1 microgram
J1441	Injection, filgrastim (g-csf), 480 mcg	J1442	Injection, Filgrastim (G-CSF), 1 microgram
C9130	Injection, immune globulin (Bivigam), 500 mg	J1556	Injection, immune globulin (Bivigam), 500 mg
C9294	Injection, taliglucerase alfa, 10 units	J3060	Injection, taliglucerase alfa, 10 units
Q2051*	Injection, Zoledronic Acid, Not Otherwise Specified, 1 mg	J3489	Injection, Zoledronic Acid, 1mg
C9298	Injection, ocriplasmin, 0.125 mg	J7316	Injection, Ocriplasmin, 0.125mg
C9295	Injection, carfilzomib, 1 mg	J9047	Injection, carfilzomib, 1 mg

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Outpatient *(continued)*

2013 HCPCS/ *CPT*® code	2013 Long descriptor	2014 HCPCS/ *CPT*® code	2014 Long descriptor
C9297	Injection, omacetaxine mepesuccinate, 0.1 mg	J9262	Injection, omacetaxine mepesuccinate, 0.01 mg
C9292	Injection, pertuzumab, 10 mg	J9306	Injection, pertuzumab, 1 mg
C9131	Injection, ado-trastuzumab emtansine, 1 mg	J9354	Injection, ado-trastuzumab emtansine, 1 mg
C9296	Injection, ziv-aflibercept, 1 mg	J9400	Injection, Ziv-Aflibercept, 1 mg
Q0171	Chlorpromazine hydrochloride, 10 mg, oral, fda approved prescription	Q0161	Chlorpromazine hydrochloride, 5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen
Q0172	Chlorpromazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy not to exceed a 48-hour dosage regimen	Q0161	Chlorpromazine hydrochloride, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen
Q2027	Injection, Sculptra, 0.1 ml	Q2028	Injection, Sculptra, 0.1 ml
Q3025	Injection, interferon beta-1a, 11 mcg for intramuscular use	Q3027	Injection, Interferon Beta-1a, 1 mcg For Intramuscular Use

c. Drugs and biologicals with payments based on average sales price (ASP) effective January 1, 2014

In 2014, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2014, payment rates for many drugs and biologicals have changed from the values published in the 2014 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of 2013. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2014 release of the OPPS Pricer.

CMS is not publishing the updated payment rates in this change request implementing the January 2014 update of the OPPS. However, the updated payment rates effective January 1, 2014, can be found in the January 2014 update of the OPPS Addendum A and Addendum B at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

d. Updated payment rate for C1204 effective October 1, 2013, through December 31, 2013

The payment rate for C1204 was incorrect in the October 2013 OPPS Pricer. The corrected payment rate is listed in Table 6, and has been installed in the January 2014 OPPS Pricer, effective for services furnished on October 1, 2013, through December 31, 2013. If you have claims that were incorrectly processed, you may ask your MAC to adjust those claims using the corrected payment rate.

Table 6 – Updated payment rates for certain HCPCS codes
Effective October 1, 2013, through December 31, 2013

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
A9520	G	1463	Tc 99m tilmanocept	$223.15	$0.00

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Outpatient *(continued)*

e. Elimination of nuclear medicine procedure-to-radiolabeled product edits

Beginning January 1, 2008, CMS implemented OPPS edits that require hospitals to include a HCPCS code for a radiolabeled product when a separately payable nuclear medicine procedure is present on a claim. Effective January 1, 2014, the nuclear medicine procedure-to-radiolabeled product edits are no longer required. Hospitals are still expected to adhere to the guidelines of correct coding and append the correct radiolabeled product code to the claim when applicable. Claims will no longer be returned to providers when HCPCS codes for radiolabeled products do not appear on claims with nuclear medicine procedures.

f. Skin substitute procedure edits

Effective January 1, 2014, the payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups:

1) high cost skin substitute products and

2) low cost skin substitute products for packaging purposes.

Table 7 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable.

