

# C Medicare A CONNECTION

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*A Newsletter for MAC Jurisdiction N Providers*

June 2014



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## Outstanding medical records create great patient outcomes

### Communication tool

Physicians have been taught throughout their training that the medical record is their best insurance policy to communicate the quality of their analytical skills, problem-solving ability, and as a controlling guide for the complexity of patient care.

Evidence emerging from increasing use of electronic health records confirms that, when properly applied, the medical record will:

- Reduce patient care errors,
- Reduce rates of missing clinical information,
- Advance evidence-based clinical decision-making,
- Reduce costs by preventing duplicative and contraindicated services,
- Provide for care coordination across the spectrum of providers, and
- Enhance the quality of patient outcomes (See references 1-13, below)

### Quality of records

When the contribution of rigorously structured medical records was studied in a critical-care setting (acute coronary syndrome) in an extensive cross-section of U.S. hospitals (more than 200), the results were dramatic: Substantial incremental differences in survival and discharge health status were observed when high standards of clinical records were maintained (14).

In contrast, inferior patient records produced the opposite outcomes in all of the above categories.

The American College of Medical Quality (ACMQ) has further refined concepts of quality of care and medical documentation (15).

### Auditing for medical necessity

Beginning with the original statute mandated by the 1965 (Medicare) provisions of the Social Security Act, and further elaborated by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), the doctrine of **medical**

See **RECORDS**, Page 3



**WHEN EXPERIENCE COUNTS & QUALITY MATTERS**

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## Expand your knowledge of Medicare

Visit the *Medicare Learning Network*® (MLN) Educational Web Guides Overview page, for educational and informational resources to improve your knowledge of Medicare billing and policies.

The *MLN Educational Web Guides* provides information on evaluation and management (E/M) services; guided pathways to resources and topics of interest; lists of health care management products; as well as easy-to-understand billing and coding products.

[Click here](#) to explore educational web guides.

## General Information

### RECORDS

From Front Page

**necessity** controls coverage and payment policy by federal healthcare payers (16). Medical necessity in turn is evidenced by a variety of criteria, including criteria for effectiveness, appropriateness to the patient's presentation, relevance to a disease process, non-provision for strictly physician convenience, etc. (17-20).

Accordingly, a nexus was established between medical necessity documentation and the vehicle of the medical record as a tool for care coordination, evidence of services, risk minimization, and outcome enhancement.

The above considerations led to the medical record audits mandated by CMS, identified as Comprehensive Error Rate Testing (CERT) (20, 21). The CERT program requires post-pay audits of medical records to establish that services were 1) provided and 2) of medical necessity, with the authority to recoup payments where evidence for these services is inadequate for a medically-trained reviewer.

It is therefore accurate to consider the CERT audit as a tool to ascertain service provision **and** as a mechanism to improve overall patient quality outcomes.

Finally, a 2014 report from the Health and Human Services Office of the Inspector General (OIG) placed Part A providers on notice that exaggerating patient complexity and morbidity to justify higher payments would be the subject of auditing activity. Exaggeration of the medical necessity for services based on poor documentation may incorrectly inflate a DRG weight leading to facility overpayment (22). The discovery of such practices may result in recoupment or more severe sanctions; such have been the results of other OIG actions against health care suppliers and providers (23).

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## Open payments (the Sunshine Act) update

### Portal registration begins

The Centers for Medicare & Medicaid Services (CMS) Enterprise Portal is now available for physicians and teaching hospital representatives to begin the registration process (phase 1).

Note that registration in the enterprise portal is a separate process from registration in the open payments system. Enterprise portal registration is a required first step to allow for registration in the open payments system when it becomes available in phase 2.

Although registration in the enterprise portal and the open payments system is a voluntary process, it is required if the physician or teaching hospital wants to be able to review and dispute any of the data reported about them by applicable manufacturers and applicable group purchasing organizations (GPOs).

Registration for physicians and teaching hospitals will be conducted in two phases for this first open payments reporting year:

**Phase 1 (available now):** Includes user registration in the CMS enterprise portal. Use the [“Phase 1 Step-by-Step CMS Enterprise Portal Registration for Physicians and Teaching Hospitals” presentation](#) for guidance on how to complete this portion of the registration; this resource is also posted on the physicians and teaching hospitals pages of the [“Open Payments” website](#).

**Phase 2 (begins in July):** Includes physician and teaching hospital registration in the open payments system, and allows them to review and dispute data submitted by applicable manufacturers and applicable GPOs prior to public posting of the data.

**Note:** Any data that is disputed, if not corrected by industry, will still be made public but will be marked as disputed. [Click here to learn more](#) about the review and dispute process



Physician and teaching hospital registration in the CMS enterprise portal is complete once you receive acknowledgement that your request for open payments system access has been received.

*You will not be able to access the open payments system before Phase 2 begins in July, so if you attempt to access open payments through the enterprise portal, the radio buttons and functions that you will see on the *Welcome to Open Payments* main screen will not be operational until the system opens for phase two in July.*

### User guide

The [open payments user guide](#) has been extensively updated and is now available as a one-stop-shop resource for providing industry, physicians, and teaching hospitals with a comprehensive understanding of open payments requirements and the open payments system.

The user guide includes definitions, screenshots, tools, and tips to provide users with a better understanding of how to operationalize the collection, reporting, and review of open

payments data.

The contents are conveniently organized by user group (industry, physician, or teaching hospital), making it easy to identify what is most applicable for you. The [open payments user guide](#) can be accessed on the [open payments program fact sheets and user guides Web page](#), other open payments website pages, and in the open payments system.

### Live help desk

For more information about open payments, please visit the [open payments website](#). If you have any questions, you can submit an email to the help desk at [openpayments@cms.hhs.gov](mailto:openpayments@cms.hhs.gov) or [openpayments@cms.hhs.gov](mailto:openpayments@cms.hhs.gov); or call 855-326-8366 for live help desk support Monday through Friday, from 7:30 a.m. to 6:30 p.m. CT, excluding federal holidays.

## 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/Help/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.



## Mandatory reporting of an eight-digit clinical trial numbers

**Note:** This article was revised June 9, 2014, to emphasize that coding “CT” in front of the clinical trial number applies **only** to paper claims. The “CT” is not to be coded on electronic claims. All other information remains the same. This information was previously published in the *May 2014 Medicare A Connection*, Pages 7-8.

### Provider types affected

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

### Provider action needed

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

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

Make sure that your billing staffs are aware of this requirement.

### Background

CR 5790, Transmittal 310, dated January 18, 2008, titled “Requirements for Including an 8-Digit Clinical Trial Number on Claims” is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R310OTN.pdf>.

The *MLN Matters*® article for CR 5790 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5790.pdf>.

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

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

Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by



consulting CMS’s clinical trials/registry website at <http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html>.

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

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

**For professional claims**, the eight-digit clinical trial number preceded by the two alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in loop 2300 REF02(REF01=P4) (**do not use CT on the electronic claim, e.g., 12345678**) when a clinical trial claim includes:

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

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

- **Claim adjustment reason code (CARC) 16:** “Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)”

See **TRIALS**, next page

## TRIALS

From previous page

- **RARC MA50:** “Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.”
- **RARC MA130:** “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.”
- **Group code:** Contractual obligation (CO).

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

### Additional information

The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2955CP.pdf>.

See *MLN Matters*® article SE1344 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1344.pdf>) for

information on an interim alternative method of satisfying the requirement in CR 8401 for providers who do not have the ability to submit the clinical trial number for trial related claims.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How Does It Work*.

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## Modifying the daily CWF to MBD file to include diagnosis codes on the HETS 270/271 transactions

**Note:** This article was rescinded May 20, 2014, as a result of a revision to change request (CR) 8456, issued on May 16.

The CR revision eliminated the need for provider education. As a result, this article is rescinded. This information was previously published in the *February 2014 Medicare A Connection, Page 33*.

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Implementation Date: October 6, 2014

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## Claims for ICD-9-CM procedure codes 05.89, 35.97, and 39.71 denied in error

Claims submitted with ICD-9-CM procedure code 39.71 for services rendered on or after December 1, 2013, and ICD-9-CM procedure codes 05.89 and 35.97 for services rendered on or after January 1, 2014, may have been denied incorrectly as not being medically necessary. This error was corrected June 4, 2014.

### No action required by providers.

Providers, whose claims were denied incorrectly due to this error, do not need to take any action. First Coast Service Options Inc. will perform adjustments to correct the error. We apologize for any inconvenience this may have caused.

## Submission of community mental health center certifications of compliance

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for community mental health centers (CMHCs) submitting institutional claims to Medicare administrative contractors (MACs) for CMHC services to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 8784, which informs MACs about the processing of CMHC certifications of compliance.

### Background

Effective October 29, 2014, under 42 CFR 485.918(b) (1) a CMHC must provide at least 40 percent of its items and services to individuals who are not eligible for benefits under title XVIII of the Social Security Act, as measured by the total number of CMHC clients treated by the CMHC for whom services are not paid by Medicare, divided by the total number of clients treated by the CMHC in the applicable timeframe.

Pursuant to this requirement, a newly enrolling or revalidating CMHC must submit to the Centers for Medicare & Medicaid Services (CMS), via its MAC, a certification statement provided by an independent entity (such as an accounting technician). The document must certify that:

- The entity has reviewed the CMHC's client care data; and
- For initial enrollments: The CMHC meets the 40 percent requirement for the prior three months.
- Revalidations: The CMHC meets the 40 percent requirement for each of the intervening 12-month periods between initial enrollment and revalidation.

The statement must be submitted as part of any initial enrollment or revalidation (including off-cycle revalidations).

### Special guidelines

1. An appropriate official of the certifying entity must sign the document. (Notarization is not required unless CMS requests it.) Such persons may include accounting technicians, CEOs, officers, directors, etc.



2. The certification should be on the certifying entity's letterhead or should otherwise indicate that the document is clearly from the entity.

### Additional Information

The official instruction, CR 8784, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R521PI.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How Does It Work*.

*MLN Matters*<sup>®</sup> Number: MM8784  
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Related CR Transmittal #: R521PI  
Implementation Date: July 15, 2014

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## General Coverage

# Percutaneous image-guided lumbar decompression for lumbar spinal stenosis

## Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for providers submitting claims to Medicare administrative contractors (MACs) for services furnished to Medicare beneficiaries.

## Provider action needed

Effective for claims with dates of service on and after January 9, 2014, Medicare will only allow coverage with evidence development (CED) for percutaneous image-guided lumbar decompression (PILD) for lumbar spinal stenosis (LSS) for beneficiaries enrolled in an approved clinical trial.

## Background

PILD is a procedure that was proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. It is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (e.g., fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epidurogram.

The Centers for Medicare & Medicaid Services (CMS) currently does not cover PILD; and moreover, after careful consideration, determines that PILD for lumbar spinal stenosis LSS is not reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act (the Act).

