Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

February 2014

In this issue

Three-day prior hospitalization

Background

In order to qualify for post-hospital extended care services, people with Medicare must have been an inpatient in a hospital for a medically necessary stay for at least three consecutive days. In addition, the beneficiary must have been transferred to a participating skilled nursing facility (SNF) within 30 days following discharge from the hospital.

In determining whether the three consecutive calendar day stay requirement has been met, the day of admission is counted as a hospital inpatient day, not the day of discharge. Time spent in observation status or in the emergency room prior to an inpatient admission to the hospital does not count toward the three-day qualifying inpatient hospital stay. For purposes of the SNF benefit qualifying hospital stay requirement, inpatient status begins with the calendar day of hospital admission.

Coverage determination

To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized.

In this context, the applicable hospital condition does not have to be the principal diagnosis that actually precipitated the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay.

Comprehensive error rate testing (CERT)

The Medicare administrative contractor (MAC) jurisdiction 9 (J9) CERT report reveals that insufficient medical documentation accounts for up to 70 percent of all SNF denied claims. The remaining 30 percent is due to coding errors.

Example one, a provider billed a resource utilization group (RUG) code for a five-day prospective payment system (PPS) assessment; however, there was insufficient documentation on the rehabilitation therapy treatment days and amount of time (in minutes) to support the billed RUG code.

-continued on Page 61

Contents

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Publication staff:
Terri Drury
Martin Smith
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

Full implementation of edits on the ordering/referring providers in Medicare Part B, DME, and Part A Home Health Agency Claims

Note: This article was revised February 6, 2014, to modify the answer to question J on page eight. The article was previously changed on November 6, 2013, to provide updated information regarding the effective date of the edits (January 6, 2014). Additional clarifying information regarding the Advance Beneficiary Notice, CARC codes and DME rental equipment has also been updated. Please review the article carefully for these changes. All other information remains the same. This article was previously published in the November 2013 edition of *Medicare A Connection*, Pages 9-15.

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

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

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

Provider types affected

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

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

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

Provider action needed

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

What providers need to know

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

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

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

This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered

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Ordering *(continued)*

items and services, including home health, DMEPOS, imaging and clinical laboratory.

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

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

The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found on *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html*. Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.

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

Background

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

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

Below are examples of some of these types of claims:

- Claims from clinical laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;
- Claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A home health agencies (HHA).
- Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:
- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.)
- Physician assistants,
- Clinical nurse specialists,
- Nurse practitioners,
- Clinical psychologists,
- Interns, residents, and fellows,
- Certified nurse midwives, and
- Clinical social workers.

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

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

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Ordering *(continued)*

identified supplier or provider specialty. CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home health agency (HHA) services may only be ordered or referred by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Optometrists may only order and refer DMEPOS products/services, and laboratory and X-ray services payable under Medicare Part B.

Questions and answers relating to the edits

1. What are the ordering and referring edits?

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

2. Why did Medicare implement these edits?

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

3. How and when will these edits be implemented?

These edits were implemented in two phases:

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

The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

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

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

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

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

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

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

N272	Missing/incomplete/invalid other payer attending provider identifier

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

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

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.1

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

The file, called the ordering referring report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner.

To keep the available information up to date, CMS will replace the report twice a week. At any given time, only one report (the most current) will be available for downloading.

To learn more about the report and to download it, go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*; click on "Ordering & Referring Information" (on the left). Information about the report will be displayed.

Phase 2: **Effective January 6, 2014, CMS will turn on the Phase 2 edits.** In phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied.

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Ordering *(continued)*

This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

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

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

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

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing (edit 289D) will continue to be rejected.

CARC code 16 and/or the RARC code N265, **N276 and MA13 shall be used for rejected claims due to the missing required matching NPI.**

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

Reason code	This reason code will assign when:
37236 : This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on • The type of bill is '32' or '33' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code
37237 This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on • The type of bill is '32' or '33' • The type of bill frequency code is '7' or 'F-P' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

Effect of edits on providers

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

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

a. You have a current Medicare enrollment record. If you are not sure you are enrolled in Medicare, you may:

1. Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
2. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
3. Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
4. If you choose iii, please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.

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Ordering *(continued)*

b. If you do not have an enrollment record in Medicare. You need to submit either an electronic application through the use of Internet-based PECOS or a paper enrollment application to Medicare.

1) For paper applications – fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
2) For electronic applications – complete the online submittal process and either e-sign or mail a printed, signed, and dated certification statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.
3) In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement.
4) If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment Web page to learn more about the Web-based system before you attempt to use it. Go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there.
5) Download and read the documents in the *Downloads* section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.
6) If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (*http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html*).

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

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

d. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries. When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

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

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

f. Make sure your claims are properly completed.

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the Ordering and Referring file found on CMS.gov.
- On paper claims (CMS-1450), you would capture the attending physician's last name, first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.
- On paper claims (CMS-1500 and CMS-1450), do not enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the ordering/referring name field, as their use could cause the claim to fail the edits.
- Ensure that the name and the NPI you enter for the ordering/referring provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral.
- Make sure that the qualifier in the electronic claim (x12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.

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Ordering *(continued)*

If there are additional questions about the informational messages, Billing Providers should contact their local A/B MAC, or DME MAC. Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability.

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

g. What if my claim is denied inappropriately?

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

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

Consistent with the Affordable Care Act and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable x-ray facilities and radiation therapy centers.

The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits.

However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

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

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

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

Claims for capped rental items will continue to be paid for up to 13 months from the physician's date of deactivation to allow coverage for the duration of the capped rental period.

Additional guidance

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

The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

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

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

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

These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or

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Ordering *(continued)*

they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

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

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

Additional information

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

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

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

Note: You must obtain a national provider identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field on your enrollment application. Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*. For more information about NPI enumeration, visit *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html*.

Additional article updates

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

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

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

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

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

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

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

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Updated mobile applications for open payments

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) is issuing this article to alert the provider community of updates to the mobile applications (apps), open payments mobile for Industry and Open Payments Mobile for Physicians, implemented as a result of user feedback to CMS. See the *Background* and *Key points* sections of this article for details.

Also, a part of SE1402 is new technical documentation: *The Open Payments QR Code Reader How-To Guide*. Included are the technical instructions for creating or importing contact information using a QR code reader and generating a QR code to transfer profile or payment information to other user devices.

Background

In July 2013, CMS released two mobile apps: Open Payments Mobile for Industry and Open Payments Mobile for Physicians. Below are enhancements to the original open payments mobile apps. The changes to the apps include the following:

- Streamlining the menu on the welcome screen;
- Adding the ability to export all profile data associated with a payment into CSV format; and
- Developing a new function to view reports of payments in bar and pie charts.

The apps are intended to support reporting under the Open Payments program. For more details refer to: *http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html*. For help with the apps contact the CMS helpdesk at *OpenPayments@cms.hhs.gov*.

Key Points of SE1402

If you already downloaded the apps, you will need to run an update to take advantage of the new app functionality. To do so, visit either the *Google Play*™ app store or *iOSApple*™ app store, look for your available updates, and select the Open Payments apps to download the updates. If you have not yet downloaded the apps, search for Open Payments in the applicable app store and you'll be prompted to download the newly updated versions.

In response to user feedback, the table below describes the enhancements made to the apps since their initial launch in July 2013. All changes are intuitive and will add elements of ease expected by app users.

Enhancement topic	Details – what it does
Changes that Apply to Both Apps (Open Payments Mobile for Industry and Open Payments Mobile for Physicians)	
Streamlined "Welcome" screen options	• A number of infrequently used menu options (e.g., "Program Information" and "Change Password") moved from the "Welcome" screen and now appear in a hidden menu. • To access the menu, swipe to the right at the "Welcome" screen.
Reports/statistics	• A new "Reports/Statistics" button, accessible on the "Welcome" screen, allows the user to create a chart (bar and pie), showing their transfer of value data sorted by physician (within Open Payments Mobile for Industry) or vendor (within Open Payments Mobile for Physicians). • This new chart creation capability will streamline data review.
CSV exporting	• When payment data is exported via CSV format, all profile data for the associated vendor/physician is included in the CSV file (including address, phone number, etc.). • The prior app version included only vendor/physician name in the CSV file. This enhancement will simplify the data review process.

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Open Payments *(continued)*

Enhancement topic	Details – what it does
Streamlined "Add payment" process	• The steps to "Add Payment" are streamlined to allow the user to enter contact information for the vendor or physician, while staying within the "Add Payment" menu. • The prior app version required the user to first enter contact information for the vendor or physician separately, and then go to the "Add Payment" menu.
Easy payment duplication	• A new button available on the "View Payment" screen allows payment data to be easily duplicated, in case a physician or vendor has multiple occurrences of the same payment. • The only data field that needs to be re-entered is the date.
Vendors/physicians sorted alphabetically	• In "Manage Vendors/Physicians," vendors or physicians are now listed alphabetically. • The prior app version listed vendors and physicians in the order in which they were entered.
Email/print QR code added	• A "Share" button is available to email or print a QR code that is generated within the app, for sharing at a later time.
Payment QR code warning added	• After a payment QR code is scanned, a red warning message appears to remind the user to manually add the vendor or physician name to the payment data conveyed in the QR code.
Additional data elements added in: **"Add Payment" > "Travel & Lodging"**	• When nature of payment in "Add payment" is "Travel & Lodging," the following additional data elements can be entered: city, state, and country of travel (note that these new data elements are required for reporting purposes; but remember, the apps are not used for reporting data, only for tracking it).
Tablet support	Both apps are optimized for viewing on tablet devices.

Enhancement topic	Details - what it does
Changes that Apply to Just One App **Open Payments Mobile for Physicians**	
"Manage companies" added	• Within "Manage vendors", a new data field allows users to assign vendors to companies when entering new vendor information. • Company information is needed for the "Reports/Statistics" functionality to illustrate all payments by company name.

The updated *frequently asked questions* about the mobile apps contain all the details about these enhancements (link to the document above, or visit the "Apps for Tracking Assistance" page on the Open Payments website).

QR Code Technical Guide Available for Apps: Also now available to support use of the Open Payments apps is a how-to-guide that explains the technical details associated with how to create Quick Response (QR) codes usable in the apps. "The Open Payments QR Code Reader How-To Guide" includes detailed, highly technical instructions for creating or importing contact information using a QR code reader, and generating a QR code to transfer profile or payment information to other user's devices.

Additional information

If you have any questions, 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*.

To review "The Open Payments Mobile Application Quick Response (QR) Code Reader Documentation: A How-To Guide to Create Java Script Object Notation (JSON) QR Code" referenced in this SE1402, see *http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Open-Payments-QR-Code-Reader-How-To-Guide-%5bDecember-2013%5d.pdf*.

To review the series of SE articles leading up to SE1402 see the following:

(continued on next page)

Open Payments *(continued)*

1. *MLN Matters*® SE1303 "Information on the National Physician Payment Transparency Program: Open Payments," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf*.

2. *MLN Matters*® SE1329 "Mobile Apps for the Open Payments program (Physician Payments Sunshine Act)" is available at: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1329.pdf* on the CMS website.

3. *MLN Matters*® SE1330 "Open Payments: An Overview for Physicians and Teaching Hospitals" may be found at: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1330.pdf*.

MLN Matters® Number: SE1402
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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New name, logo for educational task force of Part A and B MACs

During a national teleconference in August 2013, MACs announced the launch of the CERT A/B MAC Contractor Task Force. All Part A and Part B MACs have come together with the intent to educate providers on costly claim denials and billing errors to Medicare.

The goal is to collaborate on innovative educational products to reduce the national payment error rate, as measured by the CERT program.

The task force has modified its name to the CERT **A/B MAC Outreach & Education Task Force** to demonstrate the importance on CERT education.

This change emphasizes their focus on outreach and education to reduce CERT errors while distinguishing them from other entities working on CERT-related issues.

The new name is also reflected in the task force's current logo. All future educational products will have the new name and logo.

Learn about the task force

The CERT A/B MAC Outreach & Education Task Force invites you to learn about its mission and educational plans, as well as access the recording from the first teleconference on August 20, 2013. *Click here*.

The CERT A/B MAC Outreach & Education Task Force looks forward to collaborating for error-free Medicare claims and documentation with providers, associations and societies across the nation.

Participating contractors

- Cahaba Government Benefit Administrators, LLC/J10
- CGS Administrators, LLC/J15
- First Coast Service Options, Inc./J9
- National Government Services, Inc./J6 and JK
- Noridian Healthcare Solutions, LLC/JE and JF
- Novitas Solutions, Inc./JH and JL
- Palmetto GBA/J11
- Wisconsin Physicians Service Insurance Corporation/J5 and J8

Disclaimer: CERT A/B MAC Outreach & Education Task Force is independent from the Centers for Medicare & Medicaid Services (CMS) CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.

Update to Pub 100-04, *Claims Processing Manual*, Chapter One

Provider types affected

This *MLN Matters*® article is intended for individual providers or chains submitting claims to Part A Medicare administrative contractors (MAC) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8442 removes amends the *Medicare Claims Processing Manual* to show that provider chains and individual providers are no longer permitted to select the fiscal intermediary of their choice.

Background

CR 8442, from which this article is taken removes certain sections from the *Medicare Claims Processing Manual* because they contain policy based on the legacy environment during which chains and individual providers were permitted to select the fiscal intermediary of their choice.

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173 (which you can find at *http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf*, amended Title XVIII of the Social Security Act (the Act) to repeal its provider nomination provision, and replaced it with the geographic assignment rule. This means that a chain, or an individual provider, can no longer select the fiscal intermediary (FI) or MAC of its choice, and you should be aware that your MAC will no longer accept your requests for "change of intermediary."

Rather, an individual provider will be assigned to the MAC that covers the state in which the provider is located; and a chain that meets the criteria set forth at 42 CFR 421.404 may contact CMS and ask to have all eligible, downstream providers assigned to the MAC that covers the state in which the chain's home office is located. (A chain home office wishing to contact CMS to request "qualified chain" status may send an email to *Provider_MAC_Assignment_Inquiry@cms.hhs.gov*)

Additional information

The official instruction, CR 8442 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2876CP.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: MM8442
Related Change Request (CR) #: CR 8442
Related CR Release Date: February 7, 2014
Effective Date: March 7, 2014
Related CR Transmittal #: R2876CP
Implementation Date: March 7, 2014

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Psychiatry and psychotherapy services

This article has been rescinded in order to be revised. It will be posted again when the revisions are completed.

MLN Matters® Number: SE 1407 (Recinded)
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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Additional data reporting requirements for hospice claims

Note: This article was revised February 3, 2014, to reflect the revised change request (CR) 8358 issued January 31. The article was revised to add clarifying language and examples in the *Background* section. In addition, references to legacy contractors were removed. The CR release date, transmittal number, and the Web address for accessing the CR were also revised. This information was previously published in the August 2013 *Medicare A Connection*, Pages 7- 8.

