Medicare A Connection

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

April 2014

In this issue

'Sequestration' mandatory payment reduction of two percent continues through March 31, 2015

For the Medicare fee-for-service (FFS) program, claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will continue to incur a two percent reduction in Medicare payment through March 31, 2015.

Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME competitive bidding program, will continue to be reduced by two percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

The claims payment adjustment will continue to be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare secondary payment adjustments.

Though beneficiary payments for deductibles and coinsurance are not subject to the two percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the two percent reduction.

CMS encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries the impact of sequestration on Medicare's reimbursement. Questions about reimbursement should be directed to your Medicare *administrative contractor*.

Contents

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

Publication staff:
Terri Drury
Kathleen Cruz Fuentes
Sofia Lennie
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.

General Information

'Probe and educate' clarifications: Timeframes for additional documentation requests and education

Under the final rule CMS-1599-F, or "two-midnight" rule, Medicare administrative contractors (MACs) have been performing prepayment patient status probe reviews on a sample of 10 claims for most hospitals (25 claims for large hospitals) with dates of admission on or after October 1, 2013.

These "probe and educate" reviews are being conducted to assess provider understanding and compliance with the Centers for Medicare & Medicaid Services (CMS) policy on inpatient hospital and critical access hospital (CAH) admissions.

Based on the results of the initial reviews, the MACs will conduct individualized educational efforts and repeat the process where necessary. MACs are beginning the education portion of the process and have been instructed to allow providers 45 days before requesting additional documentation.

This 45-day timeframe will give hospitals additional time to implement strategies aimed at increased compliance with the rule.

CMS has instructed the MACs that any providers with incomplete probe and educate samples (i.e., less than 10 or 25 claims selected and/or received for review) will automatically be offered education and undergo a second probe review, regardless of the results of the first probe review.

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).

Denial letters for religious nonmedical health care institution services not covered by Medicare

Provider types affected

This *MLN Matters*® article is intended for religious nonmedical health care institutions (RNHCIs) submitting claims to Medicare durable medical equipment Medicare administrative contractors (DME/MACs) and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8559 which informs MACs about revisions to Medicare systems edits related to diagnosis coding instructions on RNHCI claims. It also adds instructions regarding requests for denial letters when RNHCIs provide a level of care that is not covered by Medicare to a beneficiary who does not desire to submit a notice of election (NOE) for the sole purpose of obtaining that specific service, which may be covered by another insurer. Make sure that your billing staffs are aware of these changes.

Background

Diagnosis code reporting

While coding of diagnoses is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for standard claims transactions. CR 8350 created editing in Medicare systems to ensure the following unspecified diagnosis codes are reported on RHNCI claims:

- Prior to the implementation of ICD-10: Principal Diagnosis: 799.9 and Other Diagnosis: V62.6
- After the implementation of ICD-10: Principal Diagnosis: R69 and Other Diagnosis: Z53.1

After consultation with the industry, Medicare has determined that an additional ICD-10 code should be available for reporting as “other diagnosis” on RNHCI claims. CR 8559 revises Medicare systems to allow RNHCI claims to report as the “other diagnosis” either Z53.1 or Z53.29, “procedure and treatment not carried out because of patient’s decision for other reasons.”

Denial notices for non-covered levels of RNHCI care

RNHCI facilities sometimes provide services to Medicare beneficiaries that do not qualify for Medicare coverage and for which the beneficiary may seek payment from another insurer. The other insurer may require a denial from Medicare before making payment for these services. Medicare systems require submission of a notice of election (NOE) before any RNHCI claims can be

processed. In order for a claim requesting a denial notice to be processed, the RNHCI would need to inappropriately submit an NOE, since the beneficiary is not requesting Medicare coverage of RNHCI services.

In order to avoid having the RNHCI issue an inappropriate NOE, the RNHCI may request in writing a denial notice from the appropriate MAC. In response, the MAC will provide the RNHCI with a manual denial letter. This letter may then be submitted to a secondary insurer as evidence of a prior Medicare denial.

Additional information

The official instruction, CR 8559 issued to your MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2930CP.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: MM8559
Related Change Request (CR) #: CR 8559
Related CR Release Date: April 11, 2014
Effective Date: July 14, 2014
Related CR Transmittal #: R2930CP
Implementation Date: July 14, 2014

Appeals for canceled claims related to Medicare beneficiaries 'unlawfully present' in the United States

In some cases, claims submitted for beneficiaries determined to be unlawfully present in the United States were reprocessed without offering appeal rights on the resulting overpayments.

See *MLN Matters*® article MM8009, "New Informational Unsolicited Response (IUR) Process to Identify Previously Paid Claims for Services Furnished to Medicare Beneficiaries Classified as 'Unlawfully Present' in the United States." In addition, in some cases where appeal rights were offered on the reprocessed claims, appeals were not processed appropriately.

Providers and suppliers are entitled to file appeals for these reprocessed claims, and appeals should be processed on these claims even if appeal rights were not initially offered. Providers and suppliers are entitled to submit a request for redetermination within 120 calendar days from the later of either (a) the date of receipt of the remittance advice indicating recovery of payment for such services, or (b) April 1, 2014.

In cases where a request for redetermination of such services was refused, providers and suppliers are entitled to resubmit their request within 120 calendar days from the later of either (a) the date of receipt of the letter or notice from their Medicare administrative contractor (MAC) refusing to process the appeal, or (b) April 1, 2014.

If the request for redetermination of such services resulted in a dismissal notice from their MAC, providers and suppliers may request that the dismissal be vacated.

Requests to vacate the dismissal must be filed with their MAC within six months of the later of (a) the date of receipt of the dismissal notice, or (b) April 1, 2014, provided a request for review of the dismissal was not filed with the

qualified independent contractor (QIC). Any requests pending before the QIC will be processed by the QIC.

In cases where a redetermination request for such services was processed by their MAC, providers and suppliers are entitled to request a reopening of the redetermination decision within the later of either (a) one year of the date of receipt of the redetermination notice, or (b) October 1, 2014, if they disagree with the redetermination decision, provided a request for reconsideration has not been filed with the QIC. Any requests pending before the QIC will be processed by the QIC.

For any appeal request, request to reopen an appeal decision, or a request to vacate a dismissal where the original claim was cancelled, providers must submit a paper claim that replicates the original cancelled claim with their appeal or reopening request. Failure to submit a paper claim with the appeal or reopening request will result in delays in effectuating favorable appeal decisions.

Manual medical review of therapy services will end

Effective April 15, 2014, First Coast will discontinue manual medical review for therapy claims. This does not apply to claims for 2013 dates of services.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) established a requirement for mandatory manual medical review of therapy services for dates of service October 1 through December 31, 2012, for physical therapy/speech-language pathology or occupational therapy services above $3,700. The Center for Medicare & Medicaid Services requires Medicare administrative contractors to notify providers by posting to their website when they have stopped conducting the reviews. This article serves as that notification.

For additional information on the pre-approval process, refer to *change request 8036* and related *MLN Matters® article MM8036*.

General Coverage

Medicare NCD for beta amyloid positron emission tomography in dementia and neurodegenerative disease

***Note**: This article was revised April 4, 2014, to reflect the revised change request (CR) 8526 issued March 27, 2014. In the article, the CR release date, transmittal numbers, and the Web addresses for accessing the two transmittals of CR 8526 were revised. All other information remains the same. This information was previously published in the February 2014 Medicare A Connection, Pages 24-26.*

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 Aβ imaging (one PET Aβ 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., front temporal dementia (FTD) versus AD) where the use of PET Aβ 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 Aβ imaging improves health outcomes for Medicare beneficiaries with dementia or neurodegenerative disease. However, there is sufficient evidence that the use of PET Aβ imaging could be promising in certain scenarios. Therefore, Medicare will only allow coverage for PET Aβ imaging (one PET Aβ 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 Aβ imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

Health outcomes may include the following:

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
3. Survival

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

See **DEMENTIA**, next page

DEMENTIA

From previous page

ICD-9 codes	Corresponding ICD-10 codes
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
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 Aβ 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 788.11 or 788.14
- Dx codes (see list in table above)
- Aβ HCPCS code A9586 or A9599

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

See **DEMENTIA**, next page

DEMENTIA

From previous page

- **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 Aβ scan; HCPCS code A9586 or A9599, in a patient's lifetime.

MACs will line-item deny claims for PET Aβ, HCPCS code A9586 or A9599, where a previous PET Aβ, 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 claim processing instructions.

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/R164NCD.pdf.* The second transmittal updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2915CP.pdf.*

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

MLN Matters® Number: MM8526 *Revised*
Related Change Request (CR) #: CR 8526
Related CR Release Date: March 27, 2014
Effective Date: September 27, 2013
Related CR Transmittal #: 2915CP/164NCD
Implementation July 7, 2014

Aprepitant for chemotherapy-induced emesis

Note: This article was revised April 16, 2014, to reflect revised change request (CR) 8418, issued April 15. In the article, the CR release date, transmittal numbers, and the Web addresses for accessing the transmittals are revised. Also, we have deleted references to expired HCPCS codes. All other information remains the same. It was previously published in the March 2014 edition of Medicare A Connection, Pages 6-7.