However, CMS has determined that effective for claims with dates of service on or after January 9, 2014, Medicare will cover PILD only when it is provided in a clinical study under Section 1862(a)(1)(E) of the Act, through CED, for beneficiaries with LSS who are enrolled in an approved clinical study that meets the criteria described in the *National Coverage Determinations (NCD)* manual at NCD 150.13.

## Specific payment actions

On or after January 9, 2014, effective for hospital outpatient procedures on type of bill (TOB) 13x or 85x, and for professional claims billed with a place of service (POS) 22 (outpatient) or 24 (ambulatory surgical center), Medicare will allow CED for PILD (procedure code 02757) for LSS, ICD-9 diagnosis range 724.01-724.03, or ICD-10 diagnosis range M48.05-M48.07, only when billed with:

- Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) and condition code 30 either in the primary or secondary positions; and
- Modifier Q0; and



- An eight-digit clinical trial number listed at <http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html>.

On or after January 9, 2014, effective for hospital outpatient procedures on type of bill (TOB) 13x or 85x, your MAC will reject claims for PILD, procedure code 02757 for LSS, ICD-9 diagnosis range 724.01-724.03, or ICD-10 diagnosis range M48.05-M48.07, when billed without:

- Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) in either the primary/secondary positions;
- Modifier Q0, condition code 30 (institutional claims only); and,
- An eight-digit clinical trial number listed on the CMS website.

When rejecting these claims, they will use:

- Claims adjustment reason code (CARC) 50:** These are non-covered services because this is not deemed a "medical necessity" by the payer;
- Remittance advice remarks code (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 <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD; and
- Group code:** Contractual obligation (CO).
  - MACs will return the professional PILD claim as unprocessable when billed with a diagnosis code other than 724.01-724.03 (ICD-9) or M48.05-M48.07 (ICD-10), using:

See **SPINAL**, next page



## SPINAL

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- a) **CARC B22:** “This payment is adjusted based on the diagnosis;”
- b) **RARC N704:** “Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.” And;
- c) **Group code:** Contractual obligation (CO).
  - MACs will return the professional PILD claim as unprocessable when billed in a place of service other than 22 (outpatient) or 24 (ambulatory surgical center), using:
- a) **CARC 58:** “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service;”
- b) **RARC N704:** “Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.” And;
- c) **Group code:** Contractual obligation (CO).
  - MACs will return the professional PILD claim as unprocessable if it does not contain the required clinical trial diagnosis code V70.7 (ICD-9) or Z00.6 (ICD-10) in either the primary/secondary positions, using:
- a) **CARC B22:** “This payment is adjusted based on the diagnosis;”
- b) **RARC M76:** “Missing/incomplete/invalid diagnosis or condition;”
- c) **RARC N704:** “Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.” and
- d) **Group code:** Contractual obligation (CO).
  - MACs will return the professional PILD claim as unprocessable when billed without Modifier Q0, using:
- a) **CARC 4:** “The procedure code is inconsistent with the modifier used or a required modifier is missing;”
- b) **RARC N657:** “This should be billed with the appropriate code for these services.”;
- c) **RARC N704:** “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information;” and

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

MACs will accept the numeric, eight-digit clinical trial identifier number preceded by the two alpha characters of “CT” when placed in Field 19 of paper Form CMS-1500, or when entered **without** the “CT” prefix in the electronic 837P in loop 2300 REF02 (REF01=P4). **Note:** The “CT” prefix is required on a paper claim, but it is not required on an electronic claim.

- For PILD claims submitted without a clinical trial identifier number, they will follow the requirements outlined in CR 8401, Mandatory Reporting of an Eight-Digit Clinical Trial Number on Claims, released on October 30, 2013. You can find the associated *MLN Matters*<sup>®</sup> article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf>.

MACs will not search their files to adjust claims already processed, but will adjust claims that you bring to their attention.

Finally, you should note that endoscopically assisted laminotomy/laminectomy, which requires open and direct visualization, as well as other open lumbar decompression procedures for LSS, are not within the scope of this NCD.

### Additional information

The official instruction, CR 8757, issued to your MAC, consists of two transmittals. The first updates the *Medicare National Coverage Determinations* manual and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R167NCD.pdf>. The second transmittal updates the *Medicare Claims Processing* manual and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2959CP.pdf>.

*MLN Matters*<sup>®</sup> Number: MM8757  
 Related Change Request (CR) #: CR 8757  
 Related CR Release Date: May 16, 2014  
 Effective Date: January 9, 2014  
 Related CR Transmittal #: R167NCD and R2959CP  
 Implementation Date: October 6, 2014

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## Changes to the laboratory NCD software

### Provider types affected

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

### Provider action needed

This article is based on change request (CR) 8797 which informs MACs that the laboratory national coverage determination (NCD) edit software will be updated to continue the processing of ICD-9 diagnosis codes. Make sure your billing staffs are aware of these changes.

### Background

The Laboratory NCD edit software will be updated to continue the processing of the International Classification of Diseases, Ninth Revision (ICD-9) diagnosis codes.

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 of Health and Human Services may not adopt ICD-10 codes prior to October 1, 2015. This requires Health Insurance Portability & Accountability Act of 1996 (HIPAA) covered entities to continue to use ICD-9-CM at least through September 30, 2015. Also, CR 8797 announces there are no updates to the laboratory NCD code lists for this quarter.

## How to access updates to ICD-10 local coverage determinations in the CMS Medicare coverage database

### Provider types affected

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

### Provider action needed

This *MLN Matters*<sup>®</sup> special edition article is intended to convey information on how to access updates to International Classification of Diseases, 10th Edition (ICD-10) local coverage determinations (LCDs) in the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database (MCD).

### Background

MACs may develop an LCD to further define a national coverage determination (NCD) or in the absence of a specific NCD. An LCD is a coverage decision made at a MAC's own discretion to provide guidance to the public and the medical community within a specified geographic area. An LCD cannot conflict with an NCD. An LCD is an administrative and educational tool that can assist you in submitting correct claims for payment by:

### 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/R2976CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How Does It Work*.

*MLN Matters*<sup>®</sup> Number: MM8797

Related Change Request (CR) #: CR 8797

Related CR Release Date: June 13, 2014

Effective Date: October 1, 2014

Related CR Transmittal #: R2976CP

Implementation Date: October 6, 2014

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- Outlining coverage criteria;
- Defining medical necessity; and
- Providing references upon which a policy (LCD) is based and codes that describe covered and/or non-covered services when the codes are integral to the discussion of medical necessity.

### The MCD

To access the CMS MCD, visit <http://www.cms.gov/medicare-coveredatabase/indexes/national-and-local-indexes.aspx> on the CMS website.

Use the following steps to access the list of LCDs with ICD-10 codes:

1. On the CMS MCD homepage, click on the *Indexes* tab at the top of the page;
2. Select *Local Coverage*;
3. Select one of the three display options for LCDs (*LCDs by Contractor*, *LCDs by state*, or *LCDs Listed Alphabetically*);
4. If you choose LCDs by contractor, click on that link;

See **ICD-10**, next page

## ICD-10

From previous page

5. Select a MAC;
6. In the Document types, checkmark the square for *Future LCDs/Future Contract Number LCDs*;
7. Click the *Submit* button;
8. Click on the contractor name; and
9. A list of future effective LCDs will display. Those LCDs with a 10/01/2014 effective date are ICD-10 LCDs.

### Notes:

1. The ICD-10 updates are labeled *future* as the policies are not yet in effect. These updates are subject to change as necessitated by code updates and policy revisions.
2. It is expected that the 10/01/2014 effective dates will be changed to 10/01/2015 in mid-2014.

### Printing documents on the CMS MCD

All documents on the CMS MCD may be printed. Use the following steps to print a document:

1. Open the document; and
2. In the upper right-hand corner, click on the *Print* button or use *Control + P*. Alternatively, click on the *Need a PDF?* button and click on the *Save a Copy* icon on the bottom of your screen or use *Shift + Control + S*.

## CMS successful in ICD-10 acknowledgement testing week

### Additional testing scheduled for next year

This past March, the Centers for Medicare & Medicaid Services (CMS) conducted a successful ICD-10 testing week. Testers submitted more than 127,000 claims with ICD-10 codes to the Medicare fee-for-service (FFS) claims systems and received electronic acknowledgements confirming that their claims were accepted.

Approximately 2,600 participating providers, suppliers, billing companies and clearinghouses participated in the testing week, representing about five percent of all submitters. Clearinghouses, which submit claims on behalf of providers, were the largest group of testers, submitting 50 percent of all test claims. Other testers included large and small physician practices, small and large hospitals, labs, ambulatory surgical centers, dialysis facilities, home health providers, and ambulance providers.

Nationally, CMS accepted 89 percent of the test claims, with some regions reporting acceptance rates as high as 99 percent. The normal FFS Medicare claims acceptance rates average 95-98 percent. Testing did not identify any issues with the Medicare FFS claims systems.

This testing week allowed an opportunity for testers and CMS alike to learn valuable lessons about ICD-10 claims processing. In many cases, testers intentionally included such errors in their claims to make sure that the claim

### Additional Information

For an in-depth review on how to use the CMS MCD, refer to the *Medicare Learning Network*<sup>®</sup> publication titled *How to Use the Medicare Coverage Database* located at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareCvrgeDatabase\\_ICN901346.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareCvrgeDatabase_ICN901346.pdf).

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How Does It Work*.

MLN Matters<sup>®</sup> Number: SE1421  
Related Change Request (CR) #: N/A  
Related CR Release Date: N/A  
Effective Date: N/A  
Related CR Transmittal #: N/A  
Implementation Date: N/A

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would be rejected, a process often referred to as negative testing.

To be processed correctly, all claims must have a valid diagnosis code that matches the date of service and a valid national provider identifier. Additionally, the claims using ICD-10 had to have an ICD-10 companion qualifier code and the claims using ICD-9 had to use the ICD-9 qualifier code. Claims that did not meet these requirements were rejected.

HHS 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. Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the anticipated October 1, 2015, implementation date.

Submitters should contact their local *Medicare administrative contractor* (MAC) for more information about acknowledgment testing. However, those who submit claims may want to delay acknowledgement testing until after October 6, 2014, when Medicare updates its systems.

CMS will be conducting end-to-end testing in 2015. Details about this testing will be released soon.

## 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 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

### Ferrlecit® and Venofer® – revision to the Part A LCD

**LCD ID number: L28840 (Florida)**

**LCD ID number: L28873 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) ) for Ferrlecit® and Venofer® was revised revised based on an update to the Food and Drug Administration (FDA) label for Venofer®.

The “Indications and Limitations of Coverage and/or Medical Necessity” and “Documentation Requirements” sections of the LCD for Venofer® were revised to remove language referring to “receiving supplemental erythropoietin therapy.”