Provider types affected

This *MLN Matters*® article is intended for hospices submitting claims to Medicare home health and hospice Medicare administrative contractors (HH & H MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on CR 8358 which requires additional claim data reporting for hospices to support hospice payment reform as authorized by Section 3132(a) of the Affordable Care Act. Additional data reporting includes visit reporting for general inpatient care, reporting the service facility national provider identifier (NPI) where the service was performed when the service is not performed at the same location as the billing hospice's location, and reporting of infusion pumps and prescription drugs.

Specifically, hospices shall report line-item visit data for hospice staff providing general inpatient care (GIP) to hospice patients in skilled nursing facilities or in hospitals for claims with dates of service on or after April 1, 2014. Hospices may voluntarily begin this reporting as of January 1, 2014. This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length reported as is done for the home levels of care. Make sure that your billing staff is aware of these changes.

Background

Over the past several years the Medicare Payment Advisory Commission (MedPAC), the Government Accountability Office (GAO), and the Office of the Inspector General (OIG) have all recommended that the Centers for Medicare & Medicaid Services (CMS) collect more comprehensive data in order to better evaluate trends in utilization of the Medicare hospice benefit.

CMS began collecting additional data on hospice claims beginning in January 2007, when CMS began required reporting of a Healthcare Common Procedure Code System (HCPCS) code on the claim to describe the location where services were provided. (See *MLN Matters*® article MM5245 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5245.pdf* on the CMS website.)

CMS continued the data collection effort with CR 5567 which requires Medicare hospices to, beginning in July 2008, provide detail on their claims about the number of physician, nurse, aide, and social worker visits provided to beneficiaries. (See the *MLN Matters*® article MM5567 corresponding to CR 5567 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5567.pdf* on the CMS website),

In January 2010, with the issuance of CR 6440, CMS required the reporting of visits performed by therapists and certain phone calls made by social workers, who are paid by the hospice, on hospice claims. CR 6440 also required that hospices report the length of visits made by nurses, aides, therapists, and social workers (to include certain phone calls made by social workers) who are paid by the hospice, with the associated time per visit (or per social worker call) in the number of 15 minute increments. (See MM6440 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6440.pdf*.)

Effective in October 2010, CR 6905 added an additional HCPCS site of service code (Q5010, for hospice home care provided in a hospice facility), to supplement those Q-codes implemented in 2007 with CR 5245. (See the *MLN Matters*® article MM6905 corresponding to CR 6905 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6905.pdf*.)

On several occasions, industry representatives have communicated to CMS that the required claims information was not comprehensive enough to accurately reflect hospice care. Industry stakeholders also commented that to understand hospice costs, CMS should consider non-labor costs, as these 1) can be significant, and 2) are largely comprised of data on drugs, durable medical equipment (DME), and medical supplies.

Finally, the Affordable Care Act, Section 3132(a) gives CMS the authority to collect additional data as needed to revise payments for hospice care. This claims data

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Settlement *(continued)*

collection will support hospice payment reform. See *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf* to view the Affordable Care Act.

CR 8358 instructs that Medicare hospices will report line-item visit data for hospice staff providing general inpatient care (GIP) to hospice patients in skilled nursing facilities (site of service HCPCS code Q5004) or in hospitals (site of service HCPCS codes Q5005, Q5007, Q5008). This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length reported as is done for routine home care and continuous home care.

It also includes certain calls by hospice social workers (as described in CR 6440, Transmittal 1738, dated May 15, 2009), on a line-item basis, with call and call length reported as is done for the home levels of care. CMS is not changing the existing GIP visit reporting requirements when the site of service is a hospice inpatient unit (site of service HCPCS code Q5006). For all visit/call reporting, only report visits/calls by the paid hospice staff; do not report visits by non-hospice staff. See the *MLN Matters*® article MM6440 corresponding to CR 6440 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6440.pdf*.

Hospices shall report the national provider identifier (NPI) of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving hospice services, regardless of the level of care provided, when the site of service is not the billing hospice. In compliance with the 837i requirements, the billing hospice shall report the name, address, and NPI of the service facility where the service is being performed when the service is not performed at the same location as the billing hospice's location. When the patient has received care in more than one facility during the billing month, the hospice shall report the NPI of the facility where the patient was last treated.

Hospices shall report visits and length of visits (rounded to the nearest 15-minute increment), for nurses, aides, social workers, and therapists who are employed by the hospice, that occur on the date of death, after the patient has passed away.

Due to system limitations with reporting services after the date of the death, post mortem visits occurring on a date subsequent to the date of death shall not be reported. Visits occurring after death, and on the date of death, shall be reported using a PM modifier to differentiate them from visits occurring before death. The reporting of post-mortem visits, on the date of death, shall occur regardless of the patient's level of care or site of service.

Date of death is defined as the date of death reported on the death certificate. Hospices shall report hospice visits that occur before death on a separate line from those which occur after death.

For example, assume that a nurse arrives at the home at 9 p.m. to provide routine home care (RHC) to a dying patient, and that the patient passes away at 11 pm. The nurse stays with the family until 1:30 a.m. The hospice should report a nursing visit with eight 15-minute time units for the visit from 9 p.m. to 11 p.m..

On a separate line, the hospice should report a nursing visit with a PM modifier with four 15-minute time units for the portion of the visit from 11 pm to midnight to account for the one hour post mortem visit. If the patient passes away suddenly, and the hospice nurse does not arrive until after his death at 11:00 p.m., and remains with the family until 1:30 a.m., then the hospice should report a line item nursing visit with a PM modifier and four 15-minute increments of time as the units to account for the one hour post mortem visit from 11:00 p.m. to midnight.

Hospice agencies shall report injectable and non-injectable prescription drugs for the palliation and management of the terminal illness and related conditions on their claims. Both injectable and non-injectable prescription drugs shall be reported on claims on a line-item basis per fill, based on the amount dispensed by the pharmacy. Over-the-counter drugs shall not be reported.

When a facility (hospital, SNF, NF, or hospice inpatient facility) uses a system (such as Pyxis) where each administration of a hospice medication is considered a fill for hospice patients receiving care, the hospice shall report a monthly total for each drug (i.e., report a total for the period covered by the claim), along with the total dispensed.

Hospices shall report multi-ingredient compound prescription drugs (non-injectable) using revenue code 0250. The hospice shall specify the same prescription number for each ingredient of a compound drug according to the 837i guidelines in loop 2410. In addition, the hospice shall provide the national drug

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Settlement *(continued)*

code (NDC) for each ingredient in the compound; the NDC qualifier represents the quantity of the drug filled (meaning the amount dispensed) and shall be reported as the unit measure.

When reporting prescription drugs in a comfort kit/pack, the hospice shall report the NDC of each prescription drug within the package, in accordance with the procedures for non-injectable prescriptions given in this instruction.

Hospice agencies shall report infusion pumps (a type of DME) on a line-item basis for each pump and for each medication fill and refill. The hospice claim shall reflect the total charge for the infusion pump for the period covered by the claim, whether the hospice is billed for it daily, weekly, biweekly, with each medication refill, or in some other fashion. The hospice shall include on the claim the infusion pump charges on whatever basis is easiest for its billing systems so long as, in total, the claim reflects the charges for the pump for the time period of that claim. DME other than infusion pumps, and medical supplies, are not to be reported at this time.

Note: CMS is not making any changes to the existing claims requirements for physician services reported on the hospice claim.

Coding for new required hospice claims reporting:

Hospice staff provided GIP visit reporting: Code appropriate visit revenue code + HCPCS for the discipline + Units of 15-minute increments, when site of service = Q5004, Q5005, Q5007, or Q5008

Other provider NPI reporting: Other provider location loop 2310 E (Only required on the 5010 Electronic Claim). Required for hospice claims reporting site of service HCPCS Q5003, Q5004, Q5005, Q5006 when not the same as the billing hospice, Q5007 and Q5008.

Post-mortem visit reporting: Code appropriate visit revenue code + HCPCS for the discipline + PM Modifier + Units of 15 minute increments

Injectable drugs: Report on a line-item basis per fill, using revenue code 0636 and the appropriate HCPCS code, with units representing the amount filled (i.e. if says Q1234 Drug 100mg and the fill was for 200 mg, units reported = two).

Non-injectable prescriptions: Report on a line-item basis per fill (based on the amount dispensed by the pharmacy), using revenue code 0250 and the national drug code (NDC). The NDC qualifier represents the quantity of the drug filled, and shall be reported as the unit measure.

Infusion pumps: Report on the claim, on a line-item basis per pump order and per medication refill, using revenue code 029x for the equipment and 0294 for the drugs along with the appropriate HCPCS.

Additional information

The official instruction, CR 8358 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf* on the CMS website.

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: MM8358 Revised
Related Change Request (CR) #: CR 8358
Related CR Release Date: January 31, 2014
Voluntary Reporting Effective January 1, 2014
Mandatory Reporting Effective April 1, 2014
Related CR Transmittal #: R2864CP
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*

Fluorodeoxyglucose positron emission tomography for solid tumors

Provider types affected

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

What you need to know

This article is based on change request (CR) 8468, which advises you that, effective for claims with dates of service on and after June 11, 2013, the Centers for Medicare & Medicaid Services (CMS) will cover three flourodeoxyglucose positron emission tomography (FDG PET) scans (without the coverage with evidence development (CED) requirement) when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis.

Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by the local MACs. Make sure that your billing staffs are aware of these changes.

Background

CMS was asked to reconsider Section 220.6, of the *National Coverage Determinations* (NCD) *Manual*, to end the prospective data collection requirements across all oncologic indications of FDG PET in the context of this document. The term FDG PET includes PET/computed tomography (CT) and PET/magnetic resonance (MRI).

CMS is revising the *NCD Manual*, Section 220.6.17, to reflect that CMS has ended the CED requirement for 18 Fluorodeoxyglucose FDG PET and PET/CT and PET/MRI for all oncologic indications contained in Section 220.6.17 of the *NCD Manual*. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (HCPCS A9552) only.

Effective for services performed on or after June 11, 2013:

- The CED requirement has ended and modifier -Q0/-Q1, along with condition code 30 (institutional claims only), or V70.7 (both institutional and practitioner claims) are no longer required.
- MACs shall pay FDG PET claims for subsequent management, identified by *CPT*® codes *78608*, *78811, 78812, 78813, 78814, 78815*, or *78816*, modifier – PS, HCPCS A9552, and the same cancer dx code, which exceeded three FDG PET scans when the -KX modifier is included on the claim line.
- MACs will not search their files to identify claims processed prior to implementation of CR 8468; however, they will adjust such claims that you bring to their attention. MACs will deny subsequent treatment strategy (-PS) claims for FDG PET, which exceeded three FDG PET scans when a -KX modifier is not included on the claim line using the following:
- Claim adjustment reason code (CARC) 96: "Non-covered charge(s). Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Remittance advice remarks code N435: "Exceeds number/frequency approved/allowed within time period without support documentation."
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file; or,
- Group code PR assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

Note: For clarification purposes, as an example, each, different, cancer dx is allowed one initial treatment strategy (-PI modifier) PET scan and three subsequent treatment strategy (-PS modifier) PET scans without the -KX modifier. The 4th PET scan and beyond for the same cancer dx will always require the -KX modifier. If a different cancer dx is reported, that cancer dx will allow the same scenario as above, one initial, three subsequent, no -KX modifier required, four or more for same dx requires a -KX modifier.

Note: The only exception to the above frequency is with dx 185.0, prostate cancer, which is non-covered for initial treatment strategy. Therefore, all –PI modifiers for 185.0 would be denied, and –PS modifiers would follow the same frequency as all other cancer dx codes.

For claims with dates of service on or after July 7, 2014, contractors shall deny subsequent treatment strategy (-PS) claims for oncologic FDG PET scans

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PET *(continued)*

when no initial treatment strategy (-PI) claim is present in history when appropriate. CWF will begin counting at this point. The prostate cancer exception above applies.

MACs shall deny subsequent treatment strategy (-PS) claims for oncologic FDG PET scan claims when no initial treatment strategy (-PI) claim is present in history using the following:

- CARC B5: "Coverage/program guidelines were not met or were exceeded."
- RARC N640: "Exceeds number/frequency approved/allowed within time period."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Note: Providers should refer to Attachment A of CR 8468 for appropriate oncologic diagnosis codes. Please refer to MM6632, issued on October 16, 2009, available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6632.pdf*, and MM7148, issued September 24, 2010, available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7148.pdf*, for previous information on this coverage.

Additional information

The official instruction, CR 8468, was issued to your MAC via two transmittals. The first transmittal updates the *National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R162NCD.pdf*.

The second transmittal is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2873CP.pdf* and that transmittal updates the *Medicare Claims Processing Manual*.

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: MM8468
Related Change Request (CR) #: CR 8468
Related CR Release Date: February 6, 2014
Effective Date: June 11, 2013
Related CR Transmittal #: R2873CP/R162NCD
Implementation Date: March 7, 2014: Non-shared System Edits, July 7, 2014: Shared System Edits

Advance beneficiary notice of noncoverage, Form CMS-R-131

Provider types affected

This *MLN Matters*® article is intended for hospitals submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

This article, based on change request (CR) 8597, provides the removal of language that was erroneously included in CR 8404 and in the *Medicare Claims Processing Manual*, Chapter 30, Sections 50.3 and 50.6.2. It also provides clarified manual instructions regarding home health agency issuance of the advance beneficiary notice of non-coverage (ABN) to dual eligible beneficiaries.

Background

The ABN is an Office of Management and Budget (OMB)-approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and care provided under Part A by home health agencies (HHAs), hospices, and religious non-medical healthcare institutes only.

Key points of CR 8597

- With the exception of durable medical equipment prosthetic, orthotics & supplies (DMEPOS) suppliers, providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries. DMEPOS suppliers not enrolled as Medicare suppliers are required by statute to provide ABN notification prior to furnishing any items or services to Medicare beneficiaries.
- An example of an approved customization of the ABN which can be used by providers of laboratory services (sample lab ABN) is now available for download at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html*.
- When issuing ABNs to dual eligibles or beneficiaries having a secondary insurer, HHAs are permitted to direct the beneficiary to select

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Advance *(continued)*

a particular option box on the notice to facilitate coverage by another payer. This is an exception to the usual ABN issuance guidelines prohibiting the notifier from selecting one of the options for the beneficiary.

When a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer, HHAs should instruct beneficiaries to select Option one on the ABN. HHAs may add a statement in the *Additional information* section to help a dual eligible better understand the payment situation such as, "We will submit a claim for this care with your other insurance," or "Your medical assistance plan will pay for this care." HHAs may also use the *Additional Information* on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the *Additional information* section of the notice.