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Part A Medicare administrative contractors (A/MACs) and/or durable medical equipment MACs (DME MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on CR 8418, which informs MACs that, effective for claims with dates of service on or after May 29, 2013, the Centers for Medicare & Medicaid Services (CMS) extends coverage of the oral antiemetic three-drug regimen of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone to beneficiaries who are receiving certain anticancer chemotherapeutic agents. Make sure that your billing personnel are aware of these changes.

Background

Chemotherapy induced emesis is the occurrence of nausea and vomiting during or after anticancer treatment with chemotherapy agents. The Social Security Act (the Act) permits oral drugs to be paid under Part B in very limited circumstances, one of which is antiemetic therapy administered immediately before and within 48 hours after anticancer chemotherapy as described in section1861(s)(2) of the Act. These drugs must fully replace the non-self-administered drug that would otherwise be covered.

On April 4, 2005, CMS announced a national coverage determination (NCD) for the use of the oral three-drug regimen of aprepitant, a 5HT3 antagonist, and dexamethasone for patients who are receiving certain highly emetogenic chemotherapeutic agents.

On May 29, 2013, CMS announced an update to that NCD, to cover the use of the oral antiemetic three-drug combination of oral aprepitant (J8501), an oral 5HT3 antagonist (Q0166, Q0179, Q0180), and oral dexamethasone (J8540) for patients receiving highly and moderately emetogenic chemotherapy. As a result, effective for services on or after May 29, 2013, the following anticancer chemotherapeutic agents have been added to the list of anticancer chemotherapeutic agents for which the use of the oral antiemetic 3-drug combination

of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone is deemed reasonable and necessary:

- Alemtuzumab (J9010);
- Azacitidine (J9025);
- Bendamustine (J9033);
- Carboplatin (J9045);
- Clofarabine (J9027);
- Cytarabine (J9098, J9100);
- Daunorubicin (J9150, J9151);
- Idarubicin (J9211);
- Ifosfamide (J9208);
- Irinotecan (J9206); and
- Oxaliplatin (J9263).

Please note the entire list includes the 11 new codes listed above and the nine existing anti-cancer chemotherapeutic agents listed below:

- Carmustine (J9050);
- Cisplatin (J9060);
- Cyclophosphamide (J8530, J9070);
- Dacarbazine (J9130);
- Mechlorethamine (J9230);
- Streptozocin (J9320);
- Doxorubicin (J9000, Q2049);
- Epirubicin (J9178); and
- Lomustine (S0178).

See **APREPITANT**, next page

APREPITANT

From previous page

CMS also permits the MACs to determine coverage for other all-oral three-drug antiemesis regimens of aprepitant or any other Food and Drug Administration (FDA) approved oral NK-1 antagonist in combination with an oral 5HT3 antagonist and oral dexamethasone with the chemotherapeutic agents listed, or any other anticancer chemotherapeutic agents that are FDA-approved and may in the future be defined as highly or moderately emetogenic.

CMS is defining highly emetogenic chemotherapy and moderately emetogenic chemotherapy as those anticancer agents so designated in at least two of three guidelines published by the National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO), and European Society of Medical Oncology (ESMO)/ Multinational Association of Supportive Care in Cancer (MASCC). The inclusive examples are: NCCN plus ASCO, NCCN plus ESMO/MASCC, or ASCO plus ESMO/MASCC.

Until a specific code is assigned to the new drug, any new FDA-approved oral antiemesis drug (oral NK-1 antagonist or oral 5HT3 antagonist) as part of the three-drug regimen must be billed with the following not-otherwise-classified (NOC) code effective April 1, 2014, in the IOCE update:

- Q0181 - Unspecified oral dosage form, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for a IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.

This NOC code must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy (ICD9/10 codes V58.11/Z51.11).

This coverage policy applies only to the oral forms of the three-drug regimen as a full replacement for their intravenous equivalents. All other indications or combinations for the use of oral aprepitant are non-covered under Medicare Part B, but may be considered under Medicare Part D.

For claims with dates of service on or after May 29, 2013, MACs will adjust claims processed before CR 8418 was implemented if you bring those claims to the attention of your MAC.

Effective for claims with dates of service on or after May 29, 2013, MACS will deny lines for oral aprepitant (J8501), or NOC code Q0181 if an encounter for antineoplastic chemotherapy identified by ICD 9/10 codes V58.11/Z51.11 is not present. The denied lines will reflect the following messages on the remittance advice:

- Claim adjustment reason code 96: Non-covered charge(s)

Remittance advice remarks code (RARC) M100: We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy; and

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

Additional information

The official instruction, CR 8418, was issued to your MAC via three transmittals. The first updates the *Medicare Benefit Policy Manual* and that is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R185BP.pdf*.

The second updates the *Medicare Claims Processing Manual* and is available *at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2931CP.pdf* and the third updates the *Medicare National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R165NCD.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/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM8418 *Revised*
Related Change Request (CR) #: CR 8418
Related CR Release Date: April 15, 2014
Effective Date: May 29, 2013
Related CR Transmittal #: R185BP, R2931CP, R165NCD
Implementation Date: July 7, 2014

'Medicare Benefit Policy Manual' clarifications regarding use of antigens

Effective date: January 1, 2001
Implementation: date: May 12, 2014

Summary of changes

This change request serves to make the *Medicare Benefit Policy Manual* provisions consistent with regulatory requirements. Additionally, revisions are being made to Chapter 13 of the *Medicare Program Integrity Manual* to accurately reflect the Centers for Medicare & Medicaid Services' (CMS) plan to implement Section 731 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (*transmittal 510*).

General information

Background

Section 1861(s)(2)(G) the Social Security Act (the Act) authorizes Medicare coverage of "antigens (subject to quantity limitations prescribed in regulations by the Secretary)." Implementing regulations were established at 42 CFR 410.68 to identify a reasonable supply of antigens is considered to be not more than a 12-month supply.

Policy

This change request serves to make the *Medicare Benefit Policy Manual* provisions regarding a reasonable supply of antigens consistent with the regulatory requirements mentioned above.

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

50.4.4.1 – Antigens

(Rev. 186, Issued: 04-16-14, Effective: 01-01 01, Implementation: 05-12-14)

Payment may be made for a reasonable supply of antigens that have been prepared for a particular patient if: (1) the antigens are prepared by a physician who is a doctor of medicine or osteopathy, and (2) the physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen.

Antigens must be administered in accordance with the plan of treatment and by a doctor of medicine or osteopathy or by a properly instructed person (who could be the patient) under the supervision of the doctor.

The associations of allergists that CMS consulted advised that a reasonable supply of antigens is considered to be not more than a 12-month supply of antigens that has been prepared for a particular patient at any one time. The purpose of the reasonable supply limitation is to assure that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient. (See §§20.2 and 50.2.)

90 – Routine Services and Appliances

(Rev. 186, Issued: 04-16-14, Effective: 01-01 01, Implementation: 05-12-14)

Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations are not covered.

The routine physical checkup exclusion applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury; and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies. The routine physical checkup exclusion does not apply to the following services (as noted in section 42 CFR 411.15(a)(1)):

- *Screening mammography,*
- *Colorectal cancer screening tests,*
- *Screening pelvic exams,*
- *Prostate cancer screening tests,*
- *Glaucoma screening exams,*
- *Ultrasound screening for abdominal aortic aneurysms (AAA),*
- *cardiovascular disease screening tests,*
- *diabetes screening tests,*
- *screening electrocardiogram,*
- *Initial preventive physical examinations,*
- *Annual wellness visits providing personalized prevention plan services, and*
- *Additional preventive services that meet the criteria specified in 42 CFR 410.64.*

See **ANTIGENS**, next page

ANTIGENS

From previous page

If the claim is for a diagnostic test or examination performed solely for the purpose of establishing a claim under title IV of Public Law 91-173, "Black Lung Benefits," the service is not covered under Medicare and the claimant should be advised to contact their Social Security office regarding the filing of a claim for reimbursement under the "Black Lung" program.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physicians' services (and services incident to a physicians' service) performed in conjunction with an eye disease, as for example, glaucoma or cataracts, or to post-surgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. Such prosthetic lens is a replacement for an internal body organ - the lens of the eye. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §120).

Expenses for all refractive procedures, whether performed by an ophthalmologist (or any other physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage.

A. Immunizations

Vaccinations or inoculations are excluded as immunizations unless they are either:

• Directly related to the treatment of an injury or direct exposure to a disease or condition, such as antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. (In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as smallpox, polio, diphtheria, etc., is not covered.); or

- *Specifically covered by statute, as described in the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.2.*

B. Antigens

Prior to the Omnibus Reconciliation Act of 1980, a physician who prepared an antigen for a patient could not be reimbursed for that service unless the physician also administered the antigen to the patient.