#### Effective date

This LCD revision is effective for claims processed **on or after June 3, 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, please [click here](#).

### Topotecan hydrochloride (Hycamtin®) – revision to the Part A LCD

**LCD ID number: L28993 (Florida)**

**LCD ID number: L29025 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for topotecan hydrochloride (Hycamtin®) was revised to include the off-label indication of endometrial carcinoma. The “Indications and Limitations of Coverage and /or Medical Necessity” section of the LCD was revised to add this off-label indication, and the “ICD-9 Codes that Support Medical Necessity” section of the LCD was updated to add the correlating diagnosis code 182.0. In addition, the “Sources of Information and Basis of Decision” section of the LCD was updated.

#### Effective date

This LCD revision is effective for services rendered **on or after May 29, 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, please [click here](#).

### Looking for LCDs converted to ICD-10?

A list of local coverage determinations (LCDs) converted to ICD-10 is available on the [LCDs by contractor index](#).

Use the scroll box on the index to select your Medicare administrative contractor (MAC) and select the “Submit” button to view a list of states that the specified MAC

services. You can then select your MAC name from the table to view the future translated LCDs.

See [MLN Matters® Special Edition article SE1421](#), “How to Access Updates to ICD-10 Local Coverage Determinations in the CMS Medicare Coverage Database.”

## Electronic Data Interchange

# Claim status category and codes update

### Provider types affected

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

### Provider action needed

This article is based on change request (CR) 8684 which informs the MACs of the changes to claim status category codes and claim status codes. Make sure that your billing personnel are aware of these changes.

### Background

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

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

All code changes approved during the June 2014 committee meeting will be posted on these sites on or

about July 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes will be used in the editing of all x12 276 transactions processed on or after the date of implementation and are to be reflected in x12 277 transactions issued on and after the date of implementation of CR 8684.

### Additional Information

The official instruction, CR 8684, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2967CP.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: MM8684  
 Related Change Request (CR) #: CR 8684  
 Related CR Release Date: May 23, 2014  
 Effective Date: October 1, 2014  
 Related CR Transmittal #: R2967CP  
 Implementation Date: October 6, 2014

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## Puzzled about your enrollment status?

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



# ICD-10 revisions and ICD-9 updates to national coverage determinations

## Provider types affected

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

## Provider action needed

This article is based on change request (CR) 8691 which is the first maintenance update of ICD-10 conversions and coding updates specific to national coverage determinations (NCDs).

The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, and CR 8197.

Links to related *MLN Matters*<sup>®</sup> articles MM7818, MM8109, and MM8197 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly recurring updates. No policy-related changes are included with these recurring updates.

Any policy related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these changes to the following 29 NCDs:

20.5 ECU Using Protein A Columns, 20.7 PTA, 20.20 ECP Therapy, 20.29 HBO Therapy, 50.3 Cochlear Implants, 70.2.1 Diabetic Peripheral Neuropathy, 80.2 Photodynamic Therapy, 80.2.1 OPT, 80.3 Photosensitive Drugs, 80.3.1 Verteporfin, 100.1 Bariatric Surgery, 110.8.1 Stem Cell Transplants, 110.4 Extracorporeal Photopheresis, 110.10 IV Iron Therapy, 150.3 Bone Mineral Density, 160.18 VNS, 160.24 Deep Brain Stimulation, 160.27 TENS for CLBP, 180.1 MNT, 190.1 Histocompatibility Testing, 190.8 Lymphocyte Mitogen Response Assay, 190.11 Home PT/INR, 210.1 PSA Screening Tests, 210.2 Screening Pap/Pelvic Exams, 210.3 Colorectal Cancer Screens, 210.10 Screening for STIs, 250.4 Treatment for AKs, 250.3 IVIG for Autoimmune Blistering Disease, 250.5 Dermal Injections for Facial LDS

## Background

The purpose of CR 8691 is to both create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, plus all associated coding infrastructure such as HCPCS/CPT<sup>®</sup> codes, reason/remark codes, frequency

edits, place of service (POS)/type of bill (TOB)/provider specialties, etc.

The requirements described in CR 8691 reflect the operational changes that are necessary to implement the conversion of the Medicare systems from ICD-9 to ICD-10 specific to the 29 NCD spreadsheets attached to CR 8691.

## Additional Information

The official instruction, CR 8691 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1388OTN.pdf>. **Note that there are 29 spreadsheets attached to CR 8691 and those spreadsheets relate to 9 NCDs and provide pertinent policy/coding information necessary to implement ICD-10.**

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How Does It Work*.

MM7818 is available for review at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7818.pdf>.

MM8109 is available for review at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8109.pdf>.

MM8197 is available for review at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8197.pdf>.

*MLN Matters*<sup>®</sup> Number: MM8691

Related Change Request (CR) #: CR 8691

Related CR Release Date: May 23, 2014

Effective Date: July 1, 2014 (ICD-9 updates, local system edits), October 1, 2014 (designated ICD-9 shared

system edits), October 1, 2015 (or whenever ICD-10 is implemented) (ICD-10 updates) determined for ICD-10

Related CR Transmittal #: R1388OTN

Implementation Date: July 7, 2014 (designated ICD-9 updates, local system edits, October 6, 2014 (or whenever ICD-10 is implemented) (ICD-10 updates) to be determined for ICD-10

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# July 2014 integrated outpatient code editor specifications version 15.2

## Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including the home health and hospice MACs, for outpatient services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency (HHA) not under the home health prospective payment system (HH PPS) or claims for services to a hospice patient for the treatment of a non-terminal illness.

## Provider action needed

This article is based on change request (CR) 8764 which informs MACs about the changes to the I/OCE instructions and specifications for the I/OCE that is used under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the home health prospective payment system (HH PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these changes.

## Background

This instruction informs the MACs that the I/OCE is being updated for July 1, 2014. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

The full list of I/OCE specifications is available at <http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html> on the Centers for Medicare & Medicaid Services (CMS) website. The summary of key changes for providers is in the following table:

Effective date	Modification
10/1/2014	Modify the effective begin date for edit 86 from 10/1/2013 to 10/1/2014, to be applied for claims with hospice bill types, 81x and 82x.
1/1/2014	Modify the logic for packaged laboratory services. If packaged laboratory services are submitted on a 13x bill type with modifier L1, change the Status Indicator (SI) from N to A.

Effective date	Modification
7/1/2014	Make Healthcare Common Procedure Coding System (HCPCS)/Ambulatory Payment Classification (APC)/SI changes as specified by CMS (data change files).
7/1/2014	Implement version 20.2 of the NCCI (as modified for applicable institutional providers).
1/1/2014	Add new modifier L1 (Separately payable lab test) to the valid modifier list.
7/1/2014	Add new modifier SZ (Habilitative services) to the valid modifier list.
1/1/2014	Updated documentation in Appendix F (a) and Appendix L to include bill type 13x for laboratory services reported with modifier L1.
7/1/2014	Documentation change only: modified Appendix N, List B (PHP Services) to note the add-on codes in a separate list as part of "PHP List C", referred to in Appendix C-a (Partial Hospitalization Logic effective v10.0).

## Additional Information

The official instruction, CR 8764, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2957CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

**MLN Matters<sup>®</sup> Number:** MM8764  
**Related Change Request (CR) #:** CR 8764  
**Related CR Release Date:** May 16, 2014  
**Effective Date:** July 1, 2014  
**Related CR Transmittal #:** R2957CP  
**Implementation Date:** July 7, 2014

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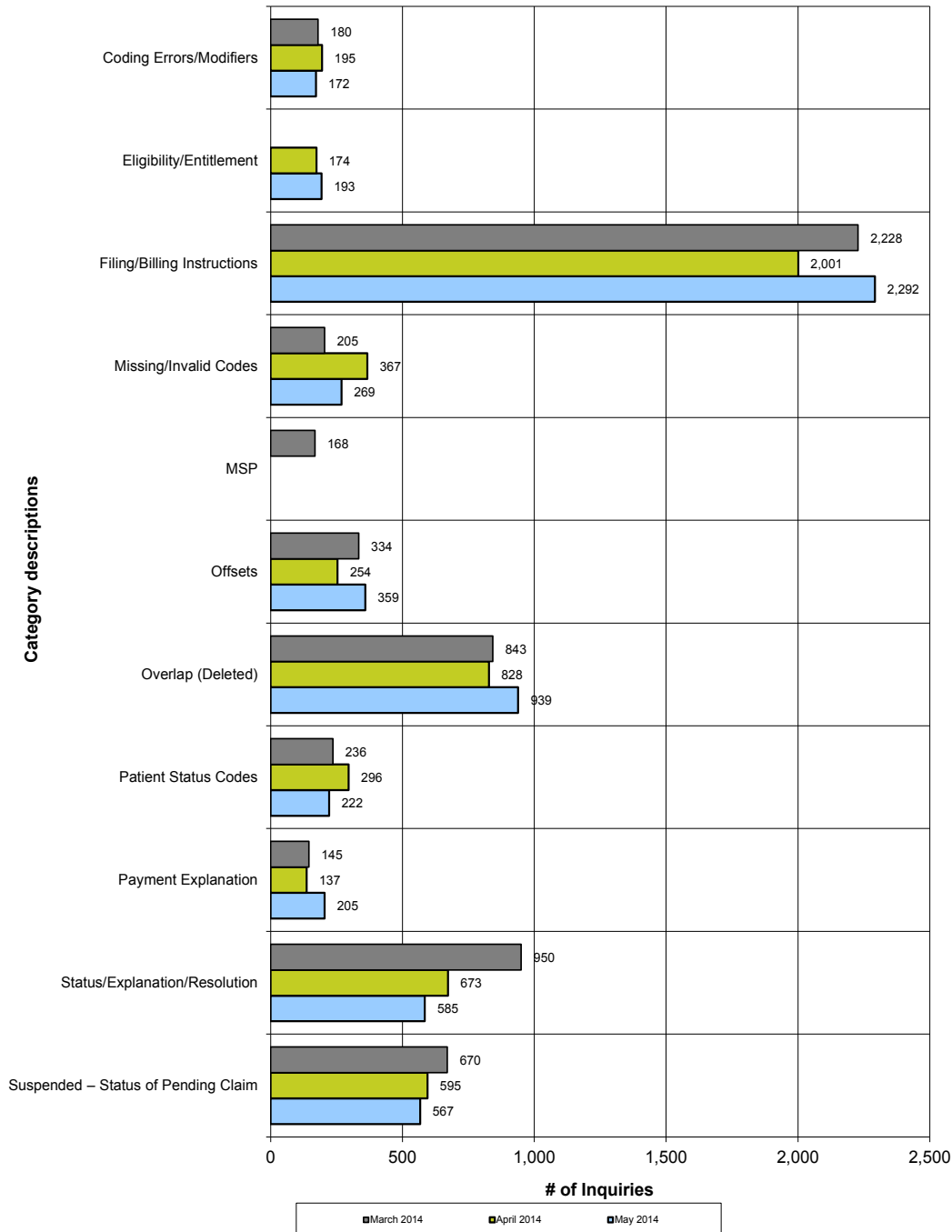
Claims and Inquiry Summary Data

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 March 2014 through May 2014.