Table 7 – Skin substitute product assignment to high cost/low cost status for 2014

2014 HCPCS code	2014 Short descriptor	2014 SI	Low/high cost skin substitute
C9358	SurgiMend, fetal	N	Low
C9360	SurgiMend, neonatal	N	Low
C9363	Integra Meshed Bil Wound Mat	N	Low
Q4100	Skin substitute, NOS	N	Low
Q4101	Apligraf	N	High
Q4102	Oasis wound matrix	N	Low
Q4103	Oasis burn matrix	N	Low
Q4104	Integra BMWD	N	Low
Q4105	Integra DRT	N	Low
Q4106	Dermagraft	N	High
Q4107	Graftjacket	N	High
Q4108	Integra matrix	N	Low
Q4110	Primatrix	N	High
Q4111	Gammagraft	N	Low
Q4115	Alloskin	N	Low
Q4116	Alloderm	N	High
Q4117	Hyalomatrix	N	Low
Q4119	Matristem wound matrix	N	Low
Q4120	Matristem burn matrix	N	Low
Q4121	Theraskin	N	Low
Q4122	Dermacell	G	n/a
Q4123	Alloskin	N	Low
Q4124	Oasis tri-layer wound matrix	N	Low

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Outpatient *(continued)*

2014 HCPCS code	2014 Short descriptor	2014 SI	Low/high cost skin substitute
Q4125	Arthroflex	N	High
Q4126	Memoderm/derma/tranz/integup	N	High
Q4127	Talymed	G	n/a
Q4128	Flexhd/Allopatchhd/matrixhd	N	Low
Q4129	Unite biomatrix	N	Low
Q4131	Epifix	G	n/a
Q4132	Grafix core	G	n/a
Q4133	Grafix prime	G	n/a
Q4134	hMatrix	N	High
Q4135	Mediskin	N	Low
Q4136	EZderm	N	Low
Q4137	Amnioexcel or biodexcel, 1cm	N	Low
Q4138	BioDfence DryFlex, 1cm	N	Low
Q4140	Biodfence 1cm	N	Low
Q4141	Alloskin ac, 1 cm	N	Low
Q4142	Xcm biologic tiss matrix 1cm	N	Low
Q4143	Repriza, 1cm	N	Low
Q4146	Tensix, 1cm	N	Low
Q4147	Architect ecm, 1cm	N	Low
Q4148	Neox 1k, 1cm	N	Low

Beginning January 1, 2014, CMS will implement an OPPS edit that requires hospitals to report all high cost skin substitute products in combination with one of the skin application procedures described by *CPT*® codes *15271-15278* and to report all low cost skin substitute products in combination with one of the skin application procedures described by HCPCS code C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by *CPT*® code *15271-15278*.

g. Offset from payment for pass-through skin substitute products

The Social Security Act (Section 1833(t)(6)(D)(i); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) requires that CMS deduct from pass-through payments for drugs or biologicals an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the drug or biological.

Effective January 1, 2014, there will be five skin substitute products receiving pass-through payment. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by *CPT*® code *15271-15278*. These skin application procedure codes are assigned to either APC *0328* (*Level III Skin Repair*) or APC 0329 (*Level IV Skin Repair*).

CMS has determined that it is able to identify a portion of the APC payment amount associated with the cost of skin substitute products in APC 0328 and APC 0329. This portion of the APC payment represents the required deduction from pass-through payments for skin substitute products when they are billed with a skin substitute application procedure code in APC 0328 or APC 0329. The offset amount for APC 0328 and APC 0329, along with the offsets for other APCs, is available under “Annual Policy Files” at *http://www.cms.gov/HospitalOutpatientPPS/* on the CMS OPPS website.

Billing for “sometimes therapy” services that may be paid as non-therapy services for hospital outpatients

Effective January 1, 2014, CMS is updating one of the services on the manual list of “sometimes therapy” services with a newly assigned HCPCS code. HCPCS code *0183T* (*Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*)

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Outpatient *(continued)*

is being replaced with HCPCS code *97610* (*Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*).

The code descriptor is not changed. The limited set of sometimes therapy services listed in the manual are paid under the OPPS when they are not furnished as therapy, meaning are not furnished under a certified therapy plan of care. When a hospital furnishes these services to a hospital outpatient as non-therapy, the hospital may submit a claim for facility payment for the services to the OPPS.

2014 Hospital outpatient clinical diagnostic laboratory test payment and billing

Since the inception of the OPPS, OPPS hospitals were paid separately for clinical diagnostic laboratory tests or services (laboratory tests) provided in the hospital outpatient setting at clinical laboratory fee schedule (CLFS) rates. Beginning in 2014, payment for most laboratory tests (except for molecular pathology tests) will be packaged under the OPPS. The general rule for OPPS hospitals is laboratory tests should be reported on a 13x bill type. There are limited circumstances described below in which hospitals can separately bill for laboratory tests. For these specific situations CMS is expanding the use of the 14x bill type to allow separate billing and payment at CLFS rates for hospital outpatient laboratory tests.