Effective January 1, 1981, payment may be made for a reasonable supply of antigens that have been prepared for a particular patient even though they have not been administered to the patient by the same physician who prepared them if:

- *The antigens are prepared by a physician who is a doctor of medicine or osteopathy, and*
- *The physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen.*

A reasonable supply of antigens is considered to be not more than a 12-month supply of antigens that has been prepared for a particular patient at any one time. The purpose of the reasonable supply limitation is to assure that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.1)

Source: *CR 8665, transmittal 186*

'Medicare Program Integrity Manual' update – deletion of Section 13.14 from Chapter 13

Effective date: January 1, 2001
Implementation: date: May 12, 2014

Summary of changes

This change request serves to make the *Medicare Benefit Policy Manual* provisions consistent with regulatory requirements (*transmittal 186*). Additionally, revisions are being made to Chapter 13 of the *Medicare Program Integrity Manual* to accurately reflect CMS's plan to implement Section 731 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

General information

Background

This change request is to ensure that Chapter 13 of the "Medicare Program Integrity Manual" accurately reflects CMS's plan to implement Section 731 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Therefore, Section 13.14 of Chapter 13 of the "Medicare Program Integrity" manual is being deleted.

Policy

Section 731 of the MMA called for the Secretary to establish a plan to evaluate new local coverage determinations (LCDs) for national coverage. CMS currently has in place a more efficient process to evaluate new and current LCDs that includes extensive engagement and collaboration through conference calls, face to face meetings and open communication with and among the Medicare administrative contractors (MACs) and CMS central office. The MACs evaluate LCDs and the evidence supporting the LCDs using the various tools CMS has available. Under this paradigm, LCDs, where appropriate, are becoming more consistent across MACs.

Source: *CR 8665, transmittal 510*

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.

More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

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.**

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**

Revised LCDs

Bortezomib (Velcade®) – revision to the Part A LCD

LCD ID number L28787 (Florida)
LCD ID number L28789 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bortezomib (Velcade®) was most recently revised April 25, 2012. Since that time, the "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD was revised to add the off-label indication of systemic light chain amyloidosis, and the "ICD-9 Codes that Support Medical Necessity" section of the LCD was updated to add the correlating diagnosis code 277.30. In addition, the "Sources of Information and Basis for Decision" section was updated.

Effective date

This LCD revision is effective for services rendered **on or after April 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*.

Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – revision to the Part A LCD

LCD ID number L30364
(Florida, Puerto Rico, U.S. Virgin Islands)

This local coverage determination (LCD) for stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) was most recently revised November 29, 2012.

Since that time, the "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add the diagnosis code 198.7 (Secondary malignant neoplasm of other specified sites, adrenal gland) for procedure codes G0173, G0251, G0339, and G0340 for SBRT making the ICD-9-CM coding congruent with the text of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after April 4, 2014, for services rendered on or after October 5, 2009**. 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*.

Psychiatric diagnostic evaluation and psychotherapy services – revision to the Part A LCD

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

The local coverage determination (LCD) for psychiatric diagnostic evaluation and psychotherapy services became effective for services rendered **on or after June 4, 2013**.

Since that time, the *Documentation Requirements* section of the LCD and the "Coding Guidelines" attachment were revised to provide clarification on psychotherapy as an "incident to" service and clarification on prolonged services.

Effective date

This LCD revision is effective for services rendered **on or after April 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*.

Intravenous immune globulin – revision to the Part A LCD

LCD ID number L28895 (Florida)
LCD ID number L28917 (Puerto Rico, U.S. Virgin Islands)

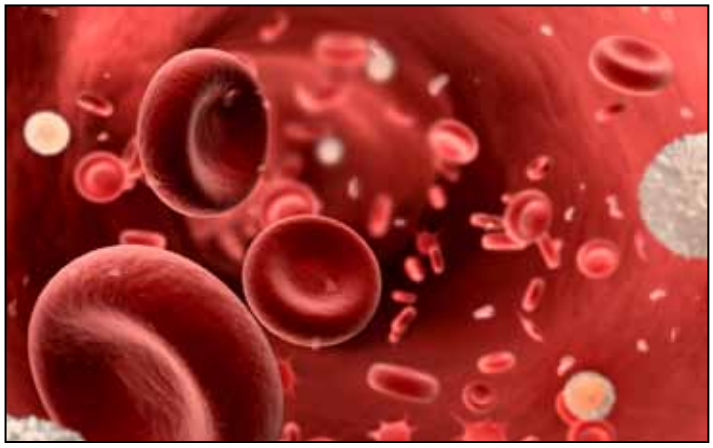
The local coverage determination (LCD) for intravenous immune globulin was most recently revised January 1, 2014.

Since that time, the LCD was revised under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add ICD-9-CM diagnosis code 357.89 (other inflammatory and toxic neuropathy).

Effective date

The LCD is effective ffor services rendered **on or after April 30, 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*.

Retired LCDs

Tositumomab and iodine I 131 tositumomab (Bexxar®) therapy – retirement of the Part A LCD

LCD ID number L30364 (Florida)
LCD ID number L29026 (Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for tositumomab and Iodine I 131 tositumomab (BEXXAR®) therapy was effective for services rendered on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9.

Currently, based on change request (CR) 8653 (April 2014 Update of Hospital Outpatient Prospective Payment System (HOPPS)) the status indicator for HCPCS code A9545 (Iodine I131 tositumomab, therapeutic, per treatment dose) changed to an E (not covered). Therefore, the LCD is being retired.

Effective date

The LCD retirement is effective for claims processed **on or after April 7, 2014**, for services rendered **on or after April 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*.

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.

Electronic Data Interchange

Implementation of Phase III CORE 360 CARCs and RARCs

***Note**: This article was revised March 19, 2014, to reflect a new change request (CR). The CR was revised to include two attachments for V3.0.3 and V 3.0.4 of the Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE), Mandated CARC/RARC Code Combination List. Version 3.0.4, published January 31, 2014, must be implemented no later than May 1, 2014. The attachment of document V 3.0.3 shows the changes made between version 3.0.2 and 3.0.3. The attachment of document V 3.0.4 shows the changes made between V 3.0.3 to V 3.0.4. Additionally, the implementation date for V 3.0.4 for Part A and Part B MACs has been delayed to May 5, 2014. The CR release date, transmittal number and link to the CR were also change. All other information remains the same. This information was previously published in the December 2013 Medicare A Connection, Pages 25.*

Provider types affected

CR 8518, from which this article is taken, instructs Medicare contractors to report only the code combinations that are listed in the current version of the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of CARC and RARC Rule. The spreadsheet attached to CR 8518 (which is available also at *http://www.caqh.org/CORECodeCombinations.php*) shows the change log for CORE code combination version 3.0.3 updates published on October 1, 2013.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C – Administrative Simplification – to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently, and to achieve greater uniformity in the transmission of health information.

More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to electronic data interchange (EDI) from paper has been slow and disappointing. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE published Code Combination version 3.0.3

October 1, 2013. This update is based on July, 2013 CARC and RARC updates as posted at the WPC website. You may review these updates at: *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

Additional information

The official instruction, CR 8518, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1360OTN.pdf*.

In CR 8365, released August 16, 2013, CMS instructed Medicare contractors to implement this updated rule set by January 6, 2014. You can find the associated *MLN Matters*® article, MM8365 "Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule – Update from CAQH CORE" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8365.pdf*.

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

MLN Matters® Number: MM8518 *Revised*
Related Change Request (CR) #: CR 8518
Related CR Release Date: March 18, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R1360OTN
Implementation April 7, 2014 (See Note below title)

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.

Termination of the common working file ELGA, ELGH, HIQA, HIQH, and HUQA Part A provider queries

Note: This article was revised April 10, 2014, to reflect the revised change request (CR) 8248 issued April 8. The article was revised to remove reference to the queries being terminated in April 2014. The CR release date, transmittal number, and Web address for accessing the CR were also changed. All other information remains the same. This article was previously published in the November 2013 edition of Medicare A Connection, Page 22.

Provider types affected

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

Provider action needed

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

Background

Effective April 1, 2013, CMS terminated the common working file (CWF) Part B provider query with CR 8086 (Termination of the Common Working File ELGB Provider Query). With CR 8248, ELGA, ELGH, HIQA, HIQH, HUQA Part A queries will be terminated in the future. When the CWF ELGA, ELGH, HIQA, HIQH, HUQA Part A queries are eliminated, providers will need to use other query capabilities, such as the HIPAA eligibility transaction system (HETS).

In May 2005, CMS implemented the HETS transaction to provide HIPAA compliant eligibility queries and replies. Currently, many providers use HETS to obtain Medicare beneficiary information. Even though the CWF queries address the same business need, they are not HIPAA compliant and do not contain the same audit and security features as HETS. In addition, due to timing of updates to the databases used for these two query mechanisms, and due to differences in the way data is displayed, the responses could be different or appear different. As a result, CMS is eliminating the CWF ELGA, ELGH, HIQA, HIQH, HUQA Part A queries.

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 advance notice of the new termination date.

Additional information

The official instruction, CR 8248 issued to your FI, RHHI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1366OTN.pdf*.