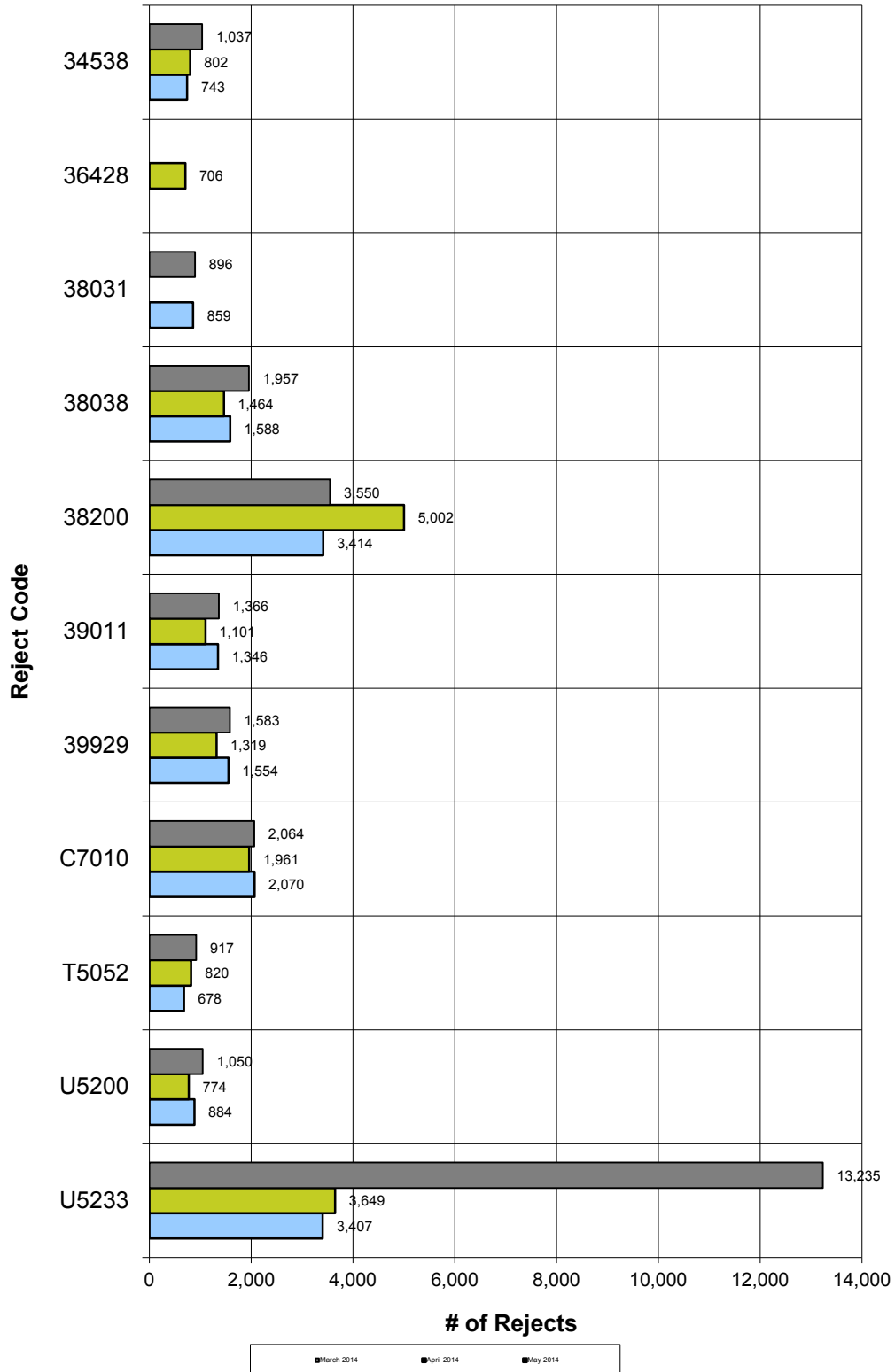
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at [http://medicare.fcso.com/Inquiries\\_and\\_denials/index.asp](http://medicare.fcso.com/Inquiries_and_denials/index.asp).

Top inquiries for March-May 2014



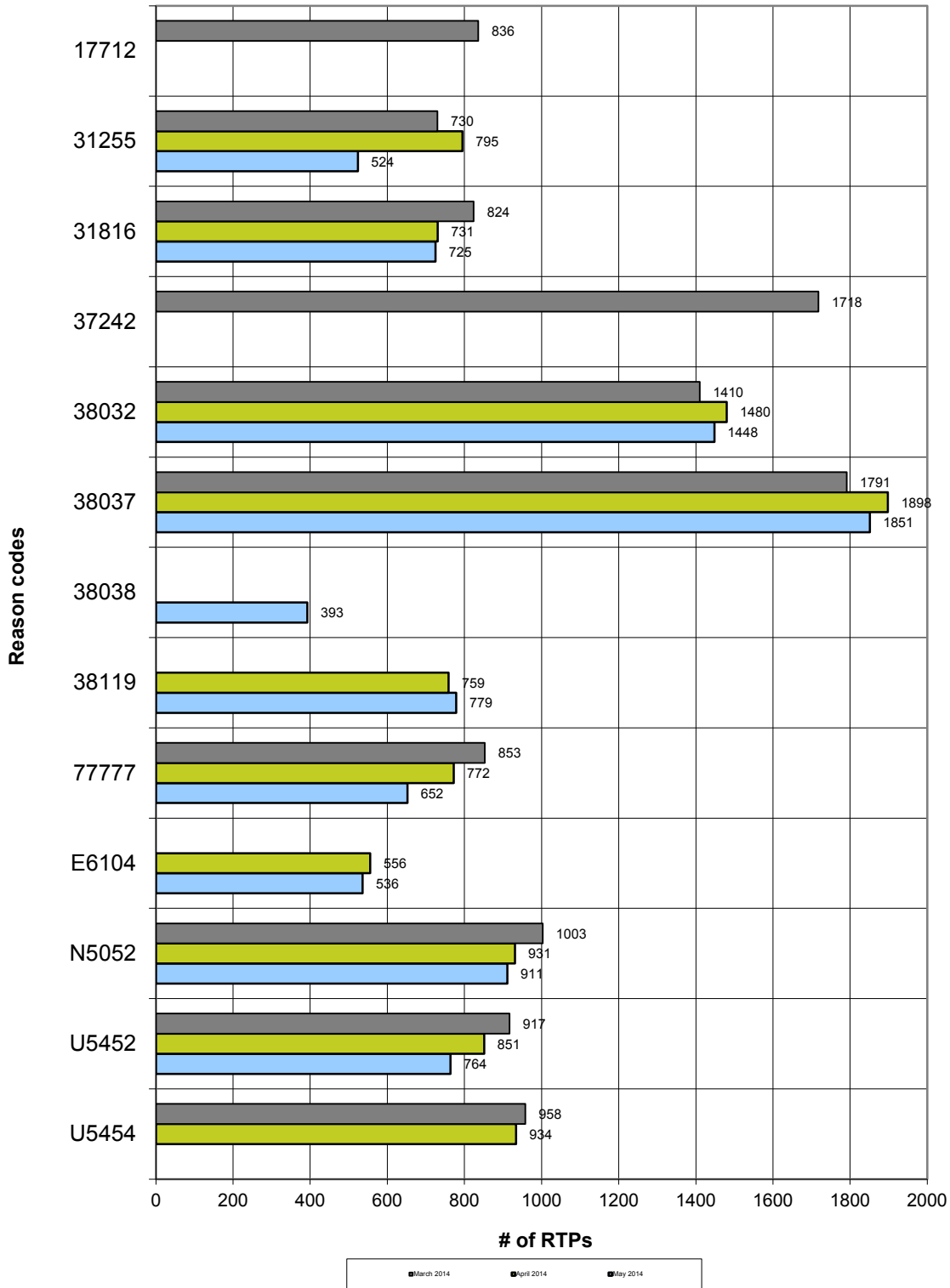
## Part A top rejects for March 2014 through May 2014

Top rejects for March-May 2014



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

### Top RTPs for March-May 2014



**Reimbursement**

## Medicare physician fee schedule database July update

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians, other providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including home health and hospice (HHH) MACs, for services provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 8773 which amends the payment files that were issued to MACs based upon the 2014 MPFS, *Final Rule* as modified by the “Pathway for SGR Reform Act of 2013” (Section 101) passed on December 18, 2013, and further modified by section 101 of the “Protecting Access to Medicare Act of 2014” on April 1, 2014. Make sure your billing staffs are aware of these changes.

### Background

The Social Security Act (Section 1848 (c)(4) (available at [http://www.socialsecurity.gov/OP\\_Home/ssact/title18/1848.htm](http://www.socialsecurity.gov/OP_Home/ssact/title18/1848.htm)) 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 based on current law and the *2014 Medicare Physician Fee Schedule (MPFS) Final Rule*, the MPFS Database (MPFSDB) has been updated using the 0.5 percent update conversion factor, effective January 1, 2014, to December 31, 2014.

Payment files were issued to MACs based upon the *2014 MPFS Final Rule*, published in the *Federal Register* on December 10, 2013, which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html>, and as modified by section 101 of the *Pathway for SGR Reform Act of 2013* passed on December 18, 2013, and further modified by section 101 of the *Protecting Access to Medicare Act of 2014* on April 1, 2014, for MPFS rates to be effective January 1, 2014, to December 31, 2014.

The summary of Healthcare Common Procedure Coding System (HCPCS) additions for the July 2014 update are shown in the following table:

HCPCS	Short descriptor	Procedure status
Q9970	Inj Ferric Carboxymaltos 1mg	E
Q9974	Morphine epidural/intratheca	E
S0144	Inj, Propofol, 10mg	I
S1034	Art pancreas system	I
S1035	Art pancreas inv disp sensor	I

HCPCS	Short descriptor	Procedure status
S1036	Art pancreas ext transmitter	I
S1037	Art pancreas ext receiver	I
0347T	Ins bone device for rsa	C
0348T	Rsa spine exam	C
0349T	Rsa upper extr exam	C
0350T	Rsa lower extr exam	C
0351T	Intraop oct brst/node spec	C
0352T	Oct brst/node i&r per spec	C
0353T	Intraop oct breast cavity	C
0354T	Oct breast surg cavity i&r	C
0355T	Gi tract capsule endoscopy	C
0356T	Insrt drug device for iop	C
0358T	Bia whole body	C
0359T	Behavioral id assessment	C
0360T	Observ behav assessment	C
0361T	Observ behav assess addl	C
0362T	Expose behav assessment	C
0363T	Expose behav assess addl	C
0364T	Behavior treatment	C
0365T	Behavior treatment addl	C
0366T	Group behavior treatment	C
0367T	Group behav treatment addl	C
0368T	Behavior treatment modified	C
0369T	Behav treatment modify addl	C
0370T	Fam behav treatment guidance	C
0371T	Mult fam behav treat guide	C
0372T	Social skills training group	C
0373T	Exposure behavior treatment	C
0374T	Expose behav treatment addl	C

All the additional codes listed in the above table are effective as of July 1, 2014. For full details on the above codes, including on descriptors, place of service codes, co-surgery indicators, etc. see the tables in CR 8773. The Web address for CR 8773 is in the *Additional information* section below.