- Some states have specific rules established regarding HHA completion of liability notices in situations where dual eligibles need to accept liability for Medicare non-covered care that will be covered by Medicaid. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort", meaning other federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges. In the past, some states directed HHAs to select the third checkbox on the HHABN to indicate the choice to bill Medicare. On the ABN, the first check box under the "Options" section indicates the choice to bill Medicare and is similar to the third checkbox on the outgoing HHABN. Note: If there has been a state directive to submit a Medicare claim for a denial, HHAs must mark the first check box when issuing the ABN.

HHAs serving dual eligibles should comply with existing HHABN state policy within their jurisdiction as applicable to the ABN unless the state instructs otherwise. The appropriate option selection for dual eligibles will vary depending on the state's Medicaid directive.

If the HHA's state Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with

Medicaid, the HHA should direct the beneficiary to choose Option two. When Option two is chosen based on state guidance, but the HHA is aware that the state sometimes asks for a Medicare claim submission at a later time, the HHA must add a statement in the *Additional information* box such as "Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan."

Additional information

The official instruction, CR 8597 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2878CP.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: MM8597
Related Change Request (CR) #: CR 8597
Related CR Release Date: February 14, 2014
Effective Date: May 15, 2014
Related CR Transmittal #: R2878CP
Implementation Date: May 15, 2014

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Free mobile applications for open payments

The *Open Payments website* provides instructions on two free mobile applications (apps) to help physicians and health care industry users track their payments and other transfers of value that applicable manufacturers and applicable group purchasing organizations will report under open payments. For further information, see Open Payments article on Page 10.

NCD for single and dual chamber permanent cardiac pacemakers

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8525 which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for the indications outlined in the *Medicare National Coverage Determinations Manual* (Chapter 1, Part 1, Section 20.8, Cardiac Pacemakers) and the *Medicare Claims Processing Manual* (Chapter 32, Section 320, Billing Requirements for Cardiac Pacemakers: Single and Dual Chamber) which were revised by and included as attachments to CR 8525. CR 8525 is effective for claims with dates of service on or after August 13, 2013. Make sure that your billing personnel know about these changes.

Background

Permanent cardiac pacemakers refer to a group of self-contained, battery operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads. Single chamber pacemakers typically target either the right atrium or right ventricle. Dual chamber pacemakers stimulate both the right atrium and the right ventricle.

The implantation procedure is typically performed under local anesthesia and requires only a brief hospitalization. A catheter is inserted into the chest, and the pacemaker's leads are threaded through the catheter to the appropriate chamber(s) of the heart. The surgeon then makes a small "pocket" in the pad of the flesh under the skin on the upper portion of the chest wall to hold the power source. The pocket is then closed with stitches.

On August 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD). In this NCD, CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion).

The following indications are covered:

1. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction. for implanted permanent single chamber or dual chamber

cardiac pacemakers:

2. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block.

The following indications are non-covered

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia. for implanted permanent single chamber or dual chamber cardiac pacemakers:
2. Asymptomatic first degree atrioventricular block.
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest.
5. Ineffective atrial contractions (e.g., chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia.
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes are prolonged or electrophysiological studies have demonstrated that the block is at or beyond the level of the "His Bundle" (a component of the electrical conduction system of the heart).
7. Syncope of undetermined cause.
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block.
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.
11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia.

(continued on next page)

Pacemaker *(continued)*

12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

MACs will determine coverage under the Social Security Act (Section 1862(a)(1)(A); see *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm*) for any other indications for the implantation and use of single chamber or dual chamber cardiac pacemakers that are not specifically addressed in this NCD.

Note: MACs will accept the inclusion of the KX modifier on the claim line(s) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia (symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion)).

Other key notes for billing:

- MACs will pay professional claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains at least one of the *CPT*® codes of *33206*, *33207*, or *33208* AND one of the following ICD-9_CM/ ICD-10-CM diagnostic codes, and only when the claim is submitted with the KX modifier:
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*® codes and at least one of the diagnosis codes listed above along with the KX modifier:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia
- Contractors will return claim lines if the KX modifier is not present using the following message:
  - Claim adjustment reason code (CARC) 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
  - Remittance advice remarks code (RARC) N517: Resubmit a new claim with the requested information.
- Effective for claims with dates of service on or after August 13, 2013, MACs will pay outpatient institutional claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, (codes C1785, C1786, C2619, or C2620) provided the claim contains the KX modifier, and contains at least one of the *CPT*® codes *33206, 33207*, or *33208*, AND one of the following ICD-9_ CM/ICD-10-CM diagnostic codes:
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6
- MACs will return outpatient institutional claims for implanted permanent cardiac pacemakers that do not meet the preceding requirements.
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*® codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia
- Effective for claims with dates of service on or after August 13, 2013, MACs will pay inpatient claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the

(continued on next page)

Pacemaker *(continued)*

claim contains one of the following ICD-9/ICD-10 diagnosis AND procedure codes:

- 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, or 37.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, AND
- 426.0/I44.2, 426.12/I44.1,
- 426.13/I44.1, 427.81/I49.5, or 746.86/Q24.6

- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*® codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia

In addition, be aware of the following:

- MACs will deny claims for implanted dual chamber for one of the following *CPT*® codes: *33206*, *33207*, or *33208* and contains at least one of the following ICD-9-CM/ICD-10-CM diagnosis codes (even if submitted with at least one of the acceptable diagnosis codes listed above):
  - 426.11/I44.0
  - 427.31/I48.1/I48.2/I48.91
  - 427.32/I48.2/I48.3/I48.4/ or I48.91
  - 427.89/I49.8/ R00.1
  - 780.2/R55

MACs will use the following messages when denying claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following HCPCS and/or *CPT*® codes: C1785, C1786, C2619, C2620, *33206, 33207*, or *33208,* and at least one diagnosis code from the list of ICD-9/ICD-10 diagnosis codes above:

- CARC 96: Non-covered charge(s).
- RARC N569: Not covered when performed for the reported diagnosis.
- Group code - CO (contractual obligation), if claim received with GZ modifier indicating no signed advance beneficiary notice (ABN) is on file or group code PR (patient responsibility) if occurrence code 32 indicating a signed ABN is on file or occurrence code 32 with modifier GA is present.

NCDs are binding on all MACs and contractors with the federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs).

An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See the Social Security Act, Section 1869(f)(1)(A)(i), at *http://www.ssa.gov/OP_Home/ssact/title18/1869.htm*.)

Additional information

The official instruction, CR 8525 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R161NCD.pdf*.

The second transmittal updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2872CP.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: MM8525
Related Change Request (CR) #: CR 8525
Related CR Release Date: February 7, 2014
Effective Date: August 13, 2013
Related CR Transmittal #: R161NCD and R2872CP
Implementation Date: July 7, 2014

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NCD Manual language-only update

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8506 as an informational alert to providers that language-only changes – updates to the *Medicare National Coverage Determinations (NCD) Manual*, Pub 100-03 – were made.

The changes were made to comply with the following:

1. Conversion from ICD-9 to ICD-10
2. Conversion from ASC x12 version 4010 to version 5010
3. Conversion of former contractor types to MACs
4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

Note: The edits made to the *NCD Manual* are technical/editorial only and in no way alter existing NCD policies.

Background

These edits to Pub. 100-03 are part of a CMS-wide initiative to update its manuals and bring them in line with recently released instructions regarding the above-noted subject matter.

Additional information

The official instruction, CR 8506, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R159NCD.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: MM8506
Related Change Request (CR) #: CR 8506
Related CR Release Date: February 5, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R159NCD
Implementation: October 1, 2014

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Notification regarding the new Benefits Coordination & Recovery Center

The Centers for Medicare & Medicaid Services (CMS) has restructured its Coordination of Benefits (COB) and Medicare Secondary Payer (MSP) recovery activities. COB activities for both group health plans and non-group health plans (that is, liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) and recovery activities for non-group health plans have been transitioned from the COB contractor and the MSP Recovery Contractor effective February 1, 2014.

The new Benefits Coordination & Recovery Center (BCRC) will assume these activities. It is important to note that there will be no change to any of the COB & MSP Recovery (COB&R) processes.

The changes that will impact providers include a new, consolidated customer service phone number and a new Post Office (P.O.) Box for correspondence.

BCRC customer service representatives are available Monday through Friday, from 8am to 8pm ET, except holidays, at toll-free lines: 1-855-798-2627 (TTY/TDD: 1-855-797-2627).

The new P.O. Box is:

Medicare - MSP General Correspondence
P.O. Box 138897
Oklahoma City, OK 73113-8897

To ensure you have the most current information regarding COB&R activities, you can *sign up* for updates. More information is available on the *COB&R Overview website*. COB&R information specific to provider services may be found on the *Provider Services website*.

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

2014 Medicare Part B participating physician and supplier directory

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

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

Source: CMS IOM Publication 100-04, Transmittal 2817, CR 8471

Medicare national coverage determination for beta amyloid positron emission tomography in dementia and neurodegenerative disease

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who submit claims to Medicare A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries with dementia or neurodegenerative disease.

What you need to know

Effective for claims with dates of service on or after, September 27, 2013, the Centers for Medicare & Medicaid Services (CMS) will only allow coverage for PET Aß imaging (one PET Aß scan per patient) through coverage with evidence development (CED) to: (1) develop better treatments or prevention strategies for Alzheimer's Disease (AD), or, as a strategy to identify subpopulations at risk for developing AD, or (2) resolve clinically difficult differential diagnoses (e.g., frontotemporal dementia (FTD) versus AD) where the use of PET Aß imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

Background

After careful consideration, effective for claims with dates of service on or after September 27, 2013, CMS believes that the evidence is insufficient to conclude that PET Aß imaging improves health outcomes for Medicare beneficiaries with dementia or neurodegenerative disease.

However, there is sufficient evidence that the use of PET Aß imaging could be promising in certain scenarios. Therefore, Medicare will only allow coverage for PET Aß imaging (one PET Aß scan per patient) through CED to:

1. Develop better treatments or prevention strategies for AD, or, as a strategy to identify subpopulations at risk for developing AD, or

2. Resolve clinically difficult differential diagnoses (e.g., FTD versus AD) where the use of PET Aß imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

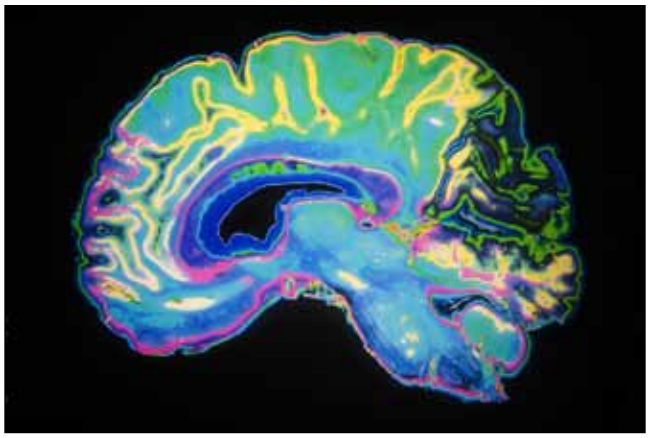
Health outcomes may include:

1. Avoidance of unnecessary or potentially harmful treatment or tests;

2. Improving, or slowing the decline of, quality of life (to include maintenance of independence) and cognitive and functional status; and,

3. Survival.

Outcomes may be short-term (e.g., related to meaningful changes in clinical management) or longterm (e.g., related to dementia outcomes).



A list of ICD-9 and corresponding ICD-10 Codes for Beta Amyloid for Dementia and Neurodegenerative Diseases is in the following table.

ICD-9 codes	Corresponding ICD-10 codes
290.0 Senile dementia, uncomplicated	F03.90 Unspecified dementia without behavioral disturbance
290.10 Presenile dementia, uncomplicated	F03.90 Unspecified dementia without behavioral disturbance
290.11 Presenile dementia with delirium	F03.90 Unspecified dementia without behavioral disturbance
290.12 Presenile dementia with delusional features	F03.90 Unspecified dementia without behavioral disturbance
290.13 Presenile dementia with depressive features	F03.90 Unspecified dementia without behavioral disturbance
290.20 Senile dementia with delusional features	F03.90 Unspecified dementia without behavioral disturbance
290.21 Senile dementia with depressive features	F03.90 Unspecified dementia without behavioral disturbance
290.3 Senile dementia with delirium	F03.90 Unspecified dementia without behavioral disturbance
290.40 Vascular dementia, uncomplicated	F01.50 Vascular dementia without behavioral disturbance
290.41 Vascular dementia with delirium	F01.51 Vascular dementia with behavioral disturbance
290.42 Vascular dementia with delusions	F01.51 Vascular dementia with behavioral disturbance

(continued on next page)

Amyloid *(continued)*

ICD-9 codes	Corresponding ICD-10 codes
290.43 Vascular dementia with depressed mood	F01.51 Vascular dementia with behavioral disturbance
294.10 Dementia in conditions classified elsewhere without behavioral disturbance	F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance
294.11 Dementia in conditions classified elsewhere with behavioral disturbance	F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance
294.20 Dementia, unspecified, without behavioral disturbance	F03.90 Unspecified dementia without behavioral disturbance
294.21 Dementia, unspecified, with behavioral disturbance	F03.91 Unspecified dementia with behavioral disturbance
331.11 Pick's Disease	G31.01 Pick's disease
331.19 Other Frontotemporal dementia	G31.09 Other frontotemporal dementia
331.6 Corticobasal degeneration	G31.85 Corticobasal degeneration
331.82 Dementia with Lewy Bodies	G31.83 Dementia with Lewy bodies
331.83 Mild cognitive impairment, so stated	G31.84 Mild cognitive impairment, so stated
780.93 Memory Loss	R41.1 Anterograde amnesia R41.2 Retrograde amnesia R41.3 Other amnesia (Amnesia NOS, Memory loss NOS)
V70.7 Examination for normal comparison or control in clinical research	Z00.6 Encounter for examination for normal comparison and control in clinical research program

Effective for claims with dates of service on or after September 27, 2013, MACs will return to provider/return as unprocessable claims for PET Aß imaging, through CED during a clinical trial, not containing the following:

• Condition code 30, (for institutional claims only);

• Modifier Q0 and/or modifier Q1 as appropriate;

• ICD-9 dx code V70.7/ICD-10 dx code Z00.6 (on either the primary/secondary position);

A PET HCPCS code 78811 or 78814;

• Dx codes (see list in table above); and

• Aß HCPCS code A9586 or A9599.

MACs will return as unprocessable claims for PET Aß imaging using the following messages:

• Claim adjustment reason code (CARC) 4 – the procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

• Remittance advice remark code (RARC) N517 – Resubmit a new claim with the requested information.

• RARC N519 – Invalid combination of HCPCS modifiers.

For claims with dates of service on or after September 27, 2013, Medicare will deny/reject claims for more than one PET Aß scan; HCPCS code A9586 or A9599, in a patient's lifetime.