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

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

MLN Matters® Number: MM8248 *Revised*
Related Change Request (CR) #: CR 8248
Related CR Release Date: April 8, 2013
Effective Date: April 7, 2014
Related CR Transmittal #: R1366OTN
Implementation Date: April 7, 2014

Operating rules for electronic funds transfers

***Note**: This article was revised on April 8, 2014, to add a link to MM8619 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8619.pdf), which provides additional information regarding healthcare electronic fund transfers. All other information is unchanged. This information was previously published in the March 2014 Medicare A Connection, Pages 28-29.*

Provider types affected

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

What you need to know

This article is based on change request (CR) 8629 which informs MACs that they must comply with NACHA operating rules that are applicable to initiators of health care payments. CR 8629 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) Network with electronic health care payments. The overarching goals of the requirements of CR 8629 are to assure that providers receiving health care payments via EFT will receive a "trace number" that facilitates automatic re-association of the EFT health care payment with its associated remittance advice.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider's financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the company entry description and the TRN segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR 8629. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of CR 8629 can be accommodated by your accounting processes and systems.

Background

In support of Health Insurance Portability & Accountability Act of 1996 (HIPAA) operating rules for health care EFT and remittance advice transactions adopted by HHS, NACHA – The Electronic Payments Association has adopted its own operating rules that apply to ACH transactions that are health care payments from health plans to providers. NACHA manages the development, administration and governance of the ACH Network used by all types of financial networks and represents more than

10,000 financial institutions.

A new NACHA standard for electronic healthcare claim payments went into effect September 20, 2013, impacting all originators and receivers of EFT used to pay healthcare claims. This healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the healthcare EFT standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The healthcare EFT standard requires the following:

- Company entry description of "HCCLAIMPMT" to identify the payment as healthcare
- Company name should be the health plan or third party administrator paying the claim
- An addenda record must be included with a record type code of "7" and an addenda type code equal to "05"
- Payment related information in the addenda record must contain the ASC X12 835 TRN (Re-association trace number) data segment that is included on the electronic remittance advice

Healthcare providers will utilize the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. See "Healthcare EFT Standard Format" in the Medicare IOM for more information.

Example:

TRN*1*12345*1512345678*9999999~
TRN, TRN01, TRN02, TRN03, TRN04, segment terminator
* data element separator

See **EFTs**, next page

EFTs

From previous page

The following table explains this example:

Element	Element name	Mandatory or optional	Data content
TRN	Reassociation trace number	M	ASC X12 835 segment identifier. This is always "TRN".
TRN01	Trace type code	M	Trace type code is always a "1".
TRN02	Reassociation information	M	This data element must contain the EFT trace number.
TRN03	Origination company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's tax identification number (TIN).
TRN04	Reference identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.

Element	Element name	Mandatory or optional	Data content
Segment terminator	Segment terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\".

Additional information

For information on the NACHA operating rules that apply to health care payments, particularly with regard to requirements for originators, see *https://healthcare.nacha.org/healthcarerules*.The official instruction, CR 8629 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1349OTN.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: MM8629 *Revised*
Related Change Request (CR) #: CR 8629
Related CR Release Date: February 21, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R1349OTN
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.

Updates to RARC, CARC, remit easy print and PC print

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8703, which updates the claims adjustment reason code (CARC) and remittance advice remark code (RARC) lists and also instructs Medicare systems maintainers to update the Medicare remit easy print (MREP) and PC print by July 1, 2014.

Make sure that your billing staffs are aware of these updates and that they obtain the updated MREP or PC Print software if you use that software.

Background

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

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

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change.

If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or use another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. CARC and RARC code sets are updated three times a year on a regular basis.

CR 8703 lists only the changes that have been approved since the last code update (CR 8561, Transmittal 2855, issued on January 10, 2014, with the related *MLN Matters*® article available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8561.pdf*), and does not provide a complete list of codes for these two code sets.

Changes in CARC list since CR 8561

The following tables list the changes in the CARC database since the last code update in CR 8561. The full CARC list is available from the Washington Publishing Company (WPC) website at *http://wpc-edi.com/Reference*.

New Codes – CARC

Code	Narrative	Effective Date
259	Additional payment for dental/ vision service utilization.	01/26/2014
260	Processed under Medicaid ACA enhanced fee schedule.	01/26/2014

Modified codes – CARC

Code	Modified narrative	Effective date
257	The disposition of the claim/ service is undetermined during the premium payment grace period, per health insurance exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with group code OA) Notes: To be used for months 2 and 3 in the grace period.	

Deactivated codes – CARC

Code	Current narrative	Effective date
A7	Presumptive payment adjustment	07/01/2015

Changes in RARC list since CR 8561

The following tables list the changes in the RARC database since the last code update in CR 8561. The full RARC list is available from the WPC website at *http://wpc-edi.com/Reference*.

New codes – RARC

Code	Narrative	Effective date
N699	Payment adjusted based on the physician quality reporting system (PQRS) incentive program.	3/1/2014
N700	Payment adjusted based on the electronic health records (EHR) incentive program.	3/1/2014
N701	Payment adjusted based on the value-based payment modifier.	3/1/2014

See **CARC**, next page

CARC

From previous page

Code	Narrative	Effective date
N702	Decision based on review of previously adjudicated claims or for claims in process for the same/ similar type of services	3/1/2014
N703	This service is incompatible with previously adjudicated claims or claims in process.	3/1/2014
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.	3/1/2014
N705	Incomplete/invalid documentation.	3/1/2014
N706	Missing documentation.	3/1/2014
N707	Incomplete/invalid orders.	3/1/2014
N708	Missing orders.	3/1/2014
N709	Incomplete/invalid notes.	3/1/2014
N710	Missing notes.	3/1/2014
N711	Incomplete/invalid summary.	3/1/2014
N712	Missing summary.	3/1/2014
N713	Incomplete/invalid report.	3/1/2014
N714	Missing report.	3/1/2014
N715	Incomplete/invalid chart	3/1/2014
N716	Missing chart.	3/1/2014
N717	Incomplete/invalid documentation of face-to-face examination	3/1/2014
N718	Missing documentation of face-to-face examination.	3/1/2014
N719	Penalty applied based on plan requirements not being met.	3/1/2014
N720	Alert: The patient overpaid you. You may need to issue the patient a refund for the difference between the patient's payment and the amount shown as patient responsibility on this notice.	3/1/2014
N721	This service is only covered when performed as part of a clinical trial.	3/1/2014
N722	Patient must use workers' compensation set-aside (WCSA) funds to pay for the medical service or item.	3/1/2014
N723	Patient must use liability set-aside (LSA) funds to pay for the medical service or item.	3/1/2014
N724	Patient must use no-fault set-aside (NFSA) funds to pay for the medical service or item.	3/1/2014
N725	A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014
N726	A conditional payment is not allowed.	3/1/2014
N727	A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014
N728	A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	

Modified Codes – RARC

Code	Modified narrative	Effective date
MA50	Missing/incomplete/invalid investigational device exemption number or clinical trial number. Start: 01/01/1997. Last modified: 03/01/2014. Notes: (Modified 2/28/03, 3/1/2014)	3/1/2014
M77	Missing/incomplete/invalid/ inappropriate place of service. Start: 01/01/1997. Last modified: 03/01/2014. Notes: (Modified 2/28/03, 3/1/2014)	3/1/2014
N29	Missing documentation/orders/ notes/summary/report/chart. Start: 01/01/2000 | Stop: 03/01/2016 | Last Modified: 03/01/2014. Notes: (Modified 2/28/03, 8/1/05, 3/1/2014) Related to N225, Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.	3/1/2014
N225	Incomplete/invalid documentation/orders/ notes/ summary/report/ chart. Start: 08/01/2004 | Stop: 03/01/2016 | Last Modified: 03/01/2014. Notes: (Modified 8/1/05, 3/1/2014) Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.	

Deactivated codes – RARC

(There are no deactivated codes.)

See **CARC**, next page

Part A to Part B rebilling tips and reminders

To facilitate the successful completion of Part A to B rebilling, First Coast Service Options' (First Coast) has prepared the following tip to help submitters avoid billing errors.

Tip #1: If you are submitting 12x type of bill (TOB) and 13x TOB rebilling claims, you must bill the 12x TOB first, then submit the 13x TOB claim. This will prevent duplicate claim edits.

Note: If you have received a duplicate returned or rejected claim in error because your 13x TOB was billed first; you should resubmit your claim.

Tip #2: If you are submitting a duplicate lab tests provided on the same line item date of service (LIDOS) even if one test appears on the 13x TOB claim and the repeat test appears on the 12x TOB claim for the same LIDOS; You should append a modifier 91 when appropriate. This will prevent duplicate edits.

Tip #3: Follow these steps for self-audit claims identified after patient discharged and claim submitted to MAC:

1. Cancel processed inpatient claim

2. Submit inpatient no-pay claim

- Occurrence span code M1
- TOB 110
- Noncovered days

3. Submit inpatient Part B claim applying rebilling instructions on 12x bill type

4. Submit outpatient hospital claim on 13x bill type if applicable

Tip #4: Follow these steps for self-audit claims identified after patient discharged and claim has not been submitted to MAC:

1. Submit inpatient no-pay claim

- Occurrence span code M1
- TOB 110
- Noncovered days

2. Submit inpatient Part B claim applying rebilling instructions on 12x bill type

3. Submit outpatient hospital claim on 13x bill type if applicable

Tip #5: For TOB 12x and 13x claims billed under the A/B rebill ruling on or before September 30, 2013:

Claim page two should have condition code "W2" attesting that this is a rebilling and no appeal is in process,

Claim page five should have a treatment authorization code of A/B rebilling in the first iteration

Claim page seven should denote the original denied inpatient claim and the last adjudication date in the format "ABREBILL12345678901234-MMDDYYYY"

Tip #6: For claims billed under the A/B Rebilling ruling on or after April 1, 2014 (for admissions occurring on or after October 1, 2013):

Claim page two should have condition code "W2" attesting that this is a rebilling and no appeal is in process,

Claim page five should have a treatment authorization code of A/B rebilling in the first iteration

Claim page seven should denote the original denied inpatient claim and the last adjudication date in the format "ABREBILL12345678901234"

For background see *MLN Matters*® articles *MM8185* and *MM8445*.