In addition to the codes that were added, codes J2271 (Morphine SO4 injection 100mg) and J2275 (Morphine sulfate injection) have a change in their procedure status code from E to I, effective July 1, 2014.

Also, Section 651 of Medicare Modernization Act (MMA) required the Secretary of Health and Human Services to conduct a demonstration for up to 2 years to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. The demonstration expanded Medicare coverage to include: “(A) care for

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neuro-musculoskeletal conditions typical among eligible beneficiaries; and (B) diagnostic and other services that a chiropractor is legally authorized to perform by the state or jurisdiction in which such treatment is provided.”

The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1) (B) of MMA mandates the Secretary to ensure that “the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented.”

The costs of this demonstration were higher than expected and CMS has been recovering costs by deducting 2 percent from payments for chiropractic services. Since CMS has determined that the costs are fully recovered, the July update eliminates the two percent reduction for CPT® codes 98940, 98941, and 98942 that was utilized for the first half of 2014, effective July 1, 2014.

### Additional Information

The official instruction, CR 8773 issued to your MAC

## Billing guide for FQHCs and rural health clinics

**Note:** *At the time this article was first published in 2010, the information reflected Medicare policy correctly at that time. Since then, more current information is available and new articles have been released. This article was updated on June 5, 2014, to refer to some of the key new articles. All other information remains the same. This article was previously published in the January 2011 edition of Medicare A Connection, Page 61-64.*

### Provider types affected

This *MLN Matters*® article is for rural health clinics (RHCs) and federally qualified health centers (FQHCs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

### What you need to know

This special edition article is based on change request (CR) 7038, CR 7208, and CR 8743; and it provides a billing guide for FQHCs and RHCs. It describes the information FQHCs are required to submit in order for the Centers for Medicare & Medicaid Services (CMS) to develop and implement a prospective payment system (PPS) for Medicare FQHCs.

It also explains how RHCs should bill for certain preventive services under the Affordable Care Act. Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for the initial preventive physical examination (IPPE) provided by RHCs.

However, to ensure coinsurance and deductible are not applied, detailed Healthcare Common Procedure Coding

regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2974CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How Does It Work*.

*MLN Matters*® Number: MM8773

Related Change Request (CR) #: CR8773

Related CR Release Date: June 6, 2014

Effective Date: July 1, 2014

Related CR Transmittal #: R2974CP

Implementation Date: July 7, 2014

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System (HCPCS) coding must be provided for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. The Affordable Care Act also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

### Background

Historically, RHCs and FQHCs billing instructions have been the same. However, effective January 1, 2011, the billing requirements will be different for each of these facilities' types.

As outlined in CR 7208, transmittal 2122, RHCs are only required to submit detailed HCPCS codes for preventive services with a United States Preventive Services Task Force (USPSTF) grade of A or B in order to waive coinsurance and deductible. As outlined in CR 7038 (see the related *MLN Matters*® article, MM7038 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7038.pdf>), FQHCs are required to submit detailed HCPCS code(s) for all services rendered during the encounter.

As outlined in CR 8743 (see the related *MLN Matters*® article, MM8743 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8743.pdf>) and effective for cost reporting periods beginning on or after October 1, 2014, FQHCs are required to implement a prospective payment system (PPS). FQHCs will remain under the all-inclusive rate (AIR) system until their first cost reporting

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period beginning on or after October 1, 2014. Listed below is a summary of the billing requirements for each facility that you need to know when submitting claims for either RHCs or FQHCs.

### RHCs (71X types of bills (TOBs))

The professional components of preventive services are part of the overall encounter, and for TOB 71x, these services have always been billed on revenue lines with the appropriate site of service revenue code in the 052x series. In previous requirements, HCPCS codes have only been required to report certain preventive services subject to frequency limits.

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are waived for the IPPE, the annual wellness visit, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. Detailed HCPCS coding is required to ensure that coinsurance and deductible are not applied to these preventive services.

Payment for the professional component of allowable preventive services is made under the all-inclusive rate when all of the program requirements are met. Lab and technical components should continue to be billed as non RHC services.

### Basic RHC billing for preventive services:

When one or more preventive service that meets the specified criteria is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance and deductible. For example, if the total charge for the visit is \$150, and \$50 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on \$100 of the total charge.

To ensure coinsurance and deductible are waived for qualified preventive services, RHCs must report an additional revenue line with the appropriate site of service revenue code in the 052x series with the approved preventive service HCPCS code and the associated charges. For example, the service lines should be reported as follows:

Line	Revenue code	HCPCS code	Date of Service	Charges
1	052x		01/01/2011	100.00
2	052x	Preventive service code	01/01/2011	50.00

The services reported without the HCPCS code will receive an encounter/visit payment. Payment will be based on the all-inclusive rate, and the coinsurance and deductible will be applied. The qualified preventive service will not receive payment, as payment is made under the all-inclusive rate for the services reported on the first revenue line. Coinsurance and deductible are not

applicable to the service line with the preventive service.

### Exceptions:

If the only service provided is a preventive service (such as the IPPE or annual wellness visit (AWV)), report only one line with the appropriate site of service revenue code (052x) and the preventive service HCPCS code. The services will be paid based on the all-inclusive rate. Coinsurance and deductible are not applicable.

**Note:** An additional visit may be paid for IPPE when billed with another qualified encounter/visit, as outlined with CR 6445 (see the related *MLN Matters*<sup>®</sup> article, MM6445, at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6445.pdf>).

RHCs are not required to report separate revenue lines for influenza virus or pneumococcal pneumonia vaccines on the 71x claims as the cost for these services are not included in the encounter. Costs for the influenza virus or pneumococcal pneumonia vaccines are included in the cost report and no line items are billed. Coinsurance and deductible do not apply to either of these vaccines.

The hepatitis B vaccine is included in the encounter rate. The charges of the vaccine and its administration shall be carved out of the office visit and reported on a separate line as outlined in the above example. An encounter cannot be billed if vaccine administration is the only service the RHC provides. For additional information on incident to services, please see the *Medicare Benefit Policy Manual* (Chapter 13, Section 60) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf>.

RHCs do not receive any reimbursement on TOBs 71x for the technical component of services provided by clinics. This is because the technical component of services are not within the scope of Medicare-covered RHC services. The associated technical component of services furnished by the clinic/center are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits.

### FQHCs (77x TOBs):

The Affordable Care Act (Section 10501(i)(3)(A)) amended the Social Security Act (Section 1834; see [http://www.ssa.gov/OP\\_Home/ssact/title18/1834.htm](http://www.ssa.gov/OP_Home/ssact/title18/1834.htm)) by adding a new subsection (o) titled *Development and Implementation of Prospective Payment System*.

This subsection provides the statutory framework for development and implementation of a Prospective Payment System (PPS) for Medicare FQHCs. The Social Security Act (Section 1834(o)(1)(B)) as amended by the Affordable Care Act, addresses collection of data necessary to develop and implement the new Medicare FQHC PPS.

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Specifically, the Affordable Care Act grants the Secretary of Health and Human Services the authority to require FQHCs to submit such information as may be required in order to develop and implement the Medicare FQHC PPS, including the reporting of services using HCPCS codes.

The Affordable Care Act requires that the Secretary impose this data collection submission requirement no later than January 1, 2011.

Beginning with dates of service on or after January 1, 2011, when billing Medicare, FQHCs must report all services provided during the encounter/visit by listing the appropriate HCPCS code.

The additional revenue lines with detailed HCPCS code(s) are for information and data gathering purposes in order to develop the FQHC PPS set to be implemented in 2014.

The additional data will not be utilized to determine current Medicare payment to FQHCs. The Medicare claims processing system will continue to make payments under the current FQHC interim per-visit payment rate methodology.

### Basic FQHC billing requirements:

For dates of service on or after January 1, 2011, all valid UB04 revenue codes except the following may be used to report the additional services that are needed for data collection and analysis purposes only:

002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x.

Medicare will make one payment at the all-inclusive rate for each date of service that contains a valid HCPCS code for professional services when one of the following revenue codes is present:

Revenue code	Definition
0521	Clinic visit by member to RHC/FQHC
0522	Home visit by RHC/FQHC practitioner
0524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)
0525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC/FQHC visiting nurse service(s) to a member's home when in a Home Health Shortage Area
0528	Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)

### Payments for encounter/visits:

Medicare will make an additional encounter payment at the all-inclusive rate on the same claim when:

- Effective January 1, 2011, two services lines are submitted with a 052x revenue code and one line contains modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon;
- Services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900;
- Diabetes self-management training (DSMT) is billed under revenue code 052x and HCPCS code G0108 and medical nutrition therapy (MNT) is billed under revenue code 052x and HCPCS code 97802, 97803, or G0270; and
- The initial preventive physical examination (IPPE) billed under revenue code 052x and HCPCS code G0402. This is a once in a lifetime benefit. HCPCS coding is required.

**Note:** Modifier 59 is not required for DSMT, MNT, or IPPE in order to receive an additional encounter payment.

When reporting multiple services on FQHC claims, the 052x revenue line should include the total charges for all of the services provided during the encounter.

For preventive services with a grade of A or B from the USPSTF, the charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance correctly.

For example, if the total charge for the visit is \$350.00, and \$50.00 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on \$300.00 of the total charge.

### Example A:

Line	Rev code	HCPCS code	Date of service	Charges
1	0521	Office Visit	01/01	300.00
2	0636	Penicillin Injection	01/01	125.00
3	0271	Wound cleaning	01/01	125.00
4	0771	Preventive service code	01/01	50.00

When reporting multiple services on the same day that are unrelated, modifier 59 must be used to report these services, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon.

