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

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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-understanding billing and coding products.

Click here to explore educational web guides.

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

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General Information

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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).

References

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; 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**


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

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

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

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

For **institutional 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.)”

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- **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


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](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

**MLN Matters® Number**: MM8401 Revised
**Related Change Request (CR) #:** CR 8401
**Related CR Release Date:** May 13, 2014
**Effective Date:** January 1, 2014
**Related CR Transmittal #:** R2955CP
**Implementation Date:** January 6, 2014

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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.

**MLN Matters® Number**: MM8456 Rescinded
**Related Change Request (CR) #:** CR 8456
**Related CR Release Date:** May 16, 2014

**Effective Date**: October 1, 2014
**Related CR Transmittal #:** R1386OTN
**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® 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:

1. The entity has reviewed the CMHC’s client care data; and
2. For initial enrollments: The CMHC meets the 40 percent requirement for the prior three months.
3. 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

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: MM8784
Related Change Request (CR) #: CR 8784
Related CR Release Date: June 13, 2014
Effective Date: July 15, 2014
Related CR Transmittal #: R521PI
Implementation Date: July 15, 2014

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Provider types affected

This MLN Matters® 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 epiduragram.

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 0275T) for LSS, ICD-9 diagnosis range 724.01-724.03, or ICD-10 diagnosis range M48.05-M48.07, only when billed with:

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


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 0275T for LSS, ICD-9 diagnosis range 724.01-724.03, or ICD-10 diagnosis range M48.05-M48.07, when billed without:

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

When rejecting these claims, they will use:

a) Claims adjustment reason code (CARC) 50: These are non-covered services because this is not deemed a “medical necessity” by the payer;
b) 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

c) 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:

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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® 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

MLN Matters® 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® 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.

Additional Information

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

Provider types affected
This MLN Matters® 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® 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:

- 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

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 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 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**

**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 (Hycamtn®) – revision to the Part A LCD**

**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

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


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

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.

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® 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® 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® 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.


MLN Matters® 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

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.
July 2014 integrated outpatient code editor specifications version 15.2

Provider types affected

This MLN Matters® 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:

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2014</td>
<td>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.</td>
</tr>
<tr>
<td>1/1/2014</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/2014</td>
<td>Make Healthcare Common Procedure Coding System (HCPCS)/Ambulatory Payment Classification (APC)/SI changes as specified by CMS (data change files).</td>
</tr>
<tr>
<td>7/1/2014</td>
<td>Implement version 20.2 of the NCCI (as modified for applicable institutional providers).</td>
</tr>
<tr>
<td>1/1/2014</td>
<td>Add new modifier L1 (Separately payable lab test) to the valid modifier list.</td>
</tr>
<tr>
<td>7/1/2014</td>
<td>Add new modifier SZ (Habilitative services) to the valid modifier list.</td>
</tr>
<tr>
<td>1/1/2014</td>
<td>Updated documentation in Appendix F (a) and Appendix L to include bill type 13x for laboratory services reported with modifier L1.</td>
</tr>
<tr>
<td>7/1/2014</td>
<td>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).</td>
</tr>
</tbody>
</table>

Additional Information


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: 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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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.
Part A top rejects for March 2014 through May 2014

Top rejects for March-May 2014

- **34538**:
  - March 2014: 1,037
  - April 2014: 802
  - May 2014: 743

- **36428**:
  - March 2014: 706

- **38031**:
  - March 2014: 896

- **38038**:
  - March 2014: 1,957
  - April 2014: 1,464
  - May 2014: 1,588

- **38200**: 5,002

- **39011**:
  - March 2014: 1,366
  - April 2014: 1,10

- **39929**:
  - March 2014: 1,583
  - April 2014: 1,319
  - May 2014: 1,554

- **C7010**: 2,070

- **T5052**:
  - March 2014: 917
  - April 2014: 820
  - May 2014: 678

- **U5200**:
  - March 2014: 1,050
  - April 2014: 774

- **U5233**:
  - March 2014: 13,235
  - April 2014: 1,050
  - May 2014: 917

- **34538**:
  - March 2014: 1,037
  - April 2014: 802
  - May 2014: 743

- **36428**:
  - March 2014: 706

- **38031**:
  - March 2014: 896

- **38038**:
  - March 2014: 1,957
  - April 2014: 1,464
  - May 2014: 1,588

- **38200**: 5,002

- **39011**:
  - March 2014: 1,366
  - April 2014: 1,10

- **39929**:
  - March 2014: 1,583
  - April 2014: 1,319
  - May 2014: 1,554

- **C7010**: 2,070

- **T5052**:
  - March 2014: 917
  - April 2014: 820
  - May 2014: 678

- **U5200**:
  - March 2014: 1,050
  - April 2014: 774

- **U5233**:
  - March 2014: 13,235
  - April 2014: 1,050
  - May 2014: 917
Part A top return to providers (RTPs) for March 2014 through May 2014