CARC

From previous page

Additional information

The official instruction, CR 8703, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2920CP.pdf*.

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

MLN Matters® Number: MM8703
Related Change Request (CR) #: CR 8703
Related CR Release Date: April 4, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R2920CP
Implementation Date: July 7, 2014

Codes G0463 and 97610 incorrectly rejecting on outpatient claims for SNF CB

First Coast Service Options (First Coast) recently discovered that the common working file was rejecting outpatient claim line items containing Healthcare Common Procedure Coding System (HCPCS) codes G0463 and/or 97610 in error as being included in skilled nursing facility consolidated billing (SNF CB).

Resolution

Claims will now suspend to a designated location when codes G0463 and/or 97610 are present on the claim and the date of service is on/after January 1, 2014, so that First Coast may override the edit that these claims are hitting.

Status/date resolved

This process will continue until the 2015 SNF CB files are implemented.

Provider action

The Centers for Medicare & Medicaid Services (CMS) have instructed Medicare administrative contractors (MACs) to not adjust previously impacted claims unless providers request adjustments to their MACs for any impacted claims.

CMS sets new ICD-10 compliance date for October 1, 2015

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015.

Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015.

The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

July 2014 ICD-10 end-to-end testing canceled: additional testing planned for 2015

CMS planned to conduct ICD-10 testing during the week of July 21-25, 2014, to give a sample group of providers the opportunity to participate in end-to-end testing with Medicare administrative contractors (MACs) and the common electronic data interchange (CEDI) contractor. The July testing has been canceled due to the ICD-10 implementation delay. Additional opportunities for end-to-end testing will be available in 2015.

Your feedback matters

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

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

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

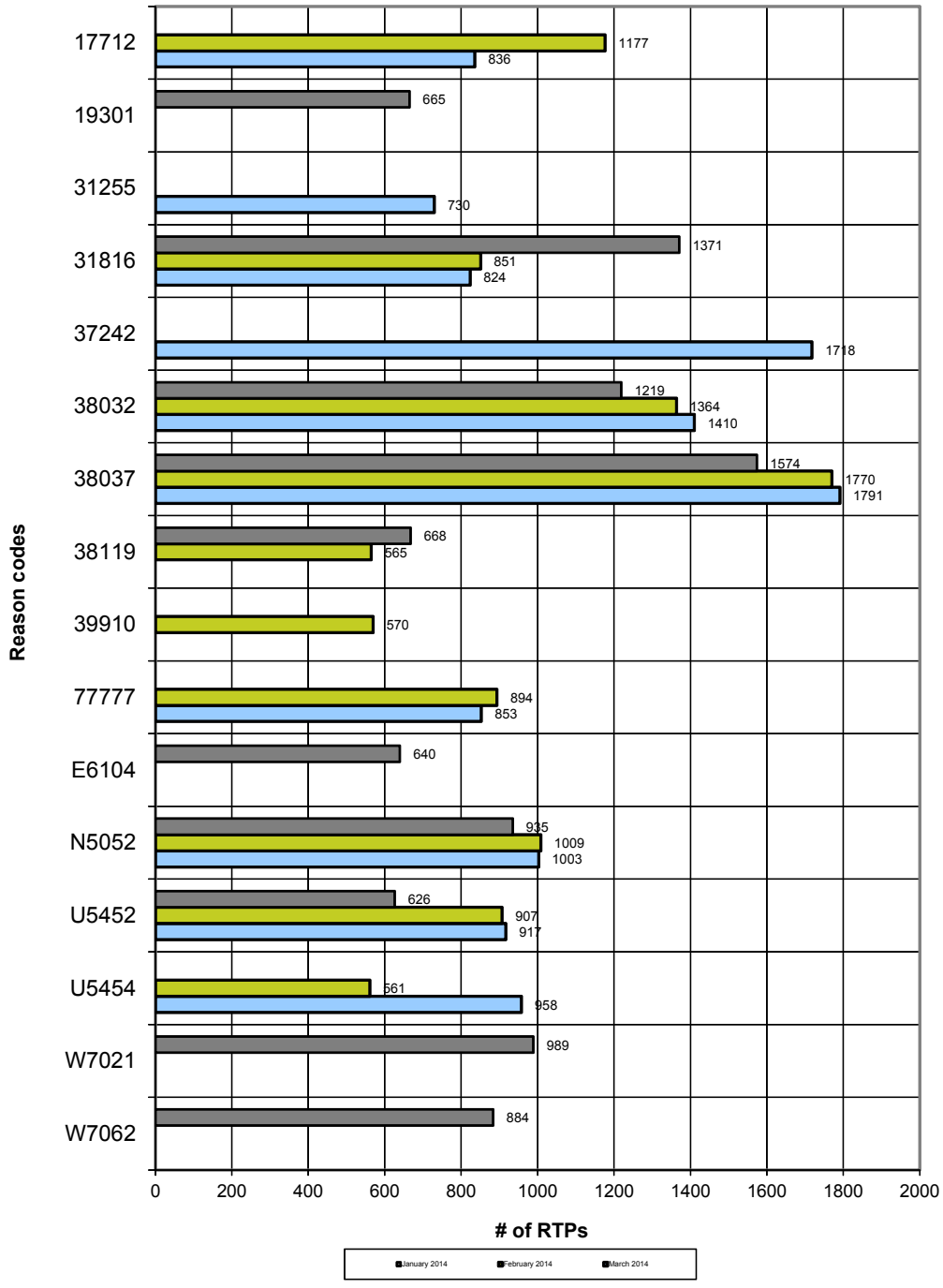
Claims and Inquiry Summary Data

Top inquiries, rejects, and return to provider claims

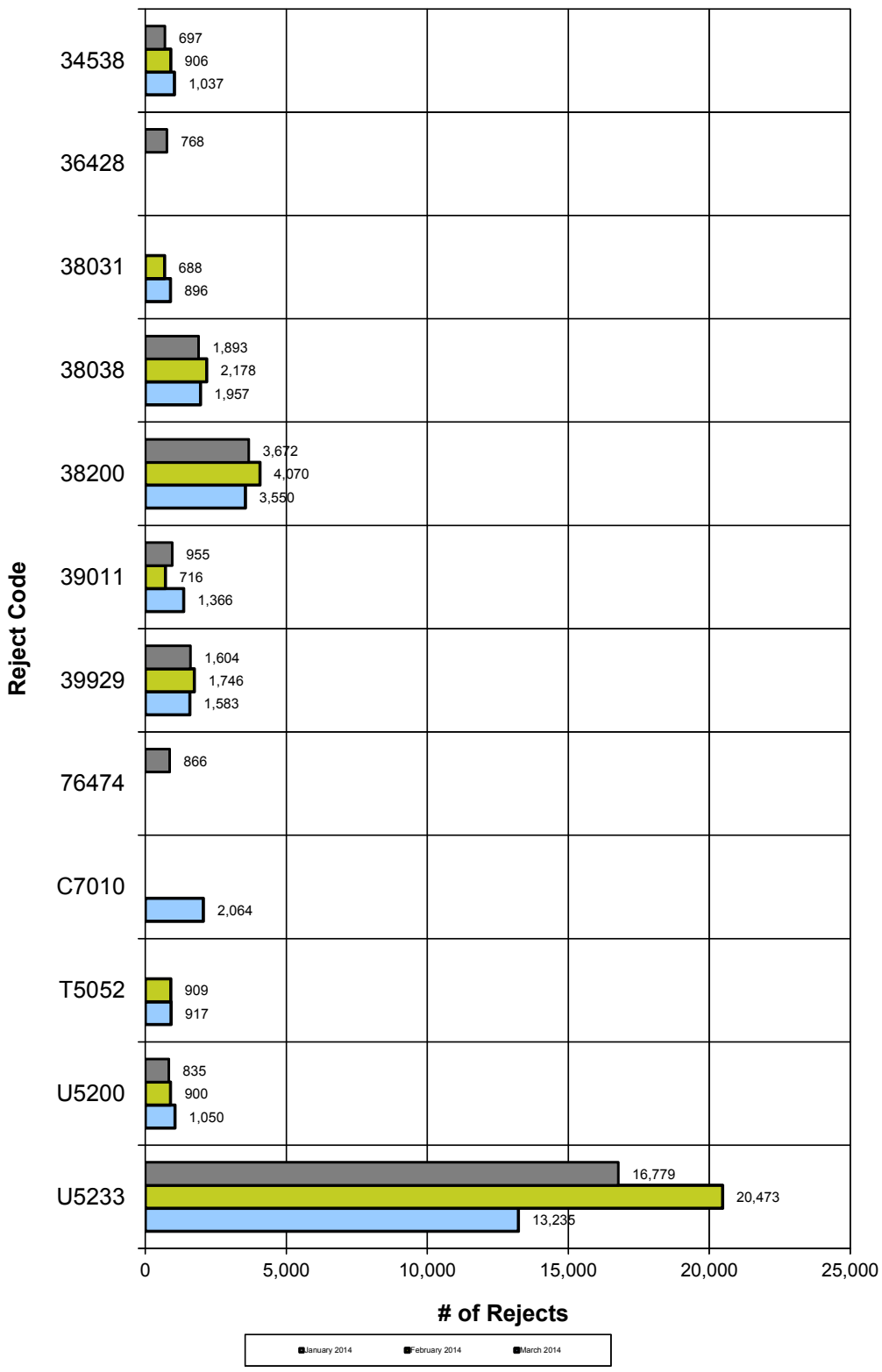
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during January 2014 through March 2014.