MACs will line-item deny claims for PET Aß, HCPCS code A9586 or A9599, where a previous PET Aß, HCPCS code A9586 or A9599 is paid in history using the following messages:

• CARC 149: "Lifetime benefit maximum has been reached for his service benefit category."

• RARC N587: "Policy benefits have been exhausted."

• Group code: PR, assigning financial liability to the beneficiary if a claim is received with occurrence code 32 indicating a signed ABN is on file, or occurrence code 32 is present with modifier GA.

• Group code: CO, assigning financial liability to the provider if a claim is received with a GZ modifier indicating no signed ABN is on file.

Note that MACs will not automatically adjust claims processed prior to implementation of CR 8526, but they will adjust such claims that you bring to their attention.

Note: Each new beta amyloid radiopharmaceutical will require a separate code. Therefore, for the interim period, HCPCS code (A9599) - Radiopharmaceutical for beta-amyloid positron emission tomography (PET) imaging, diagnostic, per study dose shall be used with an effective date of January 1, 2014.

After a new beta amyloid radiopharmaceutical is approved for a separate, individual HCPCS code, a subsequent CR will be issued to update this NCD policy.

Note: Contractors should refer to the business requirements in CR 8526 well as general clinical trial billing requirements at Pub. 100-03, chapter 1, section 310, and Pub. 100-04, chapter 32, section 69. See Pub. 100-03, *NCD Manual*, chapter 1, section 220.6.20, for the coverage of Beta Amyloid PET in Neurodegenerative Disease and Dementia, and Pub. 100-04, *Claims Processing Manual*, chapter 13, section 60.12, for claims processing instructions.

(continued on next page)

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

Note: This article was revised February 4, 2014, to reflect the revised change request (CR) 8494, issued January 31, 2014. In the article, the transmittal number, CR release date, and the Web address for accessing the CR are revised. All other information remains the same. This article was published previously in the November 2013 issue of *Medicare A Connection,* Page 23.

Provider types affected

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

Provider action needed

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

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

Background

In accordance with the *Medicare Claims Processing Manual*, Chapter 16 (Laboratory Services), Section 120.2 (Implementation and Updates of Negotiated National Coverage Determinations (NCDs) for Clinical Diagnostic Laboratory Services), the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintaining codes in the negotiated NCDs and for biannual updates of the ICD-9-CM codes.

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

Additional information

The official instruction, CR 8488 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2865CP.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: MM8494
Related Change Request (CR) #: CR 8494
Related CR Release Date: January 31, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2865CP
Implementation Date: January 6, 2014

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Amyloid *(continued)*

Additional information

The official instruction, CR 8526, is in two transmittals issued to your A/B MAC. The first transmittal updates the *National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R160NCD.pdf*.

The second transmittal updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2871CP.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: MM8526
Related Change Request (CR) #: CR 8526
Related CR Release Date: February 6, 2014
Effective Date: September 27, 2013
Related CR Transmittal #: 2871CP/160NCD
Implementation Date: July 7, 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.

Local Coverage Determinations

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

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

Effective and notice dates

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

Contents

Advance beneficiary notice

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

New LCDs

Vertebroplasty, vertebral augmentation; percutaneous – New LCD

LCD ID number: L34492 (Florida, Puerto Rico, U.S. Virgin Islands)

Data analysis by the program safeguards communication group (PSCG) identified through a spike billing report an increase in utilization of percutaneous vertebral augmentation(also referred to as kyphoplasty) represented by *Current Procedural Terminology*® (*CPT*®) codes *22523*, *22524*, and *22525*. The Medicare Part B extraction summary system (BESS) statistical medical data obtained showed results above the national average for Florida. (Note: data for Puerto Rico and the U.S. Virgin Islands was below the national average for all applicable codes).

Due to the risk for high dollar claim payment error, the Part B local coverage determination (LCD) for percutaneous vertebral augmentation (formerly kyphoplasty) has been revised to address the limited indications for these services. In addition, First Coast Service Options Inc. (First Coast) took this opportunity to combine the current Part B percutaneous vertebroplasty LCD with the percutaneous vertebral augmentation LCD to align with other Medicare administrative contractors. For consistency this LCD is now being implemented for services that may be billed to Part A.

This new LCD for Part A addresses the indications and limitations of coverage and/or medical necessity, *CPT*® codes, ICD-9-CM diagnosis codes, documentation requirements, and utilization guidelines for percutaneous vertebroplasty and percutaneous vertebral augmentation. In addition, an LCD "Coding Guidelines" attachment was created to provide instructions on coding and billing for all the codes in the LCD.

Effective date

This new LCD is effective for services rendered **on or after March 31, 2014**. First Coast Service Options, Inc. LCDs are available through the CMS Medicare coverage database at: *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Nerve conduction studies and electromyography – new LCD

LCD ID number: L34480 (Florida, Puerto Rico, U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) via the coverage and analysis department has facilitated a national contractor medical director collaboration workgroup known as, "The local coverage determination (LCD) writers."

The workgroup includes medical directors from all of the A/B Medicare administrative contractors (MACs). One of the goals of all MACs is collaboration with other contractors and consensus LCDs is one outcome of this collaboration. In most cases the contractor medical directors worked with the relevant specialty physicians in developing certain consensus draft LCDs.

When a consensus draft LCD is adopted by a contractor, there is no major change to the LCD development process, which includes a 45-comment period, the finalization of the draft based on comments received from physicians representing their society and/or any stakeholder in the community, and a 45-day notice period. The finalized LCD remains the local contractor's discretion and responsibility.

The current LCD titled electromyography and nerve conduction studies will be retired when this new LCD becomes effective.

This new LCD addresses the indications and limitations of coverage and/or medical necessity, *CPT*®/HCPCS codes, diagnosis codes, documentation requirements, provider training and credentialing, and utilization guidelines for nerve conduction and electromyography studies.

Effective date

This new LCD is effective for services rendered **on or after March 17, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Genetic testing for Lynch syndrome – new LCD

LCD ID number: L34483 (Florida, Puerto Rico, U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) via the coverage and analysis department has facilitated a national contractor medical director collaboration workgroup known as, "The local coverage determination (LCD) writers." The workgroup includes medical directors from all of the A/B Medicare administrative contractors (MACs).

One of the goals of all MACs is collaboration with other contractors and consensus LCDs is one outcome of this collaboration. In most cases, the contractor medical directors worked with the relevant specialty physicians in developing certain consensus draft LCDs.

When a consensus draft LCD is adopted by a contractor, there is no major change to the LCD development process, which includes a 45-day comment period, the finalization of the draft based on comments received from physicians representing their society and/or any stakeholder in the community, and a 45-day notice period. The finalized LCD remains the local contractor's discretion and responsibility.

This new LCD addresses the indications and limitations of coverage and/or medical necessity, *CPT*® codes, ICD-9-CM diagnosis codes, and documentation requirements for genetic testing for Lynch syndrome.

Effective date

This new LCD is effective for services rendered **on or after March 17, 2014**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Revised LCDs

Botulinum toxins – revision to the Part A LCD

LCD ID number: L28788 (Florida) LCD ID number: L28790 (Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was most recently revised May 15, 2013. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to add the off-label indication for Myobloc (rimabotulinumtoxinb) for the treatment of sialorrhea.

Also, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, subtitled "Procedure Code J0587-Injection, rimabotulinumtoxinb, 100 units" to add ICD-9-CM diagnosis code 527.7 (Disturbance of salivary secretion). In addition, the "Sources of Information and Basis for Decision" section of the LCD and "Coding Guidelines" attachment were updated.

Effective date

This LCD revision is effective for claims processed **on or after March 7, 2014**, and for services rendered **on or after December 1, 2013**. First Coast Service Options, Inc. LCDs are available through the CMS

Medicare coverage database at: *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Noncovered services – revision to the Part A LCD

LCD ID number: L28991 (Florida) LCD ID number: L29023 (Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised January 1, 2014. Since that time, the LCD has been revised. The following Category III *Current Procedural Terminology®* (*CPT®*) codes were evaluated and were determined not to meet the medically reasonable threshold for coverage.

Therefore, Category III *CPT®* codes *0329T, 0330T, 0331T, 0332T, 0333T* and *0334T* were added to the noncovered services LCD and posted for a 45-day comment period extending from October 10, 2013 through November 23, 2013. Comments were received in favor of coverage for Category III *CPT®* code *0334T* (*Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized*), when performed, includes image guidance when performed (e.g., CT or fluoroscopic).

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the quality of the evidence per the program integrity manual. When addressing the articles and related information in the public domain, the jurisdiction 9 (J9) Medicare Administrative Contractor (MAC) reached the determination that available evidence was of moderate to low quality, consisting of small case series, retrospective studies, and review articles reporting limited safety and efficacy data for sacroiliac joint fusion procedures for the treatment of pain-related sacroiliac conditions.

Due to the unavailability of high quality evidence, the J9 MAC reiterates that there is insufficient scientific evidence to support use of sacroiliac fusion in treating low back pain due to sacroiliac joint syndrome, and therefore is not considered reasonable and necessary under section 1862(a)(1)(a) of the Social Security Act. The J9 MAC will maintain Category III *CPT®* code *0334T* in its noncovered services LCD.

Any denied claim would have Medicare's appeal rights. The second level of appeal (qualified independent contractor) requires review by a clinician to uphold any denial. Providers should submit for review all the relevant medical documentation and case specific information of merit and/or new information in the public domain.

An interested stakeholder can request a reconsideration of an LCD after the notice period has ended and the draft becomes active. In the case of the noncovered services LCD, the stakeholder may request the list of the articles and related information in the public domain that were considered by the medical policy department in making the noncoverage decision. If the stakeholder has new information based on the evaluation of the list of articles and related information, an LCD reconsideration can be initiated. It is the responsibility of the interested stakeholder to request the evidentiary list from the contractor and to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the web site.

Also, any interested party could request CMS to consider developing a national coverage determination (NCD). Of note, if the evidence is not adequate for coverage under section 1862(a)(1)(A), an item or service may be considered for coverage under the CMS Coverage with Evidence Development (CED) policy in which "reasonable and necessary" is established under 1862(a)(1)(E) of the Act. Under the authority of section 1862(a)(1)(E), the NCD process may result in coverage if the item or service is covered only when provided within a setting in which there is a pre-specified process for gathering additional data, and in which that process provides additional protections and safety measures for beneficiaries, such as those present in certain clinical trials.

Additionally, Category III *CPT®* codes *0254T* and *0255T* were removed from the *Procedures* section of the LCD as they may only be allowed if performed in a clinical trial approved by this contractor. For all claims submitted with Category III *CPT®* codes *0254T* or *0255T* the Q0 or Q1 modifier should be billed to indicate participation in the GORE study.

Effective date

The LCD revision for Category III *CPT®* codes *0329T, 0330T, 0331T 0332T, 0333T* and *0334T* is effective for services rendered **on or after March 17, 2014**. The LCD revision for Category III *CPT®* codes *0254T* and *0255T* is effective for claims processed **on or after January 30, 2014**, for services rendered **on or after December 1, 2013**. First Coast Service Options Inc. LCD's are available through the CMS Medicare coverage database at: *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

Rituximab (Rituxan®) – revision to the Part A LCD

LCD ID number: L28980 (Florida)
LCD ID number: L29013 (Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for rituximab (Rituxan®) was most recently revised June 08, 2012. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to add the off-labeled indication of steroid refractory chronic graft-versus host disease.

Also, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add the following dual diagnosis requirement: 279.52 must accompany underlying cause diagnosis code 996.85 or 996.88. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after February 20, 2014**. First Coast Service Options, Inc. LCDs are available through the CMS Medicare coverage database at:

http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

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

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

Skin substitutes – revision to the Part A LCD

LCD ID number: L28985 (Florida)
LCD ID number: L29327 (Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for skin substitutes was most recently revised April 1, 2013. Based on information from the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8572 (January 2014 Update of the hospital outpatient prospective payment system [OPPS]) the LCD and "Coding Guidelines" attachment were retired.

Effective January 1, 2014, CMS implemented 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 codes C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by *CPT*® codes *15271-15278*. The Part B LCD for skin substitutes (L29279/L29393) for office/clinics submitting claims is still effective.

Effective date

This LCD retirement is effective for services rendered **on or after January 1, 2014**. First Coast Service Options, Inc. LCDs are available through the CMS Medicare coverage database at: *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Autonomic function tests – revision to the Part A LCD

LCD ID number: L31465 (Florida, Puerto Rico/U.S. Virgin Islands)

Current Procedural Terminology® (*CPT*®) code *95943* was new for 2013 and at that time was added to the autonomic function tests (AFT) local coverage determination (LCD) as a result of the annual 2013 Healthcare Common Procedure Coding System (HCPCS) update.

It is described as an autonomic function test for simultaneous, independent, quantitative measures of both parasympathetic and sympathetic function. It was created to report when an autonomic function testing does not include beat-to-beat recording, or when testing without the use of a tilt table. It was determined that the clinical validity and clinical utility of these technologies have not been established and the qualifications of the personnel performing the testing are not standardized.

Therefore, *CPT*® code *95943* is being removed from the "*CPT*®/HCPCS codes" section of the LCD, and language is being added to the *Limitations* section of the LCD and the coding guidelines attachment indicating it does not meet the medically reasonable and necessary threshold for coverage.

Additionally, *CPT*® code *95924* (AFT with passive tilt testing), also new for calendar year 2013, was also added to the AFT LCD during the annual 2013 HCPCS update; however, the LCD does not specifically address this code. Therefore, the LCD has been revised to include limited indications for this testing.

Effective date

This LCD revision is effective for services rendered **on or after March 24, 2014**. First Coast Service Options, Inc. LCDs are available through the CMS Medicare coverage database at: *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Additional information

Self-administered drug (SAD) list – Part A: J3590/C9399/Q3026

The self-administered drug (SAD) list was most recently revised June 17, 2013. Since that time, based on the 2014 Healthcare Common Procedure Coding System (HCPCS) annual update, self-administered drug HCPCS code Q3026 (Interferon beta-1a [Rebif®]) was deleted.

Effective for services rendered **on or after January 1, 2014**, the following HCPCS codes have been added to the Medicare administrative contractor (MAC) for jurisdiction 9 (J9) Part A SAD list to replace HCPCS code Q3026.

- J3590/C9399 Injection, Interferon beta 1a, 11 mcg (Rebif®)

The First Coast Service Options Inc. (First Coast) SAD lists are available through the CMS Medicare Coverage Database at: *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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**

Modifying the common working file to include diagnosis codes on the HIPPA Eligibility Transaction System 270/271 transactions

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs and durable medical equipment Medicare administrative contractors (DME/MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8456, which informs Medicare contractors about changes to the Medicare beneficiary database (MBD) file to include diagnosis codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 transactions.

The HETS 271 response transaction will include as much Medicare secondary payer (MSP) information as possible to assist providers, physicians, and suppliers to identify which diagnosis codes are relevant to given MSP no-fault, liability, and workers' compensation cases.