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## Example B:

Line	Rev code	HCPCS code	Modifier	Date of service	Charges
1	0521	Office Visit		01/01	150.00
2	0479	Removal of wax from ear		01/01	100.00
3	0521	Office visit	59	01/01	450.00
4	0271	Wound cleaning		01/01	150.00
5	0279	Bone setting with casting		01/01	300.00

When reporting an additional encounter for IPPE, the revenue lines should be reflected as follows:

## Example C:

Line	Rev code	HCPCS code	Date of service	Charges
1	0521	Office visit	01/01	75.00
2	0419	Breathing treatment	01/01	75.00
3	0521	IPPE (G0402)	01/01	150.00

As of January 01, 2011, for data collection and analysis for the PPS, FQHCs are required to report separate revenue lines for influenza virus or pneumococcal pneumonia vaccines (PPV) on the 77x claims. The charges of these vaccines and the administration shall be carved out of the office visit and reported on a separate line as outlined in example A. The cost for these services will continue to be reimbursed through cost reporting. Coinsurance and deductible do not apply to either of these vaccines.

Hepatitis B vaccine is included in the encounter rate. The charges for the vaccine and its administration will be carved out of the office visit and reported on a separate line as outlined in example A. An encounter cannot be billed if vaccine administration is the only service the FQHC provides. For additional information on incident to services, please see Chapter 13, Section 60 of the *Medicare Benefit Policy Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf>.

Laboratory and technical components should continue to be billed as non-FQHC services.

## Summary of differences

The chart below displays a list of elements and notes the differences between RHCs and FQHCs:

Element	RHCs	FQHCs
Revenue codes	052x series	All except: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096-310x
HCPCS code	Required for preventive services only excluding flu and PPV	Required for all services rendered during encounter/visit
Modifier 59	Not applicable at this time	Should be used to report two distinct unrelated visits on the same day
DSMT and MNT	Not separately payable	All inclusive payment rate

## November 2013 manual updates

In November 2013, CR 8504 updated Chapter 13 of the *Medicare Benefit Policy Manual* to reflect numerous updates that were effective on January 1, 2014. The *MLN Matters*® article MM8504, which relates to CR 8504 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8504.pdf> on the CMS website.

## The FQHC PPS

FQHCs will transition to the FQHC PPS based on their cost reporting periods. For FQHCs with cost reporting periods beginning before October 1, 2014, MACs shall continue to pay the FQHCs using the current AIR system. For FQHCs with cost reporting periods beginning on or after October 1, 2014, MACs shall pay the FQHCs using the FQHC PPS.

Under the FQHC PPS, Medicare will pay FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. Medicare will allow for an additional payment when an illness or injury occurs subsequent to the initial visit, or when a mental health visit is furnished on the same day as a medical visit.

The PPS rate will be adjusted when a FQHC furnishes care to a patient who is new to the FQHC or to a beneficiary receiving an initial preventive physical

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examination (IPPE) or an annual wellness visit (AWV). CMS is establishing specific payment codes to be used under the FQHC PPS based on descriptions of services that will correspond to the appropriate PPS rates.

The PPS rates will also be adjusted to account for geographic differences in the cost of inputs by applying FQHC geographic adjustment factors (FQHC GAFs).

In calculating the total payment amount, the FQHC GAF will be based on the locality of the site where the services are furnished. For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site.

Complete details of the FQHC PPS are available in MLN Matters® article MM8743 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8743.pdf>.

### Additional information

Additional information on vaccines can be found in the *Medicare Claims Processing Manual* (Chapter 1, section

10) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf>, and additional coverage requirements for the pneumococcal vaccine, hepatitis B vaccine, and influenza virus vaccine can be found in the *Medicare Benefit Policy Manual* (Chapter 15) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>.

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Hospitals

## Three-day prior hospitalization

### Background

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

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

### Coverage determination

To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized. In this context, the applicable hospital condition does not have to be the principal diagnosis that actually precipitated the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay.

### Comprehensive error rate testing (CERT)

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

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

Provider actions	Audit findings	Results
<p>Submitted Health Insurance Prospective Payment System (HIPPS) code RUC10 to First Coast [Ultra High Rehabilitation: requiring rehabilitation therapy, 720 minutes/one week; at least five days of one rehabilitation discipline, with a second discipline for at least three days and activities of daily living (ADL) score 11-16]. Assessment from state repository reported:</p> <ul style="list-style-type: none"> <li>• 205 minutes/five days of speech therapy</li> <li>• 234 minutes/five days occupational therapy</li> <li>• 287 minutes/five days of physical therapy</li> <li>• Medical documentation submitted</li> <li>• Records to validate qualifying hospital admission</li> <li>• Physician's certification and recertification statements</li> <li>• Treatment orders</li> <li>• History and physical</li> <li>• Physician notes</li> <li>• Nursing records</li> <li>• Therapy disciplines certified plans of care, including initial evaluations</li> <li>• Daily notes</li> <li>• Treatment logs</li> </ul>	<p>On one of the five treatment days, provider submitted therapy notes denoting treatment for all disciplines (physical, occupational, or speech therapy); however, only the occupational therapy notes document treatment time of only 10 minutes, which is insufficient to count as a treatment day.</p> <p>Medical record indicates a total of 642 total rehabilitation minutes. Specifically, four days (not five) of all therapy disciplines documented:</p> <ul style="list-style-type: none"> <li>• 173 minutes of speech therapy</li> <li>• 197 minutes of occupational therapy</li> <li>• 272 minutes of physical therapy</li> </ul>	<p>Services were recalculated by audit contractor to RUG code RMC [Rehabilitation Medium: requiring rehabilitation therapy, 150 minutes for a minimum of one week, five days any combination of three rehab disciplines, for five units: ADL 11-16].</p>

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The provider submitted a claim to First Coast with RUG code RUC10 and the reported data to the State supported the services billed to First Coast. However, the medical documentation submitted to the audit contractor indicates that the provider failed to sufficiently code therapy minutes on one of the five days of treatment, which resulted in recalculation of the therapy services for the assessment period from an ultra-high to medium rehabilitation category.

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

Provider actions	Audit findings	Results
<p>Submitted SNF claim to First Coast with dates of service 5/1 - 5/31</p> <p>Minimum data set (MDS) entered into repository</p> <p>Submitted documentation:</p> <ul style="list-style-type: none"> <li>▪ Physician orders</li> <li>▪ Therapy evaluation(s)</li> <li>▪ Plan of care</li> <li>▪ Orders and treatment logs to support billed level of skilled services</li> <li>▪ Submitted claim with occurrence span code 70 with qualifying dates of 4/20 - 4/23/2012</li> <li>▪ Conflicting documentation from emergency department regarding admission - notes indicate patient admitted on 4/20/2012; however, at end of report, notes indicate patient admitted to observation on 4/20/2012</li> </ul>	<p>Found hospital stay dates were actually 4/21 - 4/23/2012 (equals 2 stay days)</p> <p>Patient did not have a three-day medically necessary qualifying inpatient hospital stay</p> <p>Review of common working file shows hospital dates of service 4/21 - 4/23/2012</p> <p>There was no documentation of the patient's course of treatment</p>	<p>Claim does not meet the technical requirement to qualify for post hospital SNF care under the Medicare program</p> <p>Time spent in outpatient observation or in emergency room prior to or in lieu of inpatient admission does not count toward three-day qualifying inpatient hospital stay.</p> <p>Medicare should pay for skilled nursing facility care if:</p> <ul style="list-style-type: none"> <li>▪ The patient was hospitalized for at least three days and was admitted to SNF within 30 days of hospital discharge</li> <li>▪ A physician certifies that patient needs SNF care</li> <li>▪ The patient requires skilled nursing or skilled rehabilitation services, or both, on a daily basis. Skilled nursing and skilled rehabilitation services are those which require the skills of technical or professional personnel such as nurses, physical therapists, and occupational therapists. In order to be deemed skilled, service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.</li> <li>▪ Skilled nursing facility is a Medicare certified facility</li> </ul>

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

## Off-cycle release of the 2014 inpatient prospective payment system pricer

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for hospitals who submit claims to Medicare claims Part A Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

### Provider action needed

Change request (CR) 8761 updates the fiscal year (FY) 2014 inpatient prospective payment system (IPPS) pricer due to the Protecting Access to Medicare Act of 2014 and due to corrections of some uncompensated care per claim amounts. Make sure that your billing staff is aware of these updates.

### Background

On April 1, 2014, the Protecting Access to Medicare Act of 2014 was signed into law, and the new law includes the extension of certain provisions of the Affordable Care Act. (See <http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf>.) Specifically, the following Medicare fee-for-service policies have been extended through March 31, 2015:

- Section 105 - Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals

The Affordable Care Act provided for temporary changes to the low-volume hospital adjustment for fiscal years (FYs) 2011 and 2012. To qualify, the hospital must:

- Have less than 1,600 Medicare discharges, and
- Be 15 miles or greater from the nearest like hospital.

The temporary changes to the low-volume hospital adjustment were extended for FY 2013 by the American Taxpayer Relief Act (see <http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf>), and from October 1, 2013, through March 31, 2014, by the Pathway for SGR Reform Act (<http://www.gpo.gov/fdsys/pkg/BILLS-113hjres59enr/pdf/BILLS-113hjres59enr.pdf>).

The provision of the Protecting Access to Medicare Act of 2014 extends the temporary changes to the low-volume payment adjustment through March 31, 2015.

- Section 106 - Extension of the Medicare-Dependent Hospital (MDH) Program

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision of the Protecting Access to Medicare Act of 2014 extends the MDH program until March 31, 2015. Prior to this legislation, the MDH program expired March 31, 2014, as



provided by the Pathway for SGR Reform Act.

In addition, (consistent with the Centers for Medicare & Medicaid Services (CMS) policy finalized in the FY 2014 IPPS Final Rule (78 FR 50638; see <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm>)) CMS is making changes to the FY 2014 Factor 3, the total uncompensated care payments and the uncompensated care per claim amount for 38 providers included in Attachment A of CR 8761, whose uncompensated care payments were inadvertently calculated using a cost report that was less than a full year when a cost report that was a full year or closer to being a full year was available.

The updated payments reflect revisions to Factor 3 such that Medicaid days in the numerator and denominator for all affected providers are based on:

- A full year cost report from 2011, or if not available or if less than 12 months,
- A full year cost report from 2010, or
- The cost report from 2011 or 2010 that is closest to 12 months.

In addition, CMS is revising the uncompensated care per claim amount for one provider, whose uncompensated care per claim amount was inadvertently overstated, resulting in large interim overpayments. This provider is also included in Attachment A of CR 8761.

### Low-volume hospitals – criteria and payment adjustments for FY 2014

The Affordable Care Act (Sections 3125 and 10314; see <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>) amended the low-volume hospital adjustment in section 1886(d)(12) of the Social Security Act by revising, for FYs 2011 and 2012, the definition of a

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low-volume hospital and the methodology for calculating the low-volume payment adjustment.