Laboratory tests may be (or must be for a non-patient specimen) billed on a 14x claim in the following circumstances:

(1) Non-patient laboratory specimen tests; non-patient continues to be defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital;

(2) Beginning in 2014, when the hospital only provides laboratory tests to the patient (directly or under arrangement) and the patient does not also receive other hospital outpatient services during that same encounter; and

(3) Beginning in 2014, when the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting. In this case the lab test would be billed on a 14x claim and the other hospital outpatient services would be billed on a 13x claim.

It will be the hospital's responsibility to determine when laboratory tests may be separately billed on the 14x claim under these limited exceptions. In addition, laboratory tests for molecular pathology tests described by *CPT®* codes in the ranges of *81200* through *81383*, *81400* through *81408*, and *81479* are not packaged in the OPPS and should be billed on a 13x type of bill.

2014 OPPS payment adjustment for certain cancer hospitals

Consistent with the Affordable Care Act (Section 3138; see *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf*), CMS adopted a policy beginning in 2012 to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital's final payment to cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (which CMS refers to as the "target PCR") for other hospitals paid under the OPPS.

The target PCR is set in advance of the calendar year and is calculated using the most recent submitted or settled cost report data that are available at the time of final rulemaking for the calendar year. CMS is updating the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 4) by adding section 10.6.3.2, to reflect that the target PCR for 2014, for purposes of the cancer hospital payment adjustment, is 0.89 for outpatient services furnished on or after January 1, 2014, through December 31, 2014, and the revised section is included as an attachment to CR 8572.

Changes to OPPS pricer logic

a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in 2014. The rural SCH and EACH payment adjustment

(continued on next page)

Outpatient *(continued)*

excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with the Social Security Act (section 1833(t)(13)(B)), as added by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA; Section 411; see *http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf* on the Internet).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2014. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the 2014 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2014. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. The fixed-dollar threshold increase in 2014 relative to 2013. The estimated cost of a service must be greater than the APC payment amount plus $2,900 in order to qualify for outlier payments.

e. For outliers for community mental health centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2014. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective October 1, 2013, and continuing for 2014, one device is eligible for pass-through payment in the OPPS pricer logic. Category C1841 (Retinal prosthesis, includes all internal and external components), has an offset amount of $0, because CMS is not able to identify portions of the APC payment amounts associated with the cost of the device in APC 0672, Level III, Posterior segment eye procedures. For outlier purposes, when C1841 is billed with *CPT*® code *0100T*, assigned to APC 0672, it will be eligible for outlier calculation and payment.

g. Effective January 1, 2014, the OPPS pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

h. Effective January 1, 2014, there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPPS pricer logic. For APCs containing nuclear medicine procedures, pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the 2014 APC payments for nuclear medicine procedures and may be found on the CMS website.

i. Effective January 1, 2014, there will be five skin substitute products receiving pass-through payment in the OPPS Pricer logic. For skin substitute application procedure codes that are assigned to APC 0328 (Level III skin repair) or APC 0329 (Level IV skin repair), pricer will reduce the payment amount for the pass-through skin substitute product by the wage-adjusted offset for the APC when the pass-through skin substitute product appears on a claim with a skin substitute application procedure that maps to APC 0328 or APC 0329. The offset amounts for skin substitute products are the “policy-packaged” portions of the 2014 payments for APC 0328 and APC 0329.

j. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic

(continued on next page)

Outpatient *(continued)*

radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

k. Effective January 1, 2014, CMS is adopting the FY 2014 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

l. Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), a device offset cap will be applied based on the credit amount listed in the "FD" (Credit received from the manufacturer for a replaced medical device) value code. The credit amount in value code "FD" which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

Update the outpatient provider specific file (OPSF)

a.) Updating the OPSF for expiration of transitional outpatient payments (TOPs)

Cancer and children's hospitals are permanently held harmless under the Social Security Act (Section 1833(t)(7)(D)(ii)) and continue to receive hold harmless TOPs permanently. For 2014, cancer hospitals will continue to receive an additional payment adjustment.

b.) Updating the OPSF for the hospital outpatient quality data reporting program (HOP QDRP) requirements

Effective for OPPS services furnished on or after January 1, 2009, Subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in the Social Security Act (Section 1833(t)(17)(A)) will receive payment under the OPPS that reflects a two percentage point deduction from the annual OPPS update for failure to meet the HOP QDRP requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

c.) Updating the OPSF for the outpatient cost to charge ratio (CCR)

As stated in the *Medicare Claims Processing Manual* (Chapter 4, Section 50.1) MACs must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost–to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of statewide CCRs are located at *http://www.cms.gov/HospitalOutpatientPPS/* on the CMS website in the left column under *Annual Policy Files*.