The diagnosis codes that the provider community will access via the HETS 270/271 process will assist providers, physicians, and other suppliers to better determine when Medicare is the secondary payer in association with their patients' current liability, no fault, or workers' compensation incidents that may prompt beneficiaries to seek medical services. Please ensure that your billing staffs are aware of these changes.

Background

The HETS 270/271 process is used by providers, physicians, and other suppliers to receive individual beneficiary eligibility information under the Medicare program, including information found on the CWF MSP auxiliary file. Although most MSP information from the MSP record is currently included on the HETS 271 response transaction, International Classification of Diseases (ICD), Clinical Modification (CM), diagnosis codes are not included.

The Centers for Medicare & Medicaid Services (CMS) believes it would be beneficial for CWF to include ICD-CM diagnosis codes, as derived from MSP no-fault, liability, and workers' compensation MSP auxiliary records, on the interface file that it sends to MBD.

Through a separate Medicare Advantage Prescription Drug CR, CMS will ensure that the MBD table information that is exchanged with HETS will be modified to include ICD diagnosis codes.

Thereafter, the diagnosis codes will be included in the HETS 271 response transaction that CMS makes available to providers, physicians, and suppliers.

Since the HETS 271 response transaction can only accommodate up to eight diagnosis codes, CR 8456 instructs CWF to send up to 25 iterations of diagnosis codes associated with MSP no-fault, liability, and workers' compensation records for inclusion on the HETS 271 response transaction.

Additional information

The official instruction, CR 8456 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1356OTN.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: MM8456 Revised
Related Change Request (CR) #: CR 8456
Related CR Release Date: March 6, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R1356OTN
Implementation Date: October 6, 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.

Manual updates and therapy modifier consistency edits

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.

Provider action needed

This article is based on change request (CR) 8556, which creates edits in Medicare claims processing systems to ensure that certain 'always therapy' evaluation and reevaluation codes are reported with the correct modifier. It also makes several clarifications of details in the *Medicare Claims Processing Manual*, Chapter 5 - Part B outpatient rehabilitation and comprehensive outpatient rehabilitation facility (CORF) services.

CR 8556 contains no new policy. It updates Medicare systems and manuals to better reflect current published policies. Make sure that your billing staffs are aware of these updates.

Background

Longstanding Medicare billing instructions require reporting of discipline specific outpatient rehabilitation modifiers. All claims for therapy service healthcare common procedure coding system (HCPCS) codes must report a modifier that indicates the discipline of the plan of care under which the services are provided.

Through analysis of Medicare claims data, the Centers for Medicare & Medicaid Services (CMS) has identified cases where claims for discipline specific evaluation codes have reported the modifier corresponding to another discipline. For example, occupational therapy evaluations have been billed and paid while reporting a GP modifier (Services delivered under an outpatient physical therapy plan of care.). When information on a claim is clearly self-contradictory, as in this example, the claim should be returned to the provider for correction. The business requirements in CR 8556 create edits to do this, effective for dates of service July 1, 2014, and after.

In addition, CR 8556 updates *Medicare Claims Processing Manual*, Chapter 5 - Part B outpatient rehabilitation and comprehensive outpatient rehabilitation facility (CORF) services to reflect recent payment regulations. The fiscal year (FY) 2014 inpatient hospital final rule contained a policy regarding rebilling of Part B services when an inpatient stay is denied as not reasonable and necessary.

This policy is now included in Section 40.8 of Chapter 5 of the *Medicare Claims Processing Manual*. Specifically, it states that if a beneficiary receives therapy services during an inpatient hospital stay which was denied because the stay was not medically necessary, the therapy services may be rebilled under Medicare Part B coverage.

If the therapy would have been reasonable and necessary as hospital outpatient services, and provided the beneficiary has Part B entitlement, the services can be billed using type of bill 012x.

All payment and billing requirements for outpatient therapy (including therapy caps, functional reporting and other instructions in this chapter) apply to these claims.

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/R2868CP.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: MM8556
Related Change Request (CR) #: CR 8556
Related CR Release Date: February 6, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R2868CP
Implementation Date: July 7, 2014

Claim status category and claim status codes update

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8582 which informs Medicare contractors about the changes to claim status category codes and claim status codes. Make sure that your billing personnel are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the x12 276/277 health care claim status request and response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1).

These codes explain the status of submitted claim(s). Proprietary codes may not be used in the x12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each x12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*.

All code changes approved during the January 2014 committee meeting shall be posted on these sites on or about March 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes are to be used in the editing of all x12 276 transactions processed on or after the date of implementation and are to be reflected in x12 277 transactions issued on and after the date of implementation of CR 8582.

Additional information

The official instruction, CR 8582 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2884CP.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: MM8582
Related Change Request (CR) #: CR 8582
Related CR Release Date: February 24, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R2884CP
Implementation Date: April 7, 2014

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CWF editing for vaccines furnished at hospice – correction

Provider types affected

This *MLN Matters*® article is intended as an update for non-hospice providers furnishing vaccines to hospice beneficiaries and submitting claims to Medicare administrative contractors (MACs).

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8620 to alert providers that any provider background may furnish vaccines to hospice beneficiaries. Be sure your billing staffs are aware of this change.

When CR 8098, Transmittal 1298, was published, effective October 1, 2013, it denied claims for vaccines furnished to hospice patients that were provided by anyone other than the patient's hospice provider.

This was to enforce the statement in the *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.4 that vaccines "may be covered when furnished by the hospice." CMS has determined that this enforcement is too restrictive, since the manual does not say "only when furnished by the hospice." CR 8620 removes the changes made to Medicare systems in CR 8098, in order to allow any provider to furnish vaccines to hospice beneficiaries.

Key points

- Your MAC will allow professional claims for

(continued on next page)

RARC *(continued)*

vaccines (Influenza, PPV, and Hepatitis B) and vaccine administration containing modifier GW when the date of service falls within a hospice election.

- Your MAC will adjust vaccine claims with dates of service on or after October 1, 2013, which were previously rejected due to a hospice election, if you bring such claims to your MAC's attention.

Additional information

The official instruction, CR 8620 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1339OTN.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: MM8620
Related Change Request (CR) #: CR 8620
Related CR Release Date: February 6, 2014
Effective Date: October 1, 2013
Related CR Transmittal #: R1339OTN
Implementation Date: April 7, 2014

HIPAA eligibility transaction system to replace common working file Medicare beneficiary health insurance eligibility queries

Note: This article was revised February 10, 2014, to update certain language to reflect the current status of this change (see bolded language on page two). Also, clarifications have been made to the last question in the frequently asked questions section on page three. All other information is unchanged. This article was previously published in the May 2013 edition of *Medicare A Connection*, Pages 10-11.

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

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

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

Change request (CR) 8248 creates the ability for CMS to terminate these queries. While termination was originally scheduled for April 2014, CMS is delaying the date. CMS will provide at least 90 days advanced notice of the new termination date.

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

Provider types affected

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

Provider action needed

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

What you need to know

Background

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

(continued on next page)

HETS *(continued)*

and clearinghouses. HETS is Medicare's Health Care Eligibility Benefit Inquiry and Response electronic transaction, ASCX12 270/271 Version 5010, adopted under HIPAA.

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

Key points

General information

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

HETS

HETS allows Medicare providers and their agents to submit and receive X12N 270/271 eligibility request and response files over a secure connection. Many Medicare providers and their agents are already receiving eligibility information from HETS.

For more information about HETS and how to obtain access to the system, refer to the CMS HETS Help web page at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html*.

Frequently asked questions

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

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

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

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

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

Changes are currently underway in HETS to return psychiatric information to authorized providers and to return Hospice period information in the same format as CWF.

When these changes are made, HETS will return all of the information provided by the CWF eligibility queries that is needed to process Medicare claims. These changes will be in place before the termination date for the FISS DDE CWF query access.HETS returns additional information that CWF does not return. For example, HETS returns:

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

The *HETS 270/271 Companion Guide* provides specific details about the eligibility information that is returned in the HETS 271 response. The guide is available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf*.

Additional information

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

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Point of origin for admission for inpatient psychiatric facilities

Provider types affected

This *MLN Matters*® special edition article is intended for inpatient psychiatric facilities (IPFs) submitting claims to Part A/B Medicare administrative contractors (A/B MACs) that involve inpatient transfers within the same facility.

Provider action needed

Recovery auditors have conducted reviews of Medicare prospective payment system (PPS) claims for inpatient psychiatric facilities (IPF) services. These reviews have identified a substantial number of overpayments for inpatient psychiatric services directly following an acute care stay within the same facility.

These errors and overpayments occurred because the source of admission code 'D' was not applied to those claims. The point of origin for admission or visit code "D" (formerly the source of admission code) must be used when a patient is discharged from an acute-care stay in a hospital and transferred to the same hospital's inpatient psychiatric distinct part unit (DPU). Under the Medicare PPS, the Centers for Medicare & Medicaid Services (CMS) makes an additional payment to an IPF or a DPU for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department.

However, CMS does not make this payment if the beneficiary was discharged from an acute-care stay and transferred to its own hospital based IPF since payment for the emergency department services are included in the Medicare payment for the acute-care stay. The point of origin for admission or visit code "D" prevents this overpayment. The correct point of origin for admission or visit code (formerly source of admission) must be applied to prevent incorrect payments.

Case studies

Example 1: On January 10, 2010, an 85 year old female is admitted through the Emergency Room for a one day stay in an acute-care inpatient hospital setting. On January 11, 2010, the patient is admitted to the inpatient psychiatric unit of the same facility. The claim for this admission was submitted with point of origin for admission or visit code "1" (physician referral).

Resolution: Because the January 11 admission was a transfer from the same facility, the point of origin for admission or visit code should be coded "D". The incorrect source of admission code resulted in an overpayment of $105.06.

Example 2: On January 19, 2012, a 63-year-old male is admitted through the emergency room for a two day stay in an acute-care inpatient hospital setting.

On January 21, 2012, the patient is admitted to the inpatient psychiatric unit of the same facility. The claim for this admission was submitted with point of origin for admission or visit code "2" (clinic referral).

Resolution: Because of the January 21 admission was a transfer from the same facility, the point of origin for admission or visit code should be coded "D". The incorrect source of admission code resulted in an overpayment of $98.15.

Additional information

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*.

For more information about IPFs and use of point of origin for admission or visit code D, see the *MLN Matters*® article SE1020 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1020.pdf*.

MM3881 also provides additional information about point of origin for admission or visit code 'D' at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM3881.pdf*.

To review the inpatient psychiatric facility prospective payment system fact sheet that provides detailed information about the background, coverage requirements, payment rates, fiscal year 2013 updates to the IPF PPS, quality reporting, and resources; visit *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/InpatientPsychFac.pdf*.

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Medicare claims processing guidance for implementing international classification of diseases, 10th Edition – a re-issue of MM7492

Provider types affected

This *MLN Matters*® special edition article is intended for all physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider action needed

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA.

The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014.

As a result of change request (CR) 7492 (and related *MLN Matters*® article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013 implementation date for ICD-10.

This article updates MM7492 to reflect the October 1, 2014, implementation date. Make sure your billing and coding staffs are aware of these changes.

Key points of SE1408

General reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time.

Please refer to *http://www.cms.gov/Medicare/Coding/ICD10/index.html* for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General claims submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2014. Institutional claims containing ICD-9 codes for services on or after October 1, 2014, will be returned to provider (RTP) as unprocessable.

Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2014, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code.

A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2014, submit claims with the appropriate ICD-9 diagnosis code.

For dates of service on or after October 1, 2014, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim.

For claims with dates of service prior to October 1, 2014, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2014, submit with the appropriate ICD-10 procedure code.

Remember that ICD-10 codes may only be used for services provided on or after October 1, 2014. Institutional claims containing ICD-10 codes for services prior to October 1, 2014, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2014, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Claims that span the ICD-10 implementation date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered September 30, 2014, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2014, and later.

In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2014. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

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ICD-10 *(continued)*

Table A – Institutional providers

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH Date
11x	Inpatient hospitals *(incl. TERFHA hospitals, prospective payment system (PPS) hospitals, long term care hospitals (LTCHs), critical access hospitals (CAHs)*	If the hospital claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
12x	Inpatient Part B hospital services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
13x	Outpatient hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
14x	Non-patient laboratory services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

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ICD-10 *(continued)*

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH Date
18x	Swing beds	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
21x	Skilled nursing (Inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
22x	Skilled nursing facilities (Inpatient Part B)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
23x	Skilled nursing facilities (Outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
32x	Home health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2014, but require those claims to be submitted using ICD-10 codes.	THROUGH

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ICD-10 *(continued)*

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH Date
3X2	Home health – request for anticipated payment (RAPs)*	* **Note** - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corres-ponding final claim will need to use an ICD-10 code if the HH episode spans beyond 10/1/2014.	*See note
34x	Home health – (Outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
71x	Rural health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/20143 and later.	FROM
72x	End stage renal disease (ESRD)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
73x	Federally qualified health clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A

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ICD-10 *(continued)*

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH Date
74x	Outpatient therapy	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
75x	Comp-rehensive outpatient rehab facilities	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
76x	Community mental health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
77x	Federally qualified health clinics (effective 4/4/10)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

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ICD-10 *(continued)*

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH Date
81x	Hospice-hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
82x	Hospice – non hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
83x	Hospice – hospital based	N/A	N/A
85X	Critical access hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

Table B - Special outpatient claims processing circumstances

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2014, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

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ICD-10 *(continued)*

Table C – Professional claims

Type of Claim	Claims processing requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/14 but end on 10/1/14 are to be billed with ICD-9 diagnosis codes and use 9/30/14 as both the FROM and THROUGH date	FROM

Table D –Supplier Claims

Supplier type	Claims processing requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/14 (i.e., the FROM date of service occurs prior to 10/1/14 and the TO date of service occurs after 10/1/14).	FROM

Additional information

You may also want to review SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2014.

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*.

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Get ready for ICD-10

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

This transition is going to change how you do business—from registration and referrals to superbills and software upgrades. But that change doesn't have to be overwhelming. CMS has the following resources to help your practice prepare for the transition.

Online ICD-10 guide

ICD-10 basics for medical practices

ICD-10 frequently-asked questions

Medicare fee-for-service ICD-10 testing approach

Provider types affected

This article is intended for all physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider action needed

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA.

The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014. Be sure you are ready. This *MLN Matters*® special edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of International Classification of Diseases, 10th Edition (ICD-10) represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2014, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing to ensure that CMS as well as the Medicare fee-for-service (FFS) provider community is ready.

When "you" is used in this publication, we are referring to the FFS provider community.

The four-pronged approach includes:

- CMS internal testing of its claims processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail below.