These amendments were extended for FY 2013 by the American Taxpayer Relief Act (ATRA; see <http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf>), and subsequently extended for FY 2014 discharges occurring before April 1, 2014, by the Pathway for SGR Reform Act. Prior to the Protecting Access to Medicare Act of 2014, for FY 2014 discharges occurring on or after April 1, 2014, and subsequent years, the low-volume hospital qualifying criteria and payment adjustment returned to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act and subsequent legislation.

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2014 discharges occurring on or after April 1, 2014, provided for by section 105 of the Protecting Access to Medicare Act (quoted above), in accordance with the existing regulations at CFR 412.101(b)(2)(ii) and consistent with current policy, CMS published a notice in the *Federal Register* (CMS 1599-N).

In that notice, CMS established that for FY 2014 discharges occurring on or after April 1, 2014, through September 30, 2015, the low-volume hospital qualifying criteria and payment adjustment (percentage increase) is determined using FY 2012 Medicare discharge data from the March 2013 update of the MedPAR files (that is, the same discharge data used to identify qualifying low-volume hospitals and calculate the payment adjustment for discharges that occurred during the first half of FY 2014).

In Table 14 of the Addendum to that notice, CMS republishes the list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files (originally published in CMS 1599-IFC2).

This list of IPPS hospitals with fewer than 1,600 Medicare discharges is not a listing of the hospitals that qualify for the low-volume adjustment for FY 2014 since it does not reflect whether or not the hospital meets the mileage criterion (that is, to qualify for the low-volume adjustment, the hospital must also be located more than 15 road miles from any other IPPS hospital). In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2014 discharges occurring on or after April 1, 2014, a hospital must meet both the discharge and mileage criteria.

In order to receive a low-volume hospital payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, consistent with the previously established procedure, CMS is continuing to require a hospital to notify and provide documentation to its MAC that it meets the mileage criterion. Specifically, a hospital must make its request for low-volume hospital status in writing to after April 1, 2014.



The MAC must be in receipt of the hospital's written request by June 30, 2014, in order for the effective date of the hospital's low-volume hospital status to be April 1, 2014. A hospital that qualified for the low-volume payment adjustment for its FY 2014 discharges occurring on or after October 1, 2013, through March 31, 2014, does not need to notify its MAC and will continue to receive the applicable low-volume payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, without reapplying, provided it continues to meet the Medicare mileage criterion.

A hospital that qualified for the low-volume payment adjustment in FY 2013 but failed to make the required notification to its MAC by the deadline for its discharges occurring during the first half of FY 2014 may begin receiving the applicable low-volume payment adjustment for its FY 2014 discharges occurring on or after April 1, 2014, without reapplying, if it meets the Medicare discharge criterion, based on the FY 2012 MedPAR data (shown in Table 14 of that notice) and the distance criterion. However, the hospital must verify in writing to its MAC that it continues to be more than 15 miles from any other "subsection (d)" hospital no later than June 30, 2014.

For requests for low-volume hospital status for FY 2014 discharges occurring on or after April 1, 2014, received after June 30, 2014, if the hospital meets the criteria to qualify as a low-volume hospital, the MAC will establish a low-volume hospital status effective date that will be applicable prospectively within 30 days of the date of the MAC's low-volume status determination, consistent with CMS historical policy.

Hospital requests for low-volume hospital status received between the issuance of the *Federal Register* notice that implements the provisions of section 105 (quoted above) of the Protecting Access to Medicare Act through June 30, 2014, are only applicable for FY 2014 discharges occurring on or after April 1, 2014 (and will not be applied in determining payments for the hospital's FY 2014 discharges occurring before April 1, 2014, since CMS policy does not provide for retroactive effective dates).

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MACs will verify that the hospital meets the discharge criteria by using the Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files as shown in Table 14 of the *Federal Register* Notice (CMS-1599-N) and available on the Acute Inpatient PPS webpage at [http://www.cms.hhs.gov/AcuteInpatientPPS/01\\_overview.asp](http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp) (click on the link on the left side of the screen titled, "FY 2014 IPPS Final Rule Home Page").

CMS notes that in order to facilitate administrative implementation, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, is the data from the March 2013 update of the FY 2012 MedPAR file.) The Medicare discharge count includes any billed Medicare Advantage claims in the MedPAR file but excludes any claims serviced in non-IPPS units.

In order to implement this policy for FY 2014, the pricer will continue to include the table containing the provider number and discharge count determined from the March 2013 update of the FY 2012 MedPAR file. The table in the pricer includes IPPS providers with fewer than 1,600 Medicare discharges but does not consider whether the IPPS hospital meets the mileage criterion (that is, located more than 15 road miles from the nearest IPPS hospital).

The applicable low-volume payment adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, disproportionate share hospital (DSH), uncompensated care, indirect medical education (IME) and outliers.

For sole-community hospitals (SCHs) and MDHs, the applicable low-volume percentage increase is based on and in addition to either payment based on the federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

### Reinstatement of Medicare dependent hospital (MDH) status

Under the Affordable Care Act (Section 3124), the MDH program authorized by the Social Security Act (Section 1886(d)(5)(G)) was set to expire at the end of FY 2012. These amendments were extended for FY 2013 by section 606 of the American Taxpayer Relief Act, and from October 1, 2013, through March 31, 2014, by the Pathway for SGR Reform Act. As part of the Protecting Access to Medicare Act, Congress reinstated the MDH program through March 31, 2015.

CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in:

- The regulations at 42 CFR 412.108 (see <http://www.ecfr.gov/cgi-bin/text-idx?SID=cb24df348324f83565afefe0ef321163&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.7.50.13>);
- The FY 2011 IPPS/LTCH PPS final rule (75 FR 50287; see <http://www.gpo.gov/fdsys/pkg/FR-2010-08-16/html/2010-19092.htm>);
- The FY 2014 IPPS/LTCH PPS final rule (78 FR 50647 through 50649; see <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm>); and



- The FY 2014 Extension of the Low-Volume Hospital Payment Adjustment and MDH Program Interim Final rule with Comment (IFC) (March 18, 2014; 79 FR 15025 through 15028); see <http://www.gpo.gov/fdsys/pkg/FR-2014-03-18/pdf/2014-05922.pdf> on the Internet.

Consistent with the CMS implementation of previous MDH program extensions, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective April 1, 2014, with no need to reapply for MDH classification. There are the following two exceptions:

- MDHs that classified as sole-community hospitals (SCHs) on or after April 1, 2014

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by

March 1, 2014, to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification received SCH status as of April 1, 2014. Additionally, some hospitals that had MDH status as of the March 31, 2014, expiration of the MDH program may have missed the March 1, 2014, application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than April 1, 2014.

- MDHs that requested a cancellation of their rural classification under 42 CFR 412.103(b)

In order to meet the criteria to become an MDH, a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at 42 CFR 412.103. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification. You

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can review 42 CFR 412.103 at <http://www.ecfr.gov/cgi-bin/text-idx?SID=cb24df348324f83565afefe0ef321163&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.7.50.8>.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to April 1, 2014. All other former MDHs will be automatically reinstated as MDHs effective April 1, 2014. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). Specifically, the regulations at 412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (412.108(b)(2)).
2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital (412.108(b)(4)).

You can review 42 CFR 412.108 at <http://www.ecfr.gov/cgi-bin/text-idx?SID=cb24df348324f83565afefe0ef321163&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.7.50.13>.

### Cancellation of MDH status

As required by the regulations at 42 CFR 412.108(b)(5), MACs must "evaluate on an ongoing basis" whether or not a hospital continues to qualify for MDH status. Therefore, as required by the regulations at 412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at 412.108(a) and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the contractor provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2013, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would

subsequently lose their MDH status prospectively.

Attachment B of CR 8761 outlines the various possible actions to be followed for each former MDH and the corresponding examples for each scenario.

### Hospital specific (HSP) rate update for MDHs

For the payment of FY 2014 discharges occurring on or after April 1, 2014, the hospital specific (HSP) amount for MDHs in the provider specific file will continue to be entered in FY 2012 dollars (just as was done for SCHs as instructed in CR 8241 (Transmittal 2778; August 30, 2013)). Pricer will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond.

### Uncompensated care payment

There is no change to the existing policy.

### Additional Information

The official instruction, CR 8761 issued to your MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2951CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How Does It Work*.

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## Medicare Learning Network® – resources for inpatient hospitals

The Medicare Learning Network® (MLN) suite of products and resources for inpatient hospitals gives Medicare Part A providers and business management professionals with an understanding of payment systems, fee schedules, and reimbursement assistance resources.

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## July 2014 update of the outpatient payment system

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs), including home health and hospices MACs for services provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 8776 which describes changes to and billing instructions for various payment policies implemented in the July 2014 outpatient prospective payment system (OPPS) update. Make sure your billing staffs are aware of these changes.

### Background

Change request (CR) 8776 describes changes to and billing instructions for various payment policies implemented in the July 2014 OPPS update. The July 2014 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, status indicator (SI), and revenue code additions, changes, and deletions identified in CR 8776.

The July 2014 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming CR 8764. The *MLN Matters*<sup>®</sup> article related to CR 8764 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8764.pdf>.

Key changes to and billing instructions for various payment policies implemented in the July 2014 OPPS update are as follows:

#### Changes to device edits for July 2014

The most current list of device edits is available under “Device and Procedure Edits” at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/>. Failure to pass these edits will result in the claim being returned to the provider.

#### New brachytherapy source payment

The Social Security Act (Section 1833(t)(2)(H); see [http://www.socialsecurity.gov/OP\\_Home/ssact/title18/1833.htm](http://www.socialsecurity.gov/OP_Home/ssact/title18/1833.htm))



mandates the creation of additional groups of covered outpatient department (OPD) services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) (“brachytherapy sources”) separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. Cesium-131 chloride solution is a new brachytherapy source.

The HCPCS code assigned to this source as well as payment rate under OPPS are listed in Table 1 below.

#### Category III Current Procedural Terminology (CPT<sup>®</sup>) Codes

The American Medical Association (AMA) releases Category III CPT<sup>®</sup> codes twice per year: 1.) in January, for implementation beginning the following July, and 2.) in July, for implementation beginning the following January.

For the July 2014 update, CMS is implementing in the OPPS 27 Category III CPT<sup>®</sup> codes that the AMA released in January 2014 for implementation on July 1, 2014. Of the 27 Category III CPT<sup>®</sup> codes shown in Table 2 below, 17 of the Category III CPT<sup>®</sup> codes are separately payable under the hospital OPPS.

The SIs and APCs for these codes are shown in Table 2 on the next page. Payment rates for these services can be found in Addendum B of the July 2014 OPPS Update that

**Table 1—New brachytherapy source code effective July 1, 2014**

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C2644	7/01/2014	U	2644	Brachytx cesium-131 chloride	Brachytherapy source, cesium-131 chloride solution, per millicurie	\$18.97	\$3.80

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is posted at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>.