Coverage determinations

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

Additional information

The official instruction, CR 8572 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2845CP.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: MM8572
Related Change Request (CR) #: CR 8572
Related CR Release Date: December 27, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2845CP
Implementation Date: January 6, 2014

Changes to payment dispute process for non-contracted providers

Currently, the Centers for Medicare & Medicaid Services (CMS) provides the services of an independent contractor, C2C Solutions, Inc. (C2C), to adjudicate payment disputes between non-contracted providers, Medicare Advantage organizations (MAOs), and other payers.

After January 31, 2014, CMS will no longer be able to offer these services due to budgetary constraints. However, C2C will continue to adjudicate all payment disputes received by January 31, 2014, that meet the filing requirements. After January 31, 2014, C2C will return any payment disputes to providers with instructions to contact the MAO or other payer directly to dispute the payment.

Provider types affected

This information applies to all non-contracted provider types that perform services for beneficiaries enrolled in MAOs, including private fee-for-service plans, program of all-inclusive care for the elderly (PACE) organizations, Section 1876 cost-based contractors, and health care prepayment plans.

Provider action needed

Providers and billing staff should not send any requests for a payment dispute to C2C after January 31, 2014. C2C will return all payment disputes requests received after that date to the provider with instructions to contact the plan to resolve the dispute or take other action the provider deems appropriate.

Providers that have exhausted the plan's internal dispute process and who still maintain they have not been reimbursed fairly may file a complaint through 1-800-Medicare in addition to taking other action the provider deems appropriate. CMS does not offer advice to providers on their potential rights in a payment dispute.

CMS is committed to ensuring that MAOs and other payers follow regulations at 42 CFR §§422.214, 417.559 and 422.520 when reimbursing non-contracted providers for services provided to Medicare beneficiaries. Non-contracted providers are required to accept as payment, in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

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

Source: CMS PERL 201312-05

Emergency update to the 2014 Medicare physician fee schedule database

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries and which are paid under the 2014 Medicare physician fee schedule database (MPFSDB).

What you need to know

This article is based on change request (CR) 8534 which informs MACS that the payment files released for the MPFS based upon the MPFS final rule published in the *Federal Register* December 10, 2013, are updated by CR 8534. CR 8534 amends those payment files and accounts for the year-end Congressional legislation for a 0.5 percent update to the 2014 conversion factor and extends the non-budget neutral geographic practice cost index (GPCI) work floors, all effective for January 1, 2014, through March 31, 2014. This is the result of the passage of the Pathway for SGR Reform Act of 2013.

MACs will begin to pay claims using these new files no later than January 16, 2014, effective for dates of service as of January 1, 2014. In addition, MACs will post the new MPFS fees to their websites no later than January 3, 2014.

Additional information

The official instruction, CR 8534, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2847CP.pdf*.

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

MLN Matters® Number: MM8534
Related Change Request (CR) #: CR 8534
Related CR Release Date: December 27, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2847CP
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.

President Obama signs the 'Pathway for SGR Reform Act of 2013'

On December 26, 2013, President Obama signed into law the "Pathway for SGR Reform Act of 2013." This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect January 1, 2014. The new law provides for a 0.5 percent update for such services through March 31, 2014.

President Obama remains committed to a permanent solution to eliminating the sustainable growth rate (SGR) reductions that result from the existing statutory methodology. The administration will continue to work with Congress to achieve this goal.

The new law extends several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act) as well as provisions of the Affordable Care Act. Specifically, the following Medicare fee-for-service policies have been extended. The Centers for Medicare & Medicaid Services (CMS) also has included Medicare billing and claim processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, and more information about other provisions will be forthcoming.

Section 1101: Medicare Physician Payment Update – as indicated above, the new law provides for a 0.5 percent update for claims with dates of service on or after January 1, 2014, through March 31, 2014. CMS is currently revising the 2014 Medicare physician fee schedule (MPFS) to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2014 conversion factor is $35.8228.