CMS internal testing of its claim processing

CMS has a very mature and rigorous testing program for its Medicare FFS claim processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for eight weeks;
- Beta testing is performed by a separate integration contractor for eight weeks; and
- Acceptance testing is performed by each MAC for four weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claim processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-initiated Beta testing tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of beta versions of its software that include ICD-10 codes as well as national coverage determination (NCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*. The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at *http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html*. On this Web page, you can also find current versions of the ICD-10-CM MS-DRG grouper, Medicare code editor (available from National Technical Information Service), and MS-DRG Definitions Manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- A pilot version of the October 2013 integrated outpatient code editor (IOCE) that utilizes ICD-10-CM located at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf*. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in August 2014.

Crosswalks for local coverage determinations (LCDs) will be available April 2014.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2014, you should investigate downloading the free billing software that CMS offers from their MACs. The software has been updated to support ICD-10 codes and requires an internet connection. Alternatively, many MACs offer provider Internet portals, and some MACs offer a subset of these portals that you can register for to ensure that you have the flexibility to submit professional claims this way as a contingency.

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Acknowledgement testing

CMS offered ICD-10 acknowledgement testing from March 3–7, 2014. This testing allowed all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes.

While test claims were not adjudicated, the MACs returned an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected. For more information about acknowledgement testing, refer to the information on your MAC's website.

CMS is exploring offering other weeks of acknowledgement testing after it analyzes the results of the March 2014 testing week.

End-to-end testing

In summer 2014, CMS will offer end-to-end testing to a small sample group of providers. Details about the end-to-end testing process will be disseminated at a later date.

End-to-end testing includes the submission of test claims to CMS with ICD-10 codes and the provider's receipt of a remittance advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claim systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The small sample group of providers who participated in end-to-end testing were selected to represent a broad cross-section of provider types, claims types, and submitter types.

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/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html*.

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Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

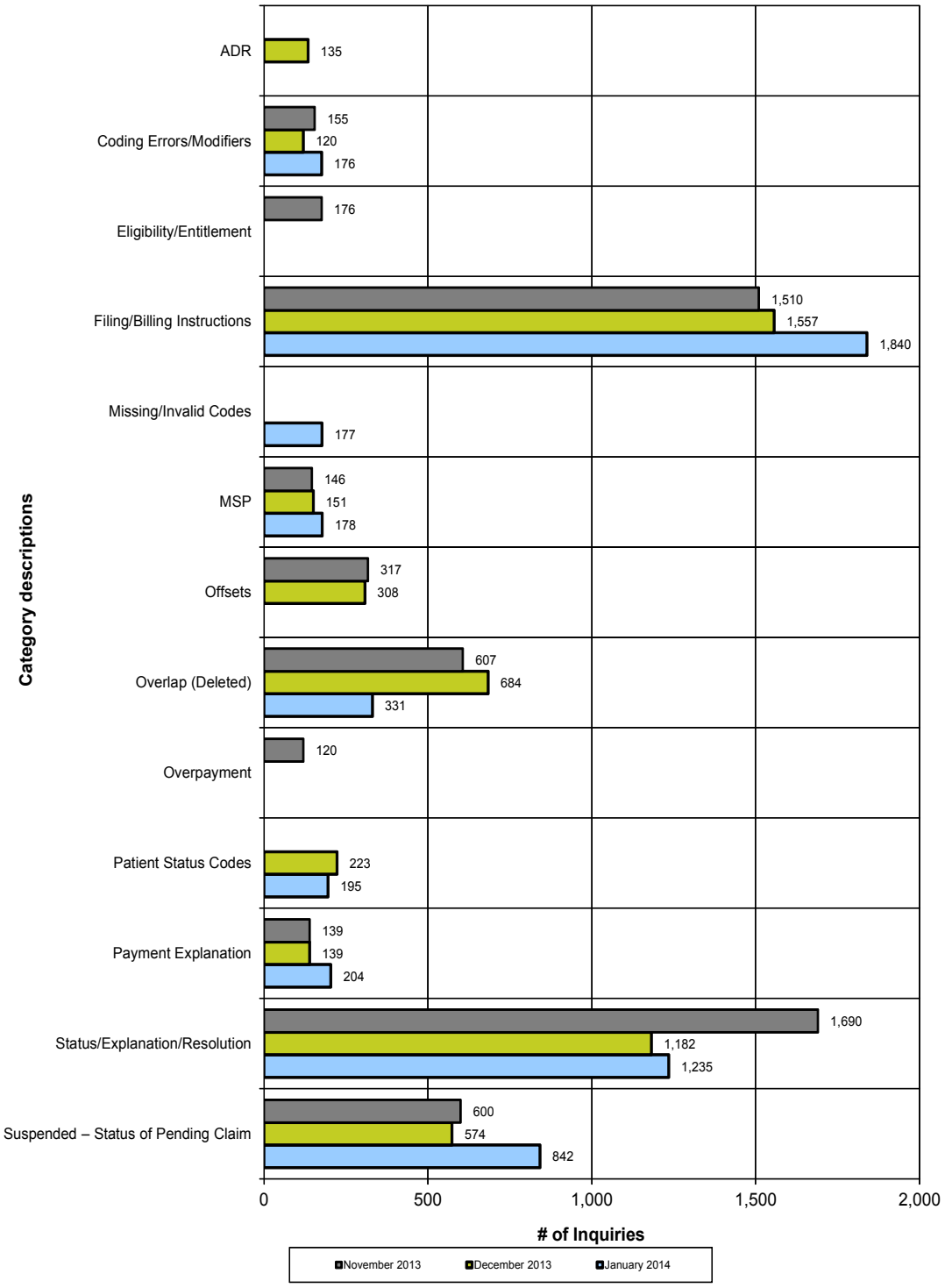
You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

Top inquiries, rejects, and return to provider claims November 2013 through January 2014

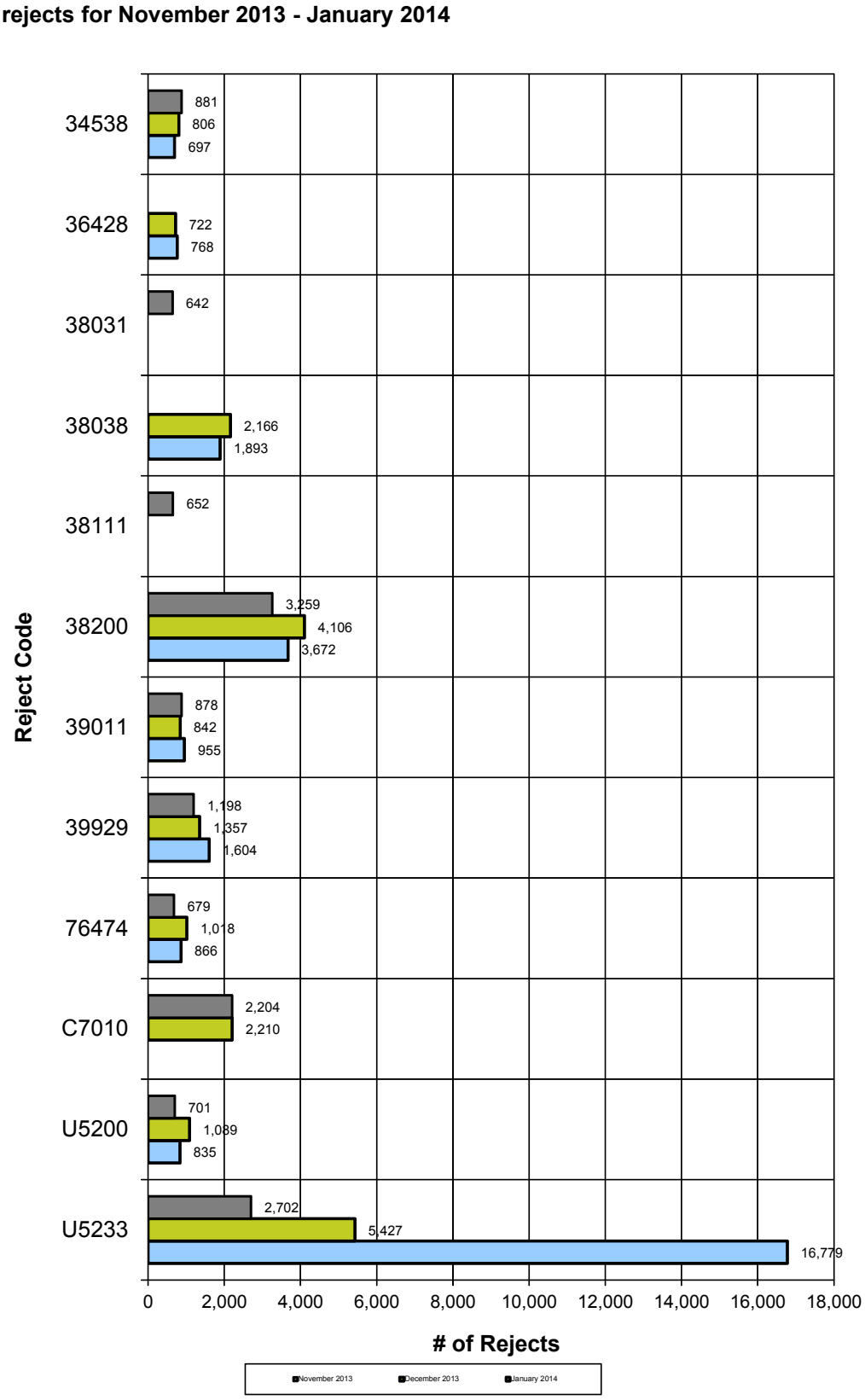
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during November 2013 through January 2014.

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 November 2013 - January 2014

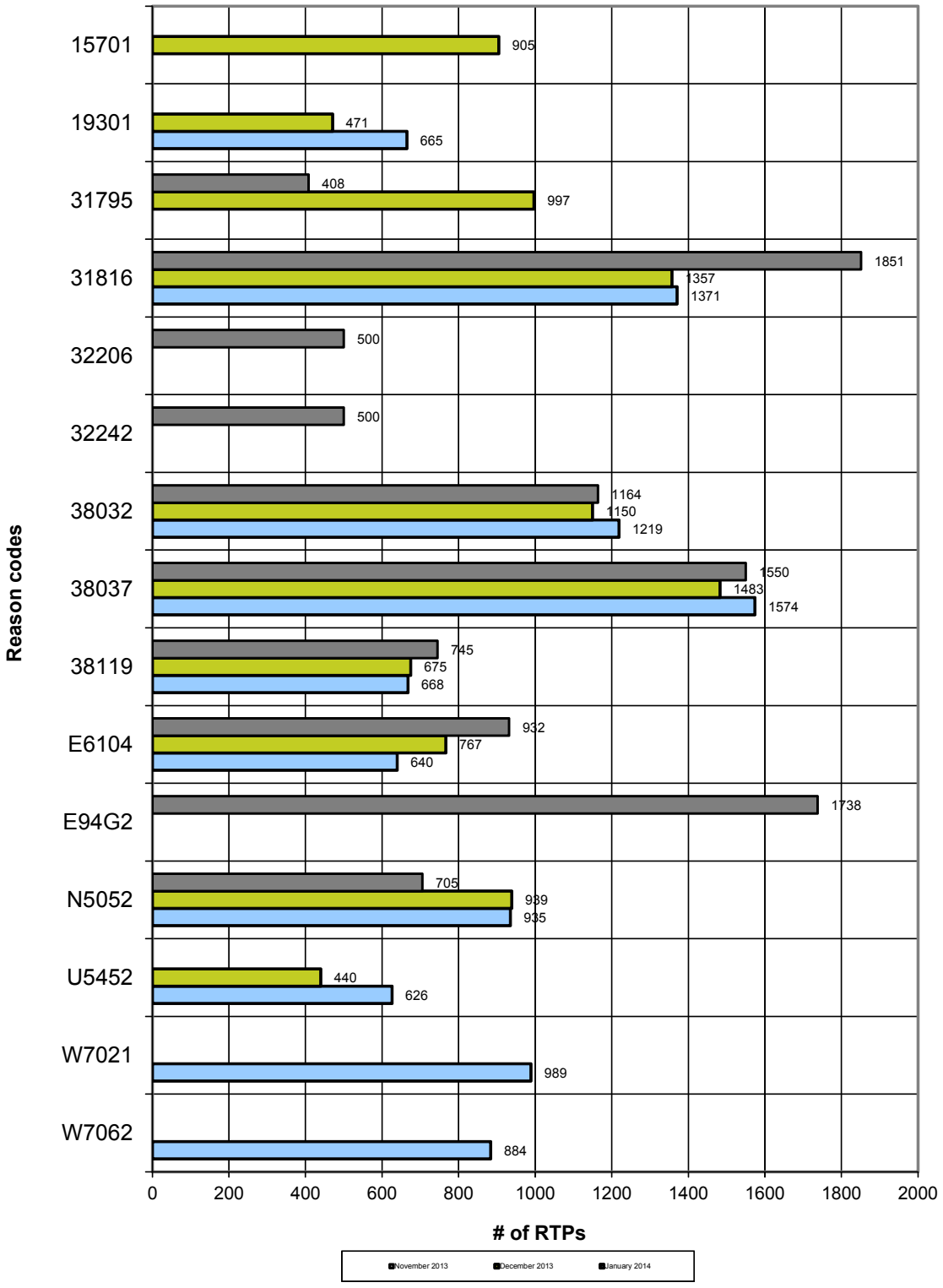


Part A top rejects for November 2013 through January 2014



Part A top return to providers (RTPs) for November 2013 through January 2014

Top RTPs for November 2013 - January 2014



Medicare billing drugs and biologicals in multiples

Drugs and biologicals should be billed in multiples of the dosage specified in the Healthcare Common Procedure Coding System (HCPCS) long descriptor. The number of units billed should be assigned based on the dosage increment specified in the HCPCS long descriptor and correspond to the actual amount of the drug administered to the patient, including any appropriate discarded drug waste. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest units.

As outlined in the Centers for Medicare & Medicaid (CMS) *Medicare Claims Processing Manual*, Publication 100-04, Chapter 17 Section 10 and Section 40.

Drugs are billed in multiples of the dosage specified in the HCPCS code long descriptor. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit based on the HCPCS long descriptor for the code in order to report the dose provided.

If the full dosage provided is less than the dosage for the HCPCS code descriptor specifying the minimum dosage for the drug, the provider reports one unit of the HCPCS code for the minimum dosage amount.

The CMS encourages physicians, hospitals and other providers and suppliers to care for and administer to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.

When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.

Multi use vials are not subject to payment for discarded amount of drug or biological.

Documentation requirements

- Documentation in the medical record should include:
- Name of drug
- Date administered
- Time administered
- Amount given (gram, microgram, international unit, etc.)
- Route (intravenous, intramuscular, subcutaneous, etc.)
- Quantity of drug wastage as applicable.
- Name and credentials of person administering drug

For further details on billing drugs and biologicals please refer to the *CMS Medicare Claim Processing Manual, Publication 100-04, Chapter 17*.