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 RTPs for January-March 2014

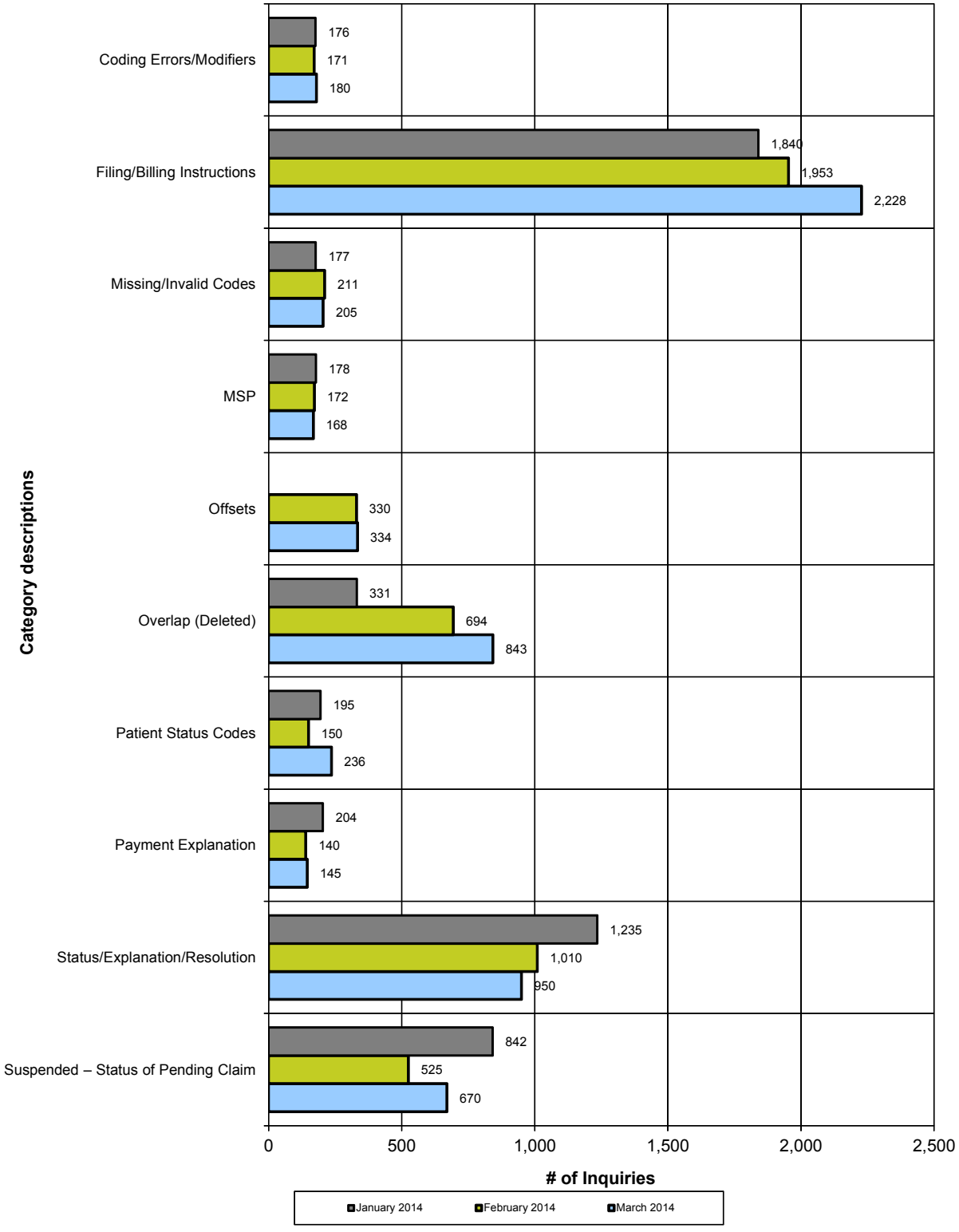


Part A top rejects for January 2014 through March 2014



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

Top inquiries for January-March 2014



Reimbursement

April 2014 physician fee schedule database update

Note: *This article was revised April 8, 2014, to reflect the revised change request (CR) 8664 issued April 4, 2014. The CR was revised to reflect the President signing into law the "Protecting Access to Medicare Act of 2014" April 1, 2014, thus averting the expiration of the 0.5 percent update to the physician fee schedule conversion factor and the 1.0 work floor GPCI, which will now remain in effect until December 31, 2014.*
Similar changes were made to this article. The CR release date and the Web address for accessing the CR are revised. All other information remains the same. This article was previously published in the March 2014 edition of Medicare A Connection, Page 33-36

Provider types affected

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

Provider action needed

This article is based on CR 8664 which amends the payment files that were issued to Medicare contractors based upon the 2014 Medicare Physician Fee Schedule (MPFS), Final Rule and passage of the "Protecting Access to Medicare Act of 2014," which the President signed April 1, 2014. Make sure that your billing staffs are aware of these changes.

Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* on the Internet) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

In order to reflect appropriate payment policy as included in the *2014 MPFS Final Rule*, the MPFSDB has been updated with April changes, and those necessitated by "Protecting Access to Medicare Act of 2014," which the President signed April 1, 2014.

This law extends the 0.5 percent update through December 31, 2014. Since the Act extends the MPFSDB policies to all of 2014, the April update payment files that were previously created to be effective from January 1, 2014 to March 31, 2014, can now be used by MACs to be effective from January 1, 2014 to December 31, 2014.

Note: Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

CR 8664 summary of changes

The summary of changes for the April 2014 update consists of the following tables, including Table 2 at the bottom of the page:

1. Short description corrections for HCPCS codes G0416 - G0419

HCPCS code	Old short description	Revised 2014 short description
G0416	Sat biopsy prostate 1-20 spc	Biopsy prostate 10-20 spc
G0417	Sat biopsy prostate 21-40	Biopsy prostate 21-40
G0418	Sat biopsy prostate 41-60	Biopsy prostate 41-60
G0419	Sat biopsy prostate: >60	Biopsy prostate: >60

Table 2. Adjust the facility and non-facility PE RVUs for HCPCS code *77293*-Global and *77293*-TC

HCPCS	Mod	Status	Description	Non-facility PE RVUs	Facility PE RVUs	Global	
77293		A	Respirator motion mgmt simul	9.96	NA	ZZZ	Jan 1 to March 31, 2014
77293	TC	A	Respirator motion mgmt simul	9.16	NA	ZZZ	Jan 1 to March 31, 2014
77293		A	Respirator motion mgmt simul	10.72	NA	ZZZ	Correction April 1, 2014
77293	TC	A	Respirator motion mgmt simul	9.92	NA	ZZZ	Correction April 1, 2014

See **MPFS**, next page

MPFS

From previous page

3. HCPCS code G9361 will be added to your Medicare contractor's systems.

HCPCS code	G9361
Procedure status	M
Short descriptor	Doc comm risk calc
Effective date	01/01/2014
Work RVU	0
Full non-facility PE RVU	0
Full non-facility NA indicator	(blank)
Full facility PE RVU	0
Full facility NA indicator	(blank)
Malpractice RVU	0
Multiple procedure indicator	9
Bilateral surgery indicator	9
Assistant surgery indicator	9
Co-surgery indicator	9
Team surgery indicator	9
PC/TC	9
Site of service	9
Global surgery	XXX
Pre	0.00
Intra	0.00
Post	0.00
Physician supervision diagnostic indicator	09
Diagnostic family imaging indicator	99
Non-facility PE used for OPPS payment amount	0.00
Facility PE used for OPPS payment amount	0.00
MP used for OPPS payment amount	0.00

HCPCS code	G9361
Type of service	9
Long descriptor	Medical indication for induction [Documentation of reason(s) for elective delivery or early induction (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-premature, prolonged maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, malposition and malpresentation of fetus, late pregnancy, prior uterine surgery, or participation in clinical trial)]

4. Correct the physician supervision of diagnostic procedures indicator for the TC's of the following codes, effective January 1, 2014.