Section 1102: Extension of Medicare Physician Work Geographic Adjustment Floor – the existing 1.0 floor on the physician work geographic practice cost index is extended through March 31, 2014. As with the physician payment update, this extension will be reflected in the revised 2014 MPFS.

Section 1103: Extension Related to Payments for Medicare Outpatient Therapy Services – Section 1103 extends the exceptions process for outpatient therapy caps through March 31, 2014. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through March 31, 2014. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD). Additional information about the exception process for therapy services may be found in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Section 10.3.

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received January 1, 2014. For physical therapy and speech language pathology services combined, the 2014 limit for a beneficiary on incurred expenses is $1,920. There is a separate cap for occupational therapy services which is $1,920 for 2014. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 1103 also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2014, through March 31, 2014, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services, including OPD therapy services, for a year. There are two separate $3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

Section 1104: Extension of Ambulance Add-On Payments -- Section 1104 extends the following two Job Creation Act ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas is extended through March 31, 2014; and (2) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus) is extended through March 31, 2014. The provision relating to air ambulance services that continued to treat as rural any area that was designated as rural on December 31, 2006, for purposes of payment under the ambulance fee schedule, expired June 30, 2013.

Section 1105: Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals – the Affordable Care Act allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges from the hospital. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment through March 31, 2014, retroactive to October 1, 2013. Be on the alert for further information about implementation of this provision.

Section 1106: Extension of the Medicare-Dependent Hospital (MDH) Program – the MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until March 31, 2014, and is retroactive to October 1, 2013. Be on the alert for further information about implementation of this provision.

Source: CMS PERL 201312-06

2014 ambulance fee schedule

The Centers for Medicare & Medicaid Services (CMS) has issued the ambulance fee schedule (AFS) file, effective for services January 1 through December 31, 2014.

Florida

Code	LOC 99 (01/02)	LOC 03	LOC 04
A0425	7.16	7.16	7.16
A0425*	7.23	7.23	7.23
A0426	260.53	274.93	275.49
A0426*	263.08	277.63	278.19
A0427	412.50	435.31	436.20
A0427*	416.54	439.57	440.47
A0428	217.10	229.11	229.58
A0428*	219.23	231.36	231.83
A0429	347.37	366.57	367.32
A0429*	350.77	370.17	370.92
A0430	2,909.78	3,023.86	3,028.31
A0430*	4,364.68	4,535.80	4,542.46
A0431	3,383.06	3,515.69	3,520.86
A0431*	5,074.59	5,273.54	5,074.59
A0432	379.93	400.94	401.76
A0432*	383.66	404.87	405.70
A0433	597.04	630.05	631.34
A0433*	602.89	636.23	637.53
A0434	705.59	744.60	746.12
A0434*	712.51	751.90	753.44
A0435	8.40	8.40	8.40
A0435*	12.60	12.60	12.60
A0436	22.43	22.43	22.43
A0436*	33.65	33.65	33.65

*** Rural rate**

U.S. Virgin Islands

Code	Allowance
A0425	7.16
A0425*	7.23
A0426	268.01
A0426*	270.64
A0427	424.35
A0427*	428.51
A0428	223.34
A0428*	225.53
A0429	282.26
A0429*	360.85
A0430	2969.05
A0430*	4453.57
A0431	3451.96
A0431*	5177.94
A0432	390.85
A0432*	394.68
A0433	614.19
A0433*	620.21
A0434	725.86
A0434*	732.97
A0435	8.40
A0435*	12.60
A0436	22.43
A0436*	33.65

*** Rural rate**

Puerto Rico

Code	Allowance
A0425	7.16
A0425*	7.23
A0426	209.64
A0426*	211.69
A0427	331.93
A0427*	335.18
A0428	174.70
A0428*	176.41
A0429	279.52
A0429*	357.34
A0430	2506.80
A0430*	3760.20
A0431	2914.53
A0431*	4371.79
A0432	305.72
A0432*	308.72
A0433	480.42
A0433*	485.13
A0434	567.77
A0434*	573.34
A0435	8.40
A0435*	12.60
A0436	22.43
A0436*	33.65

*** Rural rate**

Additional reporting requirements concerning physician ownership and investment in hospitals

Note: This article was updated January 16, 2014, to reflect current requirements and dates. It was previously published in the September 2013 edition of *Medicare A Connection*, Page 57.