Reporting principal and interest amounts when refunding previously recouped money on the remittance advice

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers submitting claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8485 which informs MACs about changes necessary to create a new process that insures refunded principal and associated interest amounts can be reported separately on remittance advices and that claim identifiers are used to identify the appropriate claim for which those amounts apply. Make sure that your billing staffs are aware of these changes.

Background

CMS was advised that the current practice of reporting principal and interest amounts for all related claims on the remittance advice (RA) as one lump sum amount was creating problems for the provider community since it was not conducive to the proper posting of payments. CR 8485 instructs the MACs on how to report refunded principal and interest amounts separately and how to use claim identifiers to indicate the appropriate claim for those amounts. Providers should see these changes appear on RAs created after CR 8485 is implemented on July 7, 2014.

Step-by-step instructions on how refunds with interest

(continued on next page)

April 2014 quarterly average sales price Medicare Part B drug pricing files and revisions

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including durable medical equipment MACs (DME MACs) and home health & hospice MACs (HH&H MACs) for services to Medicare beneficiaries.

Provider action needed

Medicare will use the April 2014 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 1, 2014, with dates of services from April 1, 2014, through June 30, 2014.

Change request (CR) 8607, from which this article is taken, instructs Medicare contractors to implement the April 2014 ASP Medicare Part B drug pricing file for Medicate Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January 2014, October 2013, July 2013, and April 2013 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual*, Chapter 4, section 50 Outpatient PRICER.

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

Files	Effective for dates of service
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014
January 2014 ASP and ASP NOC	January 1, 2014, through March 31, 3014
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013

Additional information

The official instruction, CR 8607 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2863CP.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: MM8607
Related Change Request (CR) #: CR 8607
Related CR Release Date: January 24, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R2863CP
Implementation Date: April 7, 2014

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Reporting *(continued)*

on previously recouped money are handled (including step(s) required by providers), as well as an example of reporting for the new Refund PLB Codes, are found in Attachment 1 to this CR.

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/R1342OTN.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: MM8485
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Related CR Release Date: February 6, 2014
Effective Date: July 1, 2014
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Implementation Date: July 7, 2014

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Applying the therapy caps to critical access hospitals

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administrative contractors (MACs) for outpatient therapy services provided in a critical access hospital (CAH) setting to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8426 and alerts providers that:

- Beginning January 1, 2014, outpatient therapy services furnished by a CAH are subject to the therapy cap and related policies;
- Pursuant to statute, the exceptions process, including the use of the KX modifier to attest the medical necessity of therapy services above the caps, applies to services furnished by a CAH in 2014;
- Similarly, pursuant to statute, the manual medical review of claims in excess of the $3,700 threshold applies to services furnished by a CAH in 2014; and
- MACs will no longer automatically apply the KX modifier to CAH services, effective January 1, 2014. Please be sure your billing staffs are aware of this fee update.

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

Background

The Balanced Budget Act of 1997, Section 4541c, amended Section 1833(g) of the Act to create annual limits on per beneficiary incurred expenses on therapy services known as the "therapy caps."

This provision expressly applies the therapy caps to outpatient therapy services described at Section 1861(p) of the Social Security Act (or the Act), which also applies to therapy services described under Sections 1861(g) and 1861(ll)(2) of the Act, and exempts outpatient therapy services described in Section 1833(a)(8)(B) of the Act, which is known as the "outpatient hospital services exemption."

When the therapy caps were implemented in 1999, the Centers for Medicare & Medicaid Services (CMS) interpreted the outpatient hospital services exemption to include therapy services furnished by a CAH.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) temporarily removed the outpatient hospital services exemption from October 1, 2012, through December 31, 2012. CMS concluded that the MCTRJCA amendment only affected the outpatient hospital services described under Section 1833(a)(8)(B) of the Act for which payment is made under Section 1834(k)(1)(B) of the Act. (MCTRJCA, Section 3005; see *http://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.pdf)*.

The American Taxpayer Relief Act of 2012 (ATRA) removed the outpatient hospital services exemption through December 31, 2013. The ATRA also amended the Act to count outpatient therapy services furnished between January 1, 2013, and December 31, 2013, by a CAH towards a beneficiary's annual cap and threshold using the amount that would be payable if such services were paid under Section 1834(k)(1)(B) of the Act instead of being paid under Section 1834(g) of the Act.

The ATRA amendment specifically does not change the method of payment for outpatient therapy services furnished by a CAH. CMS concluded that the ATRA amendment does not explicitly make the therapy caps applicable to services furnished by CAHs, but provides a methodology to count CAH services towards the caps using the Medicare physician fee schedule rate. As a result, from October 1, 2012, to December 31, 2013, CAH services came to be exempt from the therapy caps, whereas services furnished in other outpatient hospital settings are subject to the cap policies.

In August 2012, CMS issued CR 7881, which created a mechanism to allow Medicare administrative contractors (MACs) both to count CAH services towards the cap amounts and to apply the caps to services furnished by CAHs, if necessary. In order to ensure that CAH services counted towards the cap amounts without being subject to the cap policy, CMS issued subsequent instructions for MACs to automatically apply the KX modifier to CAH services found to be over the caps, effective January 1,2013.

To review CR 7881 you may go to *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2537CP.pdf*. A related *MLN Matters*® article MM7881 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7881.pdf.*

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Implementing Part B inpatient payment policies from CMS-1599-F

Provider types affected

This *MLN Matters*® article is intended for 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) 8445 which provides details regarding the implementation of payment policies related to hospital Part B inpatient billing from the final regulation CMS-1599-F. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2014 inpatient prospective payment system (IPPS) /long-term care hospital (LTCH) final rule (CMS-1599-F; CMS-1455-F), August 19, 2013, in which CMS finalized a policy to provide additional payment under Medicare Part B for hospital inpatient services when a hospital inpatient admission is determined not reasonable and necessary for payment under Medicare Part A, and the beneficiary should have been treated as a hospital outpatient.

You can find the CMS "FY 2014 IPPS/LTCH Final Rule Home Page" at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html.*

CR 8445 provides claims processing guidance related to the implementation of this policy for all hospitals and critical access hospitals (CAHs). CR 8445 contains related revisions to the *Medicare Claims Processing Manual* (Pub. 100-04), and CMS will issue companion revisions to the *Medicare Benefit Policy Manual* (Pub. 100-02) in a separate release.

Payment of Part B inpatient services

When Medicare Part A payment cannot be made because an inpatient admission is found to be not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient rather than a hospital inpatient, Medicare will allow payment under Part B of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status, provided the beneficiary is enrolled in Medicare Part B and provided the allowed timeframe for submitting claims is not expired.

The policy applies to all hospitals and critical access hospitals (CAHs) participating in Medicare, including those paid under a prospective payment system or alternative payment methodology such as state cost control systems, and to emergency hospitals services furnished by nonparticipating hospitals. In this document and in CR 8445, the term "hospital" includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

This policy applies when a hospital determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit).

If the hospital already submitted a claim to Medicare for payment under Part A, the hospital must cancel its Part A claim prior to submitting a claim for payment of Part B services. Whether or not the hospital has submitted a claim to Part A for payment, Medicare requires the hospital to submit a "no pay" Part A claim indicating that the provider is liable under Section 1879 of the Social Security Act for the cost of the Part A services. The hospital may then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

Those services that specifically require an outpatient status includes those that are, by definition, provided

(continued on next page)

Therapy *(continued)*

Additional information

The official instruction, CR 8426 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2859CP.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: MM8426
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Related CR Release Date: January 17, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R2859CP
Implementation Date: January 31, 2014

Part B *(continued)*

to hospital outpatients and not inpatients, including:

- Hospital outpatient visits (emergency department and clinic visits); Observation services;
- Diabetes self-management training services.

Hospitals may not bill for inpatient routine services in a hospital. Inpatient routine services generally are those services included by the provider in a daily service charge – sometimes referred to as the "room and board" charge.

Payable and non-payable services are further described in the update of the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital – Including Inpatient Hospital Part B and OPPS); Section 240 which is attached to CR 8445.

Part B inpatient services are billed using the 12x TOB.

For Part B inpatient services furnished by the hospital that are not paid under the OPPS, but rather under some other Part B payment mechanism, Part B inpatient payment will be made pursuant to the Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients. All hospitals billing Part A services are eligible to bill the Part B inpatient services, including

- Short-term acute-care hospitals paid under the IPPS;
- Hospitals paid under the OPPS;
- Long-term care hospitals (LTCHs);
- Inpatient psychiatric facilities (IPFs) and IPF hospital units;
- Inpatient rehabilitation facilities (IRFs) and IRF hospital units;
- Critical access hospitals (CAHs);
- Children's hospitals;
- Cancer hospitals; and
- Maryland waiver hospitals.

Hospitals paid under the OPPS continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in Title 42 of the *Code of Federal Regulations (CFR)* section 419.20(b) are eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies. For more information regarding 42 CFR 419.20(b), refer to *http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=f0a3c4c0d051e60e0bf1fe559cc9dfdf&tpl=/ecfrbrowse/Title42/42cfr419_main_02.tpl*.

Other circumstances when part a payment cannot be made

CMS notes that there are no changes to the policies for billing Part B under other circumstances when

Part A payment cannot be made. For example, when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for a limited set of ancillary Part B inpatient services. Some of these services are typically packaged for payment under the OPPS, and the primary service into which they are packaged is not payable.

In these circumstances, CMS will provide separate payment for the ancillary Part B inpatient service. For example, hospitals should continue to use HCPCS code C9899 created by CMS to obtain separate payment under this provision for certain implantable prosthetic devices which replace all or part of an internal body organ and do not have pass-through payment status. However, CMS revised the *Medicare Claims Processing Manual* Ch. 4 Sec. 240 to specify that this code should not be used when billing Part B following a reasonable and necessary Part A denial, because the primary service (the implantation surgery) is a payable Part B inpatient service and payment of the device is packaged with the surgery.

Payment of Part B services in the payment window for outpatient services treated as inpatient services when payment cannot be made under Part A

Medicare continues the current policy allowing hospitals to bill Part B for services furnished by the hospital that were bundled into the original Part A claim under the three-day (one-day for non-IPPS hospitals) payment window prior to the inpatient admission.

CMS revised the manual to clarify that if these services were furnished by the hospital (including referred hospital lab tests), they may be billed to Part B. CMS is clarifying that both 13x (85x for CAH) and 14x TOB may be submitted for payment of these services, subject to the revised manual instructions.

Timely filing and supporting documentation

Timely filing restrictions will apply for the Part B services billed. Therefore, Part B claims that are filed beyond 12 months from the date of service will be

(continued on next page)

Part B *(continued)*

rejected as untimely and will not be paid. Hospitals are required to maintain documentation to support the services billed on the Part B claim(s).

Provider and beneficiary liability

A "no-pay" provider-liable Part A claim (110 TOB) must be present in the claims history before accepting the Part B claim(s) for payment. The no-pay Part A claim indicates that the provider and not the beneficiary is liable under the Social Security Act (Section 1879; see *http://www.socialsecurity.gov/OP_Home/ssact/title18/1879.htm*) for the cost of the Part A services. Submission of this claim cancels any claim that may have already been submitted by the hospital for payment under Part A.

When a Medicare review contractor denies a Part A claim for medical necessity, the claims system converts the originally submitted 11x claim to a 110 TOB on behalf of the hospital. When the hospital and not the beneficiary is liable for the cost of the Part A services (pursuant to the limitation on liability provision in Section 1879 of the Social Security Act), the beneficiary is not responsible for paying the deductible and coinsurance charges related to the denied Part A claim and the beneficiary's Medicare utilization record is not charged for the services and items furnished.

The hospital must refund any payments (including coinsurance and deductible) made by the beneficiary or third party for a denied Part A claim when the provider is held financially liable for that denial (see section 1879(b) of the Act; 42 CFR § 411.402; and chapter 30 §§ 30.1.2, "Beneficiary Determined to Be Without Liability" and 30.2.2, "Provider/Practitioner/Supplier is Determined to Be Liable" of the *Medicare Claims Processing Manual*).

If the beneficiary's liability under Part A for the initial claim submitted for inpatient services is greater than the beneficiary's liability under Part B for the inpatient services they received, the hospital must refund the beneficiary the difference between the applicable Part A and Part B amounts. Conversely, if the beneficiary's liability under Part A is less than the beneficiary's liability under Part B for the services they received, the beneficiary may face greater cost sharing.

Summary of business requirements for CR 8445:

MACs will ensure that provider submitted medical necessity denial claims contain the occurrence span code "M1" and dates on the inpatient claim.

Hospital Part B Inpatient service claims that are billed after a medical necessity denial should contain the following data elements:

- A treatment authorization code of A/B rebilling submitted by a provider.
- **Note**: Providers submitting an 837I will be instructed to place the appropriate Prior Authorization code above into Loop 2300 REF02

(REF01 = G1) as follows: REF*G1*A/B Rebilling~

  - For DDE or paper claims, "A/B Rebilling" will be added in FL 63.
- A condition code "W2" attesting that this is a rebilling and no appeal is in process, and
  - The original denied inpatient claim (CCN/DCN/ICN) number, and
  - Note: Providers submitting an 837I will be instructed to place the DCN in the Billing notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234~
  - For DDE or paper claims, providers will be instructed to use the word "ABREBILL" plus the denied inpatient DCN/CCN/ICN will be added to the remarks field (form locator #80) on the claim using the following format: "ABREBILL12345678901234".
  - **Note**: The numeric string above (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.
- MACs will return to provider a TOB 121 A/B Rebilling claim that does not have a medical denied 11x claim in history that matches the DCN in remarks.
- MACs will dismiss redetermination requests of Part A 11x claims if the provider has previously billed a 121 A/B rebilling claim. However, contractors will accept appeal requests of A/B rebilled 121 claims.
- Medicare will not allow observation services (Revenue code 762), and outpatient visits (Revenue codes 45x and 51x) to be billed on the A/B rebilling 121 TOB claim. (This includes G0738, G0739, 99201-99215, 99281-99285, G0380-G0384, and G0463.)

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Part B *(continued)*

- Additionally, Medicare's claims processing systems will set edits to prevent payment on type of bill 12x for claims containing the revenue codes listed as follows:

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	029x
0390	0399	045x	050x	051x	052x	054x	055x
056x	057x	058x	059x	060x	0630	0631	0632
0633	0637	064x	065x	066x	067x	068x	072x
0762	082x	083x	084x	085x	088x	089x	0905
0906	0907	0912	0913	093x	0941	0943	0944
0945	0946	0947	0948	095x	0960	0961	0962
0963		0969	097x	098x	099x	100x	210x
310x							

* In the case of revenue code 0964, this is used by hospitals that have a CRNA exception.

Additional information

The official instruction, CR 8445 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2877CP.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*.