HCPCS code	Description	Phys. diag. supv. indicator	Effective date
70450-TC	CT head/brain w/o dye - Phys Diag Supv Correction (TC)	01	01/01/2014
70460-TC	CT head/brain w/ dye - Phys Diag Supv Correction (TC)	02	01/01/2014
70551-TC	MRI brain stem w/o dye - Phys Diag Supv Correction (TC)	01	01/01/2014
70552-TC	MRI brain stem w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
70553-TC	MRI brain stem w/o & w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72141-TC	MRI neck spine w/o dye - Phys Diag Supv Correction (TC)	01	01/01/2014

See **MPFS**, next page

MPFS

From previous page

HCPCS code	Description	Phys. diag. supv. indicator	Effective date
72142-TC	MRI neck spine w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72146-TC	MRI chest spine w/o dye - Phys Diag Supv Correction (TC)	01	01/01/2014
72147-TC	MRI chest spine w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72148-TC	MRI lumbar spine w/o dye - Phys Diag Supv Correction (TC)	01	01/01/2014
72149-TC	MRI lumbar spine w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72156-TC	MRI neck spine w/o & w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72157-TC	MRI chest spine w/o & w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72158-TC	MRI lumbar spine w/o & w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72191-TC	CT angiograph pelv w/o&w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
74174-TC	CT angio abd & pelv w/o&w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
74175-TC	CT angio abdom w/o & w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
93880-TC	Extracranial bilat study - Phys Diag Supv Correction (TC)	01	01/01/2014
93882-TC	Extracranial uni/ltd study - Phys Diag Supv Correction (TC)	01	01/01/2014
77001-TC	Fluoroguide for vein device - Phys Diag Supv Correction (TC)	03	01/01/2014
77002-TC	Needle localization by xray - Phys Diag Supv Correction (TC)	03	01/01/2014
77003-TC	Fluoroguide for spine inject - Phys Diag Supv Correction (TC)	03	01/01/2014

Additional information

The official instruction, CR 8664, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2923CP.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: MM8664 *Revised*
Related Change Request (CR) #: CR 8664
Related CR Release Date: April 4, 2014
Effective Date: January 1, 2014
Related CR Transmittal #:R2923CP
Implementation Date: April 7, 2014

2014 update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

Provider types affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

This *MLN Matters*® article is based on change request (CR) 8695 which provides instructions for the revised 2014 clinical laboratory fee schedule, including several codes that were inadvertently left off of the previous 2014 fee schedule files.

These codes, which were intended to be included on the original 2014 clinical laboratory fee schedule file, were recently given a "QW" modifier to both identify the codes and to determine payment for tests performed by a laboratory having only a certificate of waiver under CLIA.

Also, CR 8695 corrects a technical oversight that led to the misstatement of several prices on the fee schedule. Those prices reflected on this file created for CR 8695 are now correct. Be sure your billing staffs are aware of these updates.

Background

CR 8695 provides instructions for the revised 2014 clinical laboratory fee schedule.

Access to data file

The revised 2014 clinical laboratory fee schedule data file will be available on or after February 28, 2014, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*.

Other interested parties, such as the Medicaid state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, will also use the Internet to retrieve the 2014 clinical laboratory fee schedule which will be available in multiple formats including Excel, text, and comma delimited.

Mapping information

Existing codes that have been recalculated so that their national limitation amount (NLA) and/or price for each MAC is correct. These codes are *80160, 82017, 82136, 82139, 82261, 82270, 82271*, *82271*QW, *82272*, *82272*QW, *82274*, *82274*QW, *82379*, *83013*, *83080*, *85576*, *85576*QW, *86355*, *86357*, *86359*, *86367*, G0123, G0328, and G0328QW.

Existing code pricing

- Existing code *86152* is priced at the 2013 contractor gap filled rate.

- Existing code *86294*QW is priced at 100 percent of the midpoint in the NLA pricing.

Additional information

Note that your MAC will not automatically adjust claims processed prior to implementation of CR 8695. However, if you have claims that need adjustment, your MAC will adjust those claims that you bring to their attention.

The official instruction, CR 8695, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2948CP.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: MM8695
Related Change Request (CR) #: CR 8695
Related CR Release Date: May 2, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R2948CP
Implementation Date: On or before June 30, 2014

Updating beneficiary information with the benefits coordination & recovery center

***Note**: This article replaces MLN Matters® special edition (SE) article SE1205. There are no changes to the processes that were described in SE1205.*

Provider types affected

The key change is that the coordination of benefits contractor (COBC) is now known as the benefits coordination and recovery center (BCRC) and there is new contact, address, and Web address information at the end of this article that is associated with this process and the BCRC.

This *MLN Matters*® special edition (SE) article is intended for physicians, other providers, and suppliers who provide products or services to Medicare beneficiaries with insurance in addition to Medicare.

It updates *MLN Matters*® article SE1205 to provide information regarding the benefits coordination & recovery center (BCRC), which has replaced the former coordination of benefits contractor.

Provider action needed

A new Medicare secondary payer (MSP) initiative will affect how you may update beneficiary information to the BCRC.

This article describes initiatives that both the Centers for Medicare & Medicaid Services (CMS) and the BCRC are undertaking to maintain the most up-to-date and accurate beneficiary MSP information on Medicare's common working file (CWF).

You should make sure that your appropriate staffs are aware of these options for updating a beneficiary's MSP information and that they are aware of new contact information at the end of this article for the BCRC.

Background

There has been considerable discussion about the accuracy of beneficiary MSP information on the CWF and who is responsible for keeping that information updated. Further, providers have stated that the update is not accepted when they attempt to update beneficiary information with the BCRC by phone. Therefore (as noted below), CMS and the BCRC are both undertaking initiatives to resolve the issue and maintain the most up-to-date and accurate beneficiary information with regard to MSP.

In compliance with Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (known as Section 111 of the MMSEA), CMS has implemented a process through which

private insurers (both group health plans (GHP) and non-group health plans (NGHP)) submit coverage information to the BCRC when they also provide coverage to a Medicare beneficiary.

A private GHP insurer reporting under Section 111 is known as a responsible reporting entity (RRE), and the BCRC receives Section 111 data input files from approximately 1,500 GHP insurers, and each file can include large numbers of individual coverage records. This information permits CMS to more accurately determine who (either the private insurer or Medicare) has primary, or secondary, claims coverage responsibility.

CMS initiatives

Occasionally, information submitted to the BCRC from any number of sources, including GHP RREs, service providers, and beneficiaries themselves can conflict with MSP information previously reported to the BCRC.

To reduce such conflicts in the future, CMS has developed and implemented a data management "reporting hierarchy" process, which the BCRC administers (effective April 1, 2011). An explanation of the hierarchy rules can be found within the MMSEA Section 111 *GHP User Guide* available at *http://go.cms.gov/MIRGHPUserGuide*.

BCRC initiatives

The BCRC works closely with GHP RREs and other reporters in order to reduce "hierarchy" conflicts in future reporting. The following steps are in place to help providers update MSP records:

- Provider attempting update with the beneficiary in the office:

See **CENTER**, next page

CENTER

From previous page

The first time a call is made to update the record after April 4, 2011, it will be updated via the telephone call. For any subsequent calls made to update the record after April 4, 2011, no update will be made on the call, but two options are available:

1) Proof of information can be faxed or mailed on the insurer or employer's company letterhead, and the update will be made in 10-15 business days; or

2) You can contact the insurer or employer organization that last updated the record.

- Provider attempting update when the beneficiary is not in the office:

No update will be made from a telephone call. The provider has three options to have the record updated:

1) Have the beneficiary contact BCRC;

2) Contact the beneficiary's insurer to resolve the issue; or

3) Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days.

Provider with new information:

The BCRC will take new information for a beneficiary, but if the new information requires changes to an existing record, two options are available:

1) The beneficiary will need to call to close out the record; or

2) Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days.

- Provider update for deceased beneficiary:

A SINGLE update can be made by ONE provider for a deceased beneficiary, once the date of death has been confirmed.

Any subsequent updates would need to be handled by a family member with the appropriate documentation, including a death certificate.

Additional information

An explanation of the GHP RRE hierarchy rules can be found within the MMSEA Section 111 *GHP User Guide* at *http://go.cms.gov/MIRGHPUserGuide*. General information about GHP mandatory insurer reporting is available at *http://go.cms.gov/mirghp*.

The BCRC's contact information is:

Telephone: 1-855-798-2627 (8 a.m. to 8 p.m. E.T.)
Fax: 1-405-869-3307
(address fax to Medicare- MSP General Correspondence)

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

MLN Matters® Number: SE1416
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

Updating beneficiary information with the coordination of benefits contractor

Note: This article was rescinded and replaced by *MLN Matters*® article special edition (SE)1416, April 3, 2014.

That article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1416.pdf*.

SE1205 was previously published in the *February 2012 edition* of *Medicare A Connection*, Pages 5-6.

MLN Matters® Number: SE1205 *Rescinded*
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

Hospitals

Implementing Part B inpatient policies from CMS-1599-F

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8666, which implements revised policies related to payment of hospital Part B inpatient services from the fiscal year 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) final rule, CMS-1599-F.

This includes several conforming changes to the *Medicare Benefit Policy Manual* for payment of Part B inpatient services in skilled nursing facilities (SNFs). CR 8666 is a companion piece to the recently issued CR 8445 (see the related *MLN Matters*® article, MM8445, available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8445.pdf*.). Be sure your billing staffs are aware of these changes.