**Table 2 – 27 Category III CPT® codes Implemented as of July 1, 2014**

2014 CPT® code	2014 long descriptor	July 2014 OPSS status indicator	July 2014 OPSS APC
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	Q2	0420
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed)	X	0261
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow and wrist, when performed)	X	0261
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed)	X	0261
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	N	N/A
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred	B	N/A

2014 CPT® code	2014 long descriptor	July 2014 OPSS status indicator	July 2014 OPSS APC
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	N	N/A
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred	B	N/A
0355T	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report	T	0142
0356T	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each	S	0698
0358T	Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report	Q1	0340
0359T	Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/ caregiver(s), and preparation of report	V	0632

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2014 CPT® code	2014 long descriptor	July 2014 OPSS status indicator	July 2014 OPSS APC
0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient	V	0632
0361T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	N	N/A
0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient	V	0632

2014 CPT® code	2014 long descriptor	July 2014 OPSS status indicator	July 2014 OPSS APC
0363T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)	N	N/A
0364T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time	S	0322
0365T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	N	N/A
0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	S	0325

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2014 CPT® code	2014 long descriptor	July 2014 OPPS status indicator	July 2014 OPPS APC
0367T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	N	N/A
0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time	S	0322
0369T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)	N	N/A
0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	S	0324
0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	S	0324

2014 CPT® code	2014 long descriptor	July 2014 OPPS status indicator	July 2014 OPPS APC
0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients	S	0325
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient	S	0323
0374T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)	N	N/A

### Billing for drugs, biologicals, and radiopharmaceuticals

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

In the 2014 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2014 release of the OPPS pricer. The updated payment rates, effective July 1, 2014, will be included in the July 2014 update of the OPPS Addendum A and Addendum B, which will be posted at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>.

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b. Drugs and biologicals with OPPS pass-through status effective July 1, 2014

Three drugs and biologicals have been granted OPPS pass-through status effective July 1, 2014. These items, along with their descriptors and APC assignments, are identified below in Table 3.

**Table 3 – Drugs and biologicals with OPPS pass-through status effective July 1, 2014**

HCPCS code	Long descriptor	APC	Status Indicator
C9022*	Injection, elosulfase alfa, 1mg	1480	G
C9134*	Factor XIII (antihemophilic factor, recombinant), Tretten, per 10 i.u.	1481	G
J1446	Injection, tbo-filgrastim, 5 micrograms	1447	G

Note: The HCPCS codes identified with an “\*” indicate that these are new codes effective July 1, 2014.

c. New HCPCS codes effective July 1, 2014, for certain drugs and biologicals

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 4) in the hospital outpatient setting for July 1, 2014.

These codes are listed below in Table 4, and they are effective for services furnished on or after July 1, 2014.

**Table 4 – New HCPCS codes for certain drugs and biologicals effective July 1, 2014**

HCPCS code	Long descriptor	APC	Status indicator effective 7/1/14
Q9970*	Injection, ferric carboxymaltose, 1 mg	9441	G
Q9974**	Injection, Morphine Sulfate, Preservative-Free For Epidural Or Intrathecal Use, 10 mg	N/A	N



\*HCPCS code C9441 (Injection, ferric carboxymaltose, 1 mg) will be deleted and replaced with HCPCS code Q9970 effective July 1, 2014.

\*\* HCPCS code J2275 (Injection, morphine sulfate (preservative-free sterile solution), per 10 mg) and will be replaced with HCPCS code Q9974 effective July 1, 2014. The SI for HCPCS code J2275 will change to E, “Not Payable by Medicare,” effective July 1, 2014.

d. Revised SIs for HCPCS Codes J2271 and Q2052

Effective July 1, 2014, the SI for HCPCS code J2271 (Injection, morphine sulfate, 100mg) will change:

- 1) From SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.),
- 2) To SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective April 1, 2014, the SI for HCPCS code Q2052 (Services, supplies, and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration) will change:

- 1) From SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.)
- 2) To SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

e. Updated payment rates for certain HCPCS codes effective October 1, 2013, through December 31, 2013

The payment rate for one HCPCS code was incorrect in the October 2013 OPPS Pricer. The corrected payment rate is listed in Table 5 below, and it has been installed in the July 2014 OPPS Pricer, effective for services furnished on October 1, 2013, through December 31, 2013. Your MAC will adjust any claims incorrectly processed if you bring those claims to the attention of your MAC.

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**Table 5– Updated payment rates for certain HCPCS codes effective October 1, 2013 through December 31, 2013**

HCPCS code	Status indic.	APC	Short desc.	Corr. pmt. rate	Corr. min. unadj. copmt
J2788	K	9023	Rho d immune globulin 50 mcg	\$25.15	\$5.03

f. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2014, through March 31, 2014

The payment rate for one HCPCS code was incorrect in the January 2014 OPPS Pricer. The corrected payment rate is listed below in Table 6, and it has been installed in the July 2014 OPPS Pricer, effective for services furnished on January 1, 2014, through March 31, 2014. Your MAC will adjust any claims incorrectly processed if you bring those claims to the attention of your MAC.

**Table 6 – Updated payment rates for certain HCPCS codes effective January 1, 2014, through March 31, 2014**

HCPCS code	Status indic.	APC	Short desc.	Corr. pmt. rate	Corr. min. unadj. copmt
J0775	K	1340	Collage-nase, clost hist inj	\$38.49	\$7.70

### Operational change to billing lab tests for separate payment

As delineated in *MLN Matters* special edition article (SE)1412, issued on March 5, 2014, (see <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf>), effective July 1, 2014, OPPS hospitals should begin using modifier L1 on type of bill (TOB) 13x when seeking separate payment for outpatient lab tests under the clinical laboratory fee schedule (CLFS) in the following circumstances:

1) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or



2) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day.

“Unrelated” means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis. Hospitals should no longer use TOB 14x in these circumstances.

CMS is providing related updates to the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 2, Section 90; and Chapter 16, Sections 30.3, 40.3, and 40.3.1) which are included as an attachment to CR 8766.

### Clarification of payment for certain hospital Part B inpatient labs

As recently provided in CR 8445, Transmittal 2877, published on February 7, 2014 (see <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8445.pdf>), and CR 8666, Transmittal 182, published on March 21, 2014 (see <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8666.pdf>), hospitals may only bill for a limited set of Part B inpatient services when beneficiaries who have Part B coverage are treated as hospital inpatients, and:

- 1) They are not eligible for or entitled to coverage under Part A, or
- 2) They are entitled to Part A but have exhausted their Part A benefits.

CMS is clarifying its general payment policy that, 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.

See **OUTPATIENT**, next page

## OUTPATIENT

From previous page

CMS has adjusted its claims processing logic to make separate payment for laboratory services paid under the CLFS pursuant to this policy that would otherwise be OPPOS-packaged beginning in 2014.

Hospitals should consult their MAC for reprocessing of any 12x TOB claims with dates of service on or after January 1, 2014 that were denied and should be paid under this policy.

### Coverage determinations

The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPOS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program.

MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, Medicare Contractors determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

### Additional information

The official instruction, CR 8776, issued to your MAC

regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2971CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How does it work*.

MLN Matters® Number: MM8776  
Related Change Request (CR) #: CR 8776  
Related CR Release Date: May 23, 2014  
Effective Date: July 1, 2014  
Related CR Transmittal #: R2971CP  
Implementation Date: July 7, 2014

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## Medicare Speaks – Fort Lauderdale July 22-23

### Fort Lauderdale Marriott North, 6650 North Andrews Avenue, Fort Lauderdale, FL 33309

Learn what's trending now in Medicare by joining First Coast Service Options (First Coast) for Medicare Speaks, July 22-23, 2014, in Fort Lauderdale, FL.

The event features 20 classes focused on reducing documentation and claim errors, and minimizing payment delays. First Coast is also offering seminars on July 21 on PC-ACE Pro32™; Medicare's free billing software and the Centers for Medicare & Medicaid Services (CMS) initiative the physician quality reporting system (PQRS) program.

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

### Highlights

- [20 Part A and B classes chosen by your peers – view agenda](#)

- Participation from First Coast's medical director and leaders from Medical Review, Provider Enrollment, Customer Service and Provider Outreach and Education departments
- Seminar on July 21 regarding PC-ACE Pro32™ and PQRS program
- Participants can select four classes per day, or tailor the schedule to meet your needs
- Medicare experts available to answer your questions at *Ask the Contractor* tables
- Continuing education credits offered

For additional information regarding the event, including logistics and registration, view our [Medicare Speaks 2014 Fort Lauderdale](#) brochure.

### Register now

**Note:** If you do not have a training account, please click here to learn how to create one.

Educational Events

Provider outreach and educational events  
August - September 2014

Internet-based PECO's class

When: Thursday, August 21  
Time: 1:00 p.m. - 5:00 p.m. ET – Delivery language: English  
Type of Event: Face-to-face  
<http://medicare.fcso.com/Events/266999.asp>

Medicare Part A changes and regulations

When: Tuesday, September 16  
Time: 10:30 a.m. - 11:30 a.m. ET – Delivery language: English  
Type of Event: Webcast  
<http://medicare.fcso.com/Events/271655.asp>

Two easy ways to register

- 1. Online – Visit [www.fcsouniversity.com](http://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](http://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](http://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](http://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: May 29, 2014 – <http://go.usa.gov/8PgC>
- CMS MLN Connects™ Provider eNews: June 5, 2014 – <http://go.cms.gov/S8OnGR>
- CMS MLN Connects™ Provider eNews: June 12, 2014 – <http://go.usa.gov/8ugz>
- CMS MLN Connects™ Provider eNews: June 19, 2014 – <http://go.cms.gov/UMqZky>
- CMS MLN Connects™ Provider eNews: June 26, 2014 – <http://go.usa.gov/9m3B>



### Discover your passport to Medicare training

- Register for live events
- Explore online courses
- Find CEU information
- Download recorded events
- Learn more at *First Coast University*





## 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](http://medicare.fcso.com)

#### Centers for Medicare & Medicaid Services

##### Providers:

[www.cms.gov](http://www.cms.gov)

##### Beneficiaries:

[www.medicare.gov](http://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](mailto: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 Government Benefit  
Administrators  
Medicare Part A  
P.O. Box 100238  
Columbia, SC 29202-3238

#### Railroad Medicare

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

## 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 number 1-904-361-0407

### Websites

#### Providers

#### First Coast – MAC Jurisdiction N

[medicare.fcso.com](http://medicare.fcso.com)

[medicareespanol.fcso.com](http://medicareespanol.fcso.com)

#### Centers for Medicare & Medicaid Services

[www.cms.gov](http://www.cms.gov)

#### Beneficiary

#### Centers for Medicare & Medicaid Services

[www.medicare.gov](http://www.medicare.gov)