Top RTPs for March-May 2014

<table>
<thead>
<tr>
<th>Reason codes</th>
<th>March 2014</th>
<th>April 2014</th>
<th>May 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>17712</td>
<td>836</td>
<td></td>
<td>795</td>
</tr>
<tr>
<td>31255</td>
<td>730</td>
<td>524</td>
<td>795</td>
</tr>
<tr>
<td>31816</td>
<td>731</td>
<td>824</td>
<td>725</td>
</tr>
<tr>
<td>37242</td>
<td></td>
<td></td>
<td>1718</td>
</tr>
<tr>
<td>38032</td>
<td></td>
<td></td>
<td>1410</td>
</tr>
<tr>
<td>38037</td>
<td></td>
<td></td>
<td>1791</td>
</tr>
<tr>
<td>38038</td>
<td>393</td>
<td></td>
<td>779</td>
</tr>
<tr>
<td>38119</td>
<td></td>
<td>1480</td>
<td>1898</td>
</tr>
<tr>
<td>77777</td>
<td></td>
<td>1448</td>
<td>1851</td>
</tr>
<tr>
<td>E6104</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N5052</td>
<td>1003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U5452</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U5454</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reimbursement

Medicare physician fee schedule database July update

Provider types affected

This MLN Matters® 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)) 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:

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

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
MPFS

From previous page

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


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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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 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 See RURAL, next page.
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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:

<table>
<thead>
<tr>
<th>Line</th>
<th>Revenue code</th>
<th>HCPCS code</th>
<th>Date of Service</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>052x</td>
<td></td>
<td>01/01/2011</td>
<td>100.00</td>
</tr>
<tr>
<td>2</td>
<td>052x</td>
<td>Preventive service code</td>
<td>01/01/2011</td>
<td>50.00</td>
</tr>
</tbody>
</table>

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® 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) 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.

See RURAL, next page
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, 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:

<table>
<thead>
<tr>
<th>Revenue code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Clinic visit by member to RHC/FQHC</td>
</tr>
<tr>
<td>0522</td>
<td>Home visit by RHC/FQHC practitioner</td>
</tr>
<tr>
<td>0524</td>
<td>Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)</td>
</tr>
<tr>
<td>0525</td>
<td>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</td>
</tr>
<tr>
<td>0527</td>
<td>RHC/FQHC visiting nurse service(s) to a member’s home when in a Home Health Shortage Area</td>
</tr>
<tr>
<td>0528</td>
<td>Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Line</th>
<th>Rev code</th>
<th>HCPCS code</th>
<th>Date of service</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0521</td>
<td>Office Visit</td>
<td>01/01</td>
<td>300.00</td>
</tr>
<tr>
<td>2</td>
<td>0636</td>
<td>Penicillin Injection</td>
<td>01/01</td>
<td>125.00</td>
</tr>
<tr>
<td>3</td>
<td>0271</td>
<td>Wound cleaning</td>
<td>01/01</td>
<td>125.00</td>
</tr>
<tr>
<td>4</td>
<td>0771</td>
<td>Preventive service code</td>
<td>01/01</td>
<td>50.00</td>
</tr>
</tbody>
</table>

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.

See RURAL, next page
Reimbursement

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Example B:

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

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

Example C:

<table>
<thead>
<tr>
<th>Line</th>
<th>Rev code</th>
<th>HCPCS code</th>
<th>Date of service</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0521</td>
<td>Office visit</td>
<td>01/01</td>
<td>75.00</td>
</tr>
<tr>
<td>2</td>
<td>0419</td>
<td>Breathing treatment</td>
<td>01/01</td>
<td>75.00</td>
</tr>
<tr>
<td>3</td>
<td>0521</td>
<td>IPPE (G0402)</td>
<td>01/01</td>
<td>150.00</td>
</tr>
</tbody>
</table>

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](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:

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

November 2013 manual updates


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.


Additional information


MLN Matters® Number: SE1039
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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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.