Provider types affected

This *MLN Matters*® special edition article is an update of *MLN Matters*® number SE1332, originally published September 13, 2013.

It is intended for hospitals that have physician ownership or investment interests, and seek to avail themselves of the whole hospital or rural provider exceptions to the physician self-referral law. In this article, we refer to hospitals with physician owners or investors as "physician-owned hospitals."

What you need to know

Under Section 1877 of the Social Security Act (the Act), also known as the physician self-referral law, unless an exception applies and is satisfied, 1) a physician may not refer a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, and (2) the entity may not present or cause to be presented a claim to Medicare (or bill another individual, entity, or third party payer) for those referred services.

The Centers for Medicare & Medicaid Services (CMS) issues this article to address the additional reporting requirements imposed by Section 6001 of the Affordable Care Act on physician-owned hospitals seeking to avail themselves of the whole hospital or rural provider exceptions to the physician self-referral law.

The instructions in this article related to the reporting by the March 1, 2014 deadline supersede those set forth in the "Supporting Statement for Paperwork Reduction Act Submissions: Annual Report of Physician-Owned Hospital Ownership and/or Investment Interest."

This *MLN* article does not address other additional requirements imposed by Section 6001 of the Affordable Care Act.

Background

Two exceptions to the physician self-referral law for ownership or investment interests are the whole hospital and rural provider exceptions. Section 1877(i)(1)(C)(i) of the Act requires physician-owned hospitals to submit to CMS an annual report containing ownership and investment information to qualify for either exception.

This reporting requirement is implemented in the physician self-referral regulations at *42 CFR 411.362(b)(3)(i)*. (This regulation is available at

http://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=CFR-2011-title42-vol2-sec411-362&packageId=CFR-2011-title42-vol2.)

Physician-owned hospitals that report ownership and investment information by following the instructions set forth in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) or the Medicare Enrollment Application Form CMS-855A (CMS-855A), Attachment 1, for reporting physician-owned hospital ownership and investment information satisfy the above reporting requirement.

As further detailed in the instructions, physician-owned hospitals must complete and submit the required information via PECOS at *https://pecos.cms.hhs.gov/pecos/login.do*, or the manual paper process, CMS-855A, Attachment 1.

Manual submissions should be forwarded to the hospital's designated Medicare fee for service contractor. Please note that this reporting requirement is not mandatory for Medicare enrollment and does not ensure Medicare enrollment. Physician-owned hospitals seeking to avail themselves of the whole hospital or rural provider exceptions must report ownership and investment information following the above process by March 1, 2014.

Physician-owned hospitals that submitted this information on or after December 1, 2012, consistent with the above process will be considered to have met the March 1, 2014, deadline. Hospitals must submit this information on an annual basis to continue to meet the reporting requirement. We remind hospitals that information submitted under this process may be published on the CMS website pursuant to Section 1877(i)(2) of the Act.

If a hospital reports ownership or investment information under this process but is not seeking to use the whole hospital or rural provider exceptions, the hospital may request that CMS either not publish or remove its information from the website by emailing

(continued on next page)

Ownership *(continued)*

POHExceptions@cms.hhs.gov.

Additional information

For more information about provisions affecting physician-owned hospitals under the physician self-referral law, visit the Physician Self-Referral Physician-Owned Hospitals webpage at *http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals.html*.

For more information about Medicare enrollment, visit the provider-supplier enrollment webpage at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*.

MLN Matters® Number: SE1332 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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

Note: Information regarding the "two-midnight rule" and change request (CR) 8508 was previously published in the November 2013 edition of *Medicare A Connection*, Page A18.

The Centers for Medicare & Medicaid Services (CMS) recently revised instructions for suspension of post-payment patient status reviews for inpatient claims with dates of admission October 1, 2013, through December 31, 2013.

CR 8508 describes how Medicare contractors may conduct "patient status" reviews for inpatient hospital admissions.

Patient status reviews help determine if inpatient hospital admission and Part A payment was the appropriate for the level of care provided.

These review types include denial language to indicate that while the patient care provided may have been appropriate, the setting in which it occurred was not warranted.

For further details, please *review CR 8508*.