You can review the FY 2014 IPPS/LTCH Final Rule (CMS-1599-F; CMS-1455-F) displayed in the *Federal Register* Vol. 78, No. 160 dated August 19, 2013 at *http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf*.

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Probe & educate medical review strategy: probe reviews of inpatient hospital claims and corresponding provider outreach and education

Provider types affected

This *MLN Matters*® special edition (SE) is intended for providers and suppliers who submit institutional claims to Medicare administrative contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries.

What you need to know

This article describes a focused prepayment medical review strategy for MACs to conduct prepayment review of inpatient hospital claims with dates of admission from October 1, 2013, through March 31, 2014. See the *Background* and *Additional information* sections of this article for further details regarding these changes, and make sure that your billing staffs are aware of these changes.

Background

The focused prepayment medical review strategy for MACs is being implemented to:

- Ensure provider understanding of 42 CFR 412.3, and
- Provide responsive provider-specific education, as necessary, to correct improper payment(s).

On August 2, 2013, the Centers for Medicare & Medicaid Services (CMS) released regulation number CMS-1599-F (Fiscal Year (FY) 2014 Hospital Inpatient Prospective Payment System (PPS) Final Rule), in which CMS clarifies and modifies its guidance regarding the proper billing of inpatient hospital stays.

This regulation is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html*. This rule, as codified, is available at *http://www.ecfr.gov/cgi-bin/textidx?SID=e41124920411234f0c9a1897eac4225b&node=42:2.0.1.2.12&rgn=div5*.

The FY 2014 hospital inpatient PPS final rule helps clarify when a beneficiary should be admitted as an inpatient to any acute care hospital, long-term care hospital (LTCH), inpatient psychiatric facility (IPF), or critical access hospital (CAH). This rule is not applicable to inpatient admissions at inpatient rehabilitation facilities (IRFs).

The rule is applicable to inpatient admissions beginning on or after October 1, 2013. Under the rule, if an admitting physician expects a beneficiary's surgical procedure, diagnostic test, or other treatment (not specifically designated as inpatient-only) to require a medically necessary stay in the hospital spanning two or more midnights, it is generally appropriate for the physician to order and formally admit the beneficiary as an inpatient and for the claim to be paid under Medicare Part A.

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Probe *(continued)*

The rule emphasizes the need for a formal inpatient admission order to begin inpatient status and time (as it relates to skilled nursing facility (SNF) coverage or other benefit eligibilities).

However, the rule permits the physician and the medical reviewer to consider all time a beneficiary has spent in the hospital receiving continuous hospital services, including outpatient services (such as observation services and treatment in the emergency department, operating room, or other treatment area), in guiding their two-midnight expectation.

The probe and educate reviews will allow CMS to identify those providers that have properly understood and implemented the two-midnight benchmark, and those providers who might benefit from additional education, as evidenced by high claim error rates.

Probe sample medical reviews

- MACs will review a pre-payment, provider-specific probe sample of inpatient hospital Part A claims for appropriateness of inpatient admission under the revised two-midnight benchmark with dates of admission between October 1, 2013 and March 31, 2014.
- Samples will only be selected from acute care inpatient hospitals, LTCHs, and IPFs impacted by CMS-1599-F.

Note: MACs will send additional documentation requests (ADRs) per the timelines provided in Chapter 3 of the CMS *Program Integrity Manual* (see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf*).

- MACs will review the claims in conjunction with review instruction provided by CMS and shared with providers at *http://go.cms.gov/InpatientHospitalReview* in our *Reviewing Hospital Claims for Patient Status* document.
- MACs will send detailed results letters for all providers per current *Program Integrity Manual* instruction.
- MACs will indicate in their letters the offer for 1:1 telephone explanations, as needed, for providers requiring moderate-significant or major corrective action.

Note: This requirement will include sending result letters to providers with no findings.

Review results letters required per the general complex probe process will be sent per the guidance provided in Chapter 3 of the CMS *Program Integrity Manual* (Publication 100-08; see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf*).

Education and corrective action

- MACs will implement, upon review of the completed probe, corrective action plans on a provider specific basis. Provider concern levels will be categorized as minor, moderate, or major concerns.

1. **Minor concern**: A provider with a low error rate and no pattern of errors, defined as 0-1 errors out of 10 claims or 0-2 errors out of 25 claims. MACs will educate the provider via the results letter indicating the reasons for denial of the inpatient claim.
2. **Moderate-significant concern**: A provider with a moderate error rate, defined as 2-6 errors out of 10 claims or 3-13 errors out of 25 claims. MACs will offer 1:1 telephonic provider education in addition to the written review results letters. MACs will repeat the probe strategy for dates of admission January through March 2014.
3. **Major concern**: A provider with a high error, defined as seven or more errors out of 10 claims or 14 or more errors out of 25 claims. MACs will offer 1:1 telephonic provider education in addition to the written review results letters. MACs will repeat the probe strategy for dates of admission January through March 2014.
4. If at the end of the six month review period continuing major concerns are identified, MACs will select 100 claims (for providers with 10 sampled claims) and 250 claims (for providers with 25 sampled claims) for additional review.

Additional information

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*. Questions pertaining to the probe & educate medical review strategy may also be submitted to *IPPSAdmission@cms.hhs.gov*.

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Implementation Date: n/a

New fields and expansion of existing model 1 discount percentage field in the inpatient hospital provider specific file in the IPPS pricer output

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8546 which informs MACs about changes to the PSF. The PSF is maintained by MACs to facilitate proper payments to providers.

Note: CR 8546 is not implementing the hospital acquired condition (HAC) reduction program initiative or the electronic health records (EHR) incentive program, but is only preparing the Centers for Medicare & Medicaid Services (CMS) systems for the future. Specific instructions implementing these programs, including manual updates to Addendum A of the *Medicare Claims Processing Manual*, will be issued in the future in the event these policies are finalized. Make sure that your billing staffs are aware of these changes.

Background

Section 3008 of the Affordable Care Act establishes a program, beginning in fiscal year (FY) 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. Under the HAC reduction program, hospitals that rank in the lowest-performing quartile of selected HAC measures will be subject to a reduction of what they would otherwise be paid under the IPPS.

Section 3133 of the Affordable Care Act provides for an additional payment for a hospital's uncompensated care. Each Medicare disproportionate-share (DSH) hospital will receive an uncompensated care payment (UCP) based on its share of uncompensated care as calculated by CMS for Medicare DSH hospitals. Currently, for FY 2014, the estimated per claim UCP amount is stored in PRICER. In order to make changes to the amounts more efficient, CMS is adding the estimated per claim UCP amount to the PSF.

The Medicare EHR incentive program provides incentive payments for eligible acute-care inpatient hospitals that are meaningful users of certified EHR technology. Eligible-acute care inpatient hospitals are defined as "subsection (d) hospitals"—which are generally hospitals that are paid under the IPPS and are located in one of the 50 states or the District of Columbia. Hospitals that are not meaningful users of certified EHR technology will be subject to payment adjustments beginning in FY 2015.

Model 1 of the bundled payments for care improvement (BPCI) initiative provides a discounted payment to Model 1 participating hospitals for the acute-care hospital stay. The discount will be phased in over the performance period of three years. To accommodate the 0.5 percent discount for months 7 to 12, the Model 1 discount percentage field in the PSF must be expanded.

Summary of CR 8546 changes

The inpatient PSF will be expanded to include three new fields and an expansion of the existing Model 1 discount percentage field as follows:

1. Add an indicator for hospitals subject to the hospital acquired conditions (HAC) reduction program for future implementation.
2. Add an estimated interim per claim uncompensated care payment amount.
3. Add an indicator for hospitals subject to an electronic health records incentive program reduction for future implementation.
4. Expand the existing 2-byte Model 1 discount percentage field to 3-bytes.

In order to avoid confusion with the 4 new payment amount fields created in CR 8217, we are renaming them here. In addition, we are redefining existing filler in the output record PRICER returns to fiscal intermediary standard system (FISS) to accommodate future policy and/or legislative changes that might require system changes. The new fields are:

- PPS- EHR-PAYMENT-ADJUST-AMT PIC S9(07) V9(02).
- PPS-FLX5- PAYMENT PIC S9(07)V9(02).
- PPS-FLX6- PAYMENT PIC S9(07)V9(02)

(continued on next page)

Occurrence span code 72; identification of outpatient time associated with an inpatient hospital admission and inpatient claim for payment

Provider types affected

This *MLN Matters*® article is intended for hospitals submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8586 to provide clarification to hospitals regarding the billing of inpatient hospital stays and the two-midnight rule, codified under the fiscal year 2014 Inpatient Prospective Payment System Final Rule CMS-1599-F.

The two-midnight rule allows hospitals to account for total hospital time (including outpatient time directly proceeding the inpatient admission) when determining if an inpatient admission order should be written based on the expectation that the beneficiary will stay in the hospital for two or more midnights receiving medically necessary care.

Because currently the inpatient claim only permits CMS to accurately track inpatient time after formal inpatient order and admission (i.e., utilization days/midnights), CMS would also like to use occurrence span code 72 to track the total, contiguous outpatient care prior to inpatient admission in the hospital. This will enable CMS to identify claims in which the beneficiary received care as an outpatient for one or more midnights and was subsequently admitted as an inpatient based on the expectation that the beneficiary would require two or more midnights of hospital care.

Background

The change in billing instruction is associated with CMS-1599-F, in which CMS clarifies and modifies its guidance regarding the proper billing of inpatient hospital stays.

Under the rule, surgical procedures, diagnostic tests, and other treatments (not specifically designated as inpatient-only) are generally appropriate for inpatient hospital payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses at least 2 midnights and admits the beneficiary to the hospital based on that expectation.

The final rule emphasizes the need for a formal order of inpatient admission to begin inpatient status and time, but permits the physician and the medical reviewer to consider all time a beneficiary has already spent in the hospital receiving outpatient services (including observation services and treatment in the emergency department, operating room, or other treatment area) in guiding their two-midnight expectation. This rule is available in the *Federal Register* on Page 50508 at *http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf.*

The redefinition of occurrence span code 72 allows providers to voluntarily identify those claims in which the two-midnight benchmark was met because the beneficiary was treated as an outpatient in the hospital prior to the formal inpatient order and admission.

In other words, it permits providers and subsequently review contractors to identify the "contiguous outpatient hospital services [midnights] that preceded the inpatient admission," as well as the total number of midnights after formal inpatient order and admission, on the face of the claim.

While MACs may still select this claim type for medical

(continued on next page)

Fields *(continued)*

- PPS-FLX7- PAYMENT PIC S9(07)V9(02).

The renamed fields are:

- From PPS-FLX1-PAYMENT to PPS-UNCOMP-CARE-AMOUNT
- • From PPS-FLX2-PAYMENT to PPS-BUNDLE-ADJUST-AMT
- • From PPS-FLX3-PAYMENT to PPS-VAL-BASED-PURCH-ADJUST-AMT
- • From PPS-FLX4-PAYMENT to PPS-READMIS-ADJUST-AMT

Additional information

The official instruction, CR 8546 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2870CP.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: MM8546
Related Change Request (CR) #: CR 8546
Related CR Release Date: February 5, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R2870CP
Implementation Date: July 7, 2014

Code *(continued)*

review, the use of occurrence span 72 will help support the medical record and the MAC's review decision.

Since the two-midnight benchmark allows hospitals to account for total hospital time in determining if the beneficiary is expected to meet the two-midnight benchmark, CMS has provided examples scenarios below, to illustrate circumstances in which an outpatient midnight was pertinent to the inpatient admission decision. In the future, occurrence span 72 may also be used to guide the claim selection process at CMS' discretion.

Examples in which the two-midnight benchmark was met based on total (outpatient and inpatient) hospital time. CMS would like to track the outpatient time on an automated basis, using occurrence span code 72, so we may focus medical review as needed:

Example 1: Beneficiary is an outpatient and is receiving observation services at 10 p.m. on December 1, 2013, and is still receiving observation services at one minute past midnight on December 2, 2013, and continues as an outpatient until admission. Beneficiary is admitted as an inpatient on December 2, 2013 at 3 a.m., under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. Beneficiary is discharged on December 3, 2013, at 8 a.m. Total time in the hospital meets the two-midnight benchmark.

Example 2: Beneficiary having arrived at the hospital and begun treatment in the ED at 8 p.m. on December 11, 2013, is still in the emergency department (ED) at one minute past midnight on December 12, 2013, and continues as an outpatient until admission.

The beneficiary is admitted as an inpatient on December 12, 2013, at 2 a.m., under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. The beneficiary is discharged on December 13, 2013, at 8 a.m. Total time in the hospital meets the two-midnight benchmark.

Example 3: Beneficiary in an outpatient surgical encounter at 6 p.m. on December 21, 2013, is still in the outpatient encounter at one minute past midnight, December 22, 2013, and continues as an outpatient

until admission. Beneficiary is admitted as an inpatient, December 22, 2013, at 1 a.m., under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. Beneficiary is discharged on December 23, 2013, at 8 a.m. Total time in the hospital meets the two-midnight benchmark.

Additional information

The official instruction, CR 8586 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/ R1334OTN.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: MM8586
Related Change Request (CR) #: CR 8586
Related CR Release Date: January 24, 2014
Effective Date: December 1, 2013
Related CR Transmittal #: R1334OTN
Implementation Date: February 25, 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.

Three night stay *(continued from front page)*

The provider submitted a claim to First Coast with RUG code RUC10 and the reported data to the State supported the services billed to First Coast.

However, the medical documentation submitted to the audit contractor indicates that the provider failed to sufficiently code therapy minutes on one of the five days of treatment, which resulted in recalculation of the therapy services for the assessment period from an ultra-high to medium rehabilitation category.

Example two, a provider billed a claim to First Coast; however, the technical requirement to qualify for post hospital SNF care was not met.

Providers are encouraged to review all claims to ensure the medical documentation submitted thoroughly supports all services billed. *Click here* to access a tool created by First Coast to assist SNFs when responding to medical documentation requests.

Educational Events

Provider outreach and educational events – April 2014

Inpatient hospital – Part A to B rebilling process (A/B)

When: Thursday, April 3, 2014
Time: 11:30 a.m. -1:00 p.m. ET – Delivery language: English
Type of Event: Webcast

Medicare rules on inpatient hospital admissions (A)

When: Tuesday, April 8
Time: 1 p.m. - 3:00 p.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 23, 2014, – *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-23-enews.pdf*
- CMS MLN Connects™ Provider eNews: January 30, 2014, – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-30eNews.pdf*
- CMS MLN Connects™ Provider eNews: February 6, 2014 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-02-06-Enews.pdf*
- CMS MLN Connects™ Provider eNews: February 13, 2014 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-02-13Enews.pdf*
- CMS MLN Connects™ Provider eNews: February 20, 2014 – *http://go.usa.gov/Bfxh*

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