Background

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, such as outpatient visits, emergency department visits, and observation services, that are, by definition, provided to hospital outpatients and not inpatients.

Part B payment may only be made if the beneficiary is enrolled in Part B, the allowed timeframe for submitting claims is not expired, and waiver of liability payment is not made.

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 article, 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 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.

For Part B inpatient services furnished by the hospital that are not paid under the hospital outpatient prospective payment system (OPPS), but rather under some other Part B payment mechanism, Part B inpatient payment is made according to the Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients.

When payment cannot be made under Medicare Part A, Medicare continues to pay for Part B services included in the 3-day (1-day for hospitals not paid under the inpatient prospective payment system (IPPS)) payment window preceding the inpatient admission, including services requiring an outpatient status. The Part B coverage and payment rules for individual services apply. Hospitals are required to maintain documentation to support the Part B services rendered and billed.

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, LTCHs, inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, CAHs, children's hospitals, cancer hospitals, Maryland waiver hospitals, and other facilities as provided by the Centers for Medicare & Medicaid Services (CMS). Hospitals paid under the OPPS must continue billing the OPPS for Part B inpatient services.

See **INPATIENT**, next page

INPATIENT

From previous page

Hospitals that are excluded from payment under the OPPS in 42 CFR 419.20(b) are eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies. Beneficiaries are liable for their usual Part B financial liability.

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.

Timely filing restrictions apply for the Part B services billed. Claims that are filed beyond one calendar year from the date of service will be rejected as untimely and will not be paid. CMS notes that 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 the limited set of ancillary Part B inpatient services specified in the *Medicare Benefit Policy Manual*, Chapter 6, Section 10.2, attached as part of CR 8666.

Hospitals may also be paid under Part B for services included in the payment window prior to the point of inpatient admission for outpatient services treated as inpatient services (see the *Medicare Claims Processing Manual*, Chapter 4, Section 10.12, available at), including services requiring an outpatient status.

The hospital can only bill for services that it provided directly or under arrangement in accordance with Part B payment rules.

Outpatient therapeutic services furnished at an entity that is wholly owned or wholly operated by the hospital and is not part of the hospital (such as a physician's office), may not be billed by the hospital to Part B. Reference labs may be billed only if the referring laboratory does not bill for the laboratory test (see the *Medicare Claims Processing Manual*, Chapter 16, Section 40.1, "Laboratories Billing for Referred Tests" available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf*).

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for Part B services submitted following a reasonable and necessary Part A claim denial or hospital utilization review determination must be filed no later than the close of the period ending 12 months or one calendar year after the date of service.

Other circumstances in which payment cannot be made under Part A

Part B payment could be made to a hospital for the medical and other health services listed in this section for inpatients enrolled in Part B if:

- No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before or during the admission; or
- The patient was not otherwise eligible for or entitled to coverage under Part A (See Chapter 16 Section 180 of the *Medicare Claims Processing Manual* for services received as a result of non-covered services).

Beginning in 2014, for hospitals paid under the OPPS these Part B inpatient services are separately payable under Part B, and are excluded from OPPS packaging if the primary service with which the service would otherwise be bundled is not a payable Part B inpatient service.

The following inpatient services are payable under the OPPS:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Acute dialysis of a hospital inpatient with or without end stage renal disease. The charge for hemodialysis is a charge for the use of a prosthetic device, billed in accordance with Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 200.2, "Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD)."
- Screening pap smears;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;

See **INPATIENT**, next page

INPATIENT

From previous page

- Colorectal screening;
- Bone mass measurements;
- Prostate screening;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision;
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO) that is not covered under the end-stage renal disease benefit.

The following inpatient services are payable under the non-OPPS Part B fee schedules or prospectively determined rates listed:

- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations (DMEPOS fee schedule);
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of intraocular lens (DMEPOS fee schedule, except for implantable prosthetic devices paid at the applicable rate under the *Medicare Claims Processing Manual*, Chapter 4, Section 240.3, "Inpatient Part B Hospital Services - Implantable Prosthetic Devices");
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including replacements if required because of a change in the patient's physical condition (DMEPOS fee schedule);
- Physical therapy services, speech-language pathology services, and occupational therapy services (see Chapter 15, Sections 220 and 230 of the *Medicare Benefit Policy Manual*, "Covered Medical and Other Health Services") (applicable rate based on the Medicare physician fee schedule);
- Ambulance services (ambulance fee schedule); and
- Screening mammography services (Medicare physician fee schedule).

Additional information

The official instruction, CR 8666, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R182BP.pdf*.

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

MLN Matters® Number: MM8666
Related Change Request (CR) #: CR 8666
Related CR Release Date: March 21, 2014
Effective Date: October 1, 2013
Related CR Transmittal #: R182BP
Implementation Date: April 21, 2014

Adjustment of community mental health center claims for telehealth originating facility fees

Community mental health center (CMHC) claims for telehealth originating facility fees (procedure code Q3014) processed from January 7, 2013, through February 23, 2014, were incorrectly reimbursed at 100 percent of billed charges.

These claims will be adjusted in the next 90 days. Claims processed on and after February 24, 2014, are paying correctly. Beneficiary liability for deductible and coinsurance is correct and calculated based on the fee schedule amount. No action is required by CMHCs.

Reopenings of inpatient 'probe & educate' claims

On August 2, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a final rule, *CMS-1599-F*, updating fiscal year (FY) 2014 Medicare payment policies and rates under the inpatient prospective payment system (IPPS) and the long-term care hospital prospective payment system (LTCH PPS).

The final rule modifies and clarifies CMS's longstanding policy on how Medicare contractors review inpatient hospital and critical access hospital (CAH) admissions for payment purposes. CMS subsequently released guidance *September 5, 2013*, and *January 30, 2014*, that clarified the physician order and physician certification requirements for hospital inpatient admissions.

CMS is requesting that the Medicare administrative contractors (MACs) re-review all claim denials under the "probe & educate" process to ensure the claim decision and subsequent education is consistent with the most recent clarifications. T

he MAC may reverse their decision and issue payment outside of the appeals process if the MAC determines that a claim is payable upon re-review by the MAC.

Therefore, CMS urges providers to work with their MACs to determine if a claim has undergone final adjustment (in other words, has been re-reviewed) prior to submitting an appeal request.

To ensure that the re-review process does not affect the ability of a provider to file a timely appeal of a denied

claim, CMS will waive the 120 day timeframe for filing redetermination requests received before September 30, 2014, for claim denials under the "probe & educate" process that occurred on or before January 30, 2014.

Claim denials under the "probe & educate" process that occurred on or before January 30, 2014, for which an appeal has been filed will also be subject to re-review. Claims determined payable following re-review will be adjusted accordingly.

Claims for which the denial is affirmed following re-review will be transferred to appeals automatically for a redetermination. Providers can access the September 5, 2013, and January 30, 2014, *documents here*.

CMS proposes changes to hospital outpatient supervision designation levels

Based on the hospital outpatient payment (HOP) panel's recommendations at its meeting March 10, 2014, the Centers for Medicare & Medicaid Services (CMS) is proposing changes to certain current outpatient supervision level requirements described in the 2012 Hospital Outpatient Prospective Payment System / Ambulatory Surgical Center final rule.

The requirements open to public comment are outlined in CMS' *Preliminary Decisions on the Recommendations of the Hospital Outpatient Payment Panel on Supervision Levels for Select Services*.

Comments may be submitted via email to *HOPSupervisionComments@cms.hhs.gov* through 5 p.m. ET, April 30, 2014. As indicated in the final rule, CMS will consider any comments and post final decisions that will be effective on July 1, 2014.

Updated intern and resident database files available

The Centers for Medicare & Medicaid Services' (CMS) Office of Financial Management posted two intern and resident information system (IRIS) programs with updated files on the CMS website, February 28, 2014.

The uploaded files include medical school codes, residency type codes, and operating instructions for using the IRIS system.

Teaching hospitals and others in the provider community use these programs to collect and report information on resident training in hospital and non-hospital settings. The primary purpose of IRIS is to ensure that Medicare counts interns and residents as only one full-time equivalent employee in the calculation of payments for the costs of direct graduate medical education and indirect medical education.

IRIS program files and instructions are available on the CMS website for download by *clicking here*.

Educational Events

Provider outreach and educational events May-June 2014

Medicare rules on inpatient hospital admissions

When: Wednesday, May 22, 2014
Time: 1:30 p.m. -3:00 p.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/269159.asp

Medicare Part A changes and regulations

When: Tuesday, June 24
Time: 1:30 p.m. - 3:30 p.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/267483.asp

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: April 3, 2014 – *http://go.usa.gov/KJRh*
- CMS MLN Connects™ Provider eNews: April 10, 2014 – *http://go.usa.gov/kgMH*
- CMS MLN Connects™ Provider eNews: April 17, 2014 – *http://go.usa.gov/kkfk*
- CMS MLN Connects™ Provider eNews: April 24, 2014 – *http://go.usa.gov/KpSh*

Florida/USVI 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/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 & 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

Florida/USVI 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, 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 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

Puerto Rico 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 number1-904-361-0407

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