Educational Events

Provider outreach and educational events – February - March 2014

EDI presents an overview of PC-ACE Pro32TM, Medicare's free billing software

When: Monday, February 17
Time: 11:30 a.m. -1:30 p.m. ET – Delivery language: English
Type of Event: Face-to-face
Location: The Florida Hotel & Conference Center, 1500 San Lake Road, Orlando, FL 32809

Medicare Part A changes and regulations

When: Tuesday, March 25
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: January 9, 2014, – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-09enews.pdf*
- CMS MLN Connects™ Provider eNews: January 16, 2014 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-16-enews.pdf*

Source: CMS PERL 201401-01, 201401-02

MLN Connects ™ Provider e-News special edition Monday, December 30

This *special edition of the MLN Connects™ Provider e-News,* published December 30, 2013, included the following information:

Announcements

Verifying patient coverage in a Health Insurance Marketplace Plan

MLN Connects™ national provider calls

- National partnership to improve dementia care in nursing homes – register now

National provider calls, which have already occurred, were referenced in the special edition:

January 14, 2014 – Two-Midnight Benchmark for Inpatient Hospital Admissions

January 15, 2014 – End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule

January 16, 2014 – 2012 Quality and Resource Use Reports Overview and December Addendum

Recordings of these calls may be reviewed at *http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html*.

Announcements

Verifying patient coverage in a health insurance marketplace plan

It is the beginning of the New Year and you'll be verifying your patient's insurance status when they show up in your office. With the beginning of the health insurance marketplace, also known as health insurance exchange, over a million people will have a new insurance plan.

In many cases, this will be the first time they have had insurance in years. Many of these people will have signed up for their plan within the past few days. They may not have received their card yet or they may be unaware of the need to carry their insurance information. You may find your office needing to verify their coverage.

How do you verify their coverage?

If the marketplace in your state is run by the federal government, it is best to call their plan's customer service line, a list of all plans and their customer service numbers can be found in this *database*.

Here's a *fact sheet* for using the data base. If you can't find the number, call the marketplace call center (1-800-318-2596).

If your state has its own health insurance exchange, contact your state. To find the website for your state exchange, select the name of your state in the box at the left hand side of the *healthcare.gov website*.

How else can you help your patient?

Remind your patients to keep all of their paperwork and receipts from all of their doctor's appointments and from the pharmacy as well. They may need them for their insurer. Remind them they should carry their card at all times. If they don't have a card, they can contact their plan to get a card.

If the patient is uninsured, they have until March 31 to sign up for non-employer based coverage. They can go to *HealthCare.gov* to sign up for a plan and apply for financial assistance. The vast majority of uninsured will qualify for financial assistance to reduce their costs. You can also download copies of *fact sheets* or educational material for your patients.

(continued on next page)

Connects *(continued)*

comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual.

The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications in nursing homes and eventually other care settings as well.

During this *MLN Connects™ Call,* a CMS subject matter expert will discuss the critical role of both state and federal surveyors in the implementation of the partnership. Additional speakers will be presenting on the importance of leadership, as well as the strong correlation that exists between proper pain assessment and antipsychotic medication use. A question and answer session will follow the presentation.

Agenda

- Role of surveyors
- Importance of leadership
- Proper pain assessment
- Next steps

SOURCE: CMS PERL 201312-07

Updates to clarify skilled nursing facility, inpatient rehabilitation facility, home health, and outpatient coverage pursuant to *Jimmo vs. Sebelius*

MLN Matters® article #MM8458 , "Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius" has been released and is now available in downloadable format.

The article was prepared and is being distributed as a result of the settlement agreement in the case of Jimmo v. Sebelius.

This article is designed to provide education on the updated portions of the Medicare Benefit Policy Manual (MBPM). It includes clarification on the coverage requirements of skilled nursing and skilled therapy services to Medicare beneficiaries.

SOURCE: CMS PERL 201303-03

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

Puerto Rico Contact Information

Addresses

Claims

Additional documentation
General mailing
Congressmen mailing
First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Redeterminations

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

Debt recovery (except for MSP)

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

Post-payment medical exams

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

Freedom of Information Act (FOIA*) related requests

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

Medicare fraud and abuse

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

Provider enrollment

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

Electronic Data Interchange (EDI*)

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

MSPRC DPP debt collection – Part A

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

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

Audit and reimbursement department

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

Overnight mail and other special handling postal services

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

Other Medicare carriers and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)
CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

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

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

Phone Numbers

Providers

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

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

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

Beneficiary

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

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

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number
1-904-361-0407

Audit And Reimbursement Department

Fax number
1-904-361-0407

Websites

Providers

First Coast – MAC J9
medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services
www.medicare.gov