<table>
<thead>
<tr>
<th>Provider actions</th>
<th>Audit findings</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>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].</td>
<td>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. Medical record indicates a total of 642 total rehabilitation minutes. Specifically, four days (not five) of all therapy disciplines documented:</td>
<td>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].</td>
</tr>
<tr>
<td>• 205 minutes/five days of speech therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 234 minutes/five days occupational therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 287 minutes/five days of physical therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical documentation submitted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Records to validate qualifying hospital admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician’s certification and recertification statements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treatment orders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• History and physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nursing records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Therapy disciplines certified plans of care, including initial evaluations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Daily notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treatment logs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Provider actions</th>
<th>Audit findings</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitted SNF claim to First Coast with dates of service 5/1 - 5/31</td>
<td>Found hospital stay dates were actually 4/21 - 4/23/2012 (equals 2 stay days)</td>
<td>Claim does not meet the technical requirement to qualify for post hospital SNF care under the Medicare program</td>
</tr>
<tr>
<td>Minimum data set (MDS) entered into repository</td>
<td>Patient did not have a three-day medically necessary qualifying inpatient hospital stay</td>
<td>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.</td>
</tr>
<tr>
<td>Submitted documentation:</td>
<td>Review of common working file shows hospital dates of service 4/21 - 4/23/2012</td>
<td>Medicare should pay for skilled nursing facility care if:</td>
</tr>
<tr>
<td>▪ Physician orders</td>
<td>There was no documentation of the patient's course of treatment</td>
<td>▪ The patient was hospitalized for at least three days and was admitted to SNF within 30 days of hospital discharge</td>
</tr>
<tr>
<td>▪ Therapy evaluation(s)</td>
<td></td>
<td>▪ A physician certifies that patient needs SNF care</td>
</tr>
<tr>
<td>▪ Plan of care</td>
<td></td>
<td>▪ 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.</td>
</tr>
<tr>
<td>▪ Orders and treatment logs to support billed level of skilled services</td>
<td></td>
<td>▪ Skilled nursing facility is a Medicare certified facility</td>
</tr>
<tr>
<td>▪ Submitted claim with occurrence span code 70 with qualifying dates of 4/20 - 4/23/2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ 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</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
Hospitals

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

Provider types affected

This MLN Matters® 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 hospital 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, 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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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=cb24df34b83565afefe0ef321163&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 50649; see http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm); and

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:

a. 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.

b. 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.
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can review 42 CFR 412.103 at http://www.ecfr.gov/cgi-bin/text-idx?SID=cb24df348324f83565afe0f321163&node=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)).


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


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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Related Change Request (CR) #: CR 8761
Related CR Release Date: May 12, 2014
Effective Date: July 1, 2014
Related CR Transmittal #:R2951CP
Implementation Date: July 7, 2014

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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.

It includes information and direct links to Medicare payment policies and procedures, provider enrollment, streamlining claims review and submission requirements, and payment rates and classification criterion for reimbursement.

Click here for more information.
July 2014 update of the outpatient payment system

Provider types affected

This MLN Matters® 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.


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(l)(2)(H); see 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.


The American Medical Association (AMA) releases Category III CPT® 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® codes that the AMA released in January 2014 for implementation on July 1, 2014. Of the 27 Category III CPT® codes shown in Table 2 below, 17 of the Category III CPT® 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>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective date</th>
<th>SI</th>
<th>APC</th>
<th>Short descriptor</th>
<th>Long descriptor</th>
<th>Payment</th>
<th>Minimum unadjusted copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2644</td>
<td>7/01/2014</td>
<td>U</td>
<td>2644</td>
<td>Brachytx cesium-131 chloride</td>
<td>Brachytherapy source, cesium-131 chloride solution, per millicurie</td>
<td>$18.97</td>
<td>$3.80</td>
</tr>
</tbody>
</table>

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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](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

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>0347T</td>
<td>Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)</td>
<td>Q2</td>
<td>0420</td>
</tr>
<tr>
<td>0348T</td>
<td>Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)</td>
<td>X</td>
<td>0261</td>
</tr>
<tr>
<td>0349T</td>
<td>Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow and wrist, when performed)</td>
<td>X</td>
<td>0261</td>
</tr>
<tr>
<td>0350T</td>
<td>Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed)</td>
<td>X</td>
<td>0261</td>
</tr>
<tr>
<td>0351T</td>
<td>Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0352T</td>
<td>Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>0353T</td>
<td>Optical coherence tomography of breast, surgical cavity; real time intraoperative</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0354T</td>
<td>Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>0355T</td>
<td>Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report</td>
<td>T</td>
<td>0142</td>
</tr>
<tr>
<td>0356T</td>
<td>Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each</td>
<td>S</td>
<td>0698</td>
</tr>
<tr>
<td>0358T</td>
<td>Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report</td>
<td>Q1</td>
<td>0340</td>
</tr>
<tr>
<td>0359T</td>
<td>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</td>
<td>V</td>
<td>0632</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>2014 CPT&lt;sup&gt;®&lt;/sup&gt; code</th>
<th>2014 long descriptor</th>
<th>July 2014 OPPS status indicator</th>
<th>July 2014 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0360T</td>
<td>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</td>
<td>V</td>
<td>0632</td>
</tr>
<tr>
<td>0361T</td>
<td>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)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0362T</td>
<td>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</td>
<td>V</td>
<td>0632</td>
</tr>
</tbody>
</table>

#### 2014 CPT<sup>®</sup> code | 2014 long descriptor                                                                 | July 2014 OPPS status indicator | July 2014 OPPS APC |
<table>
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<tbody>
<tr>
<td>0363T</td>
<td>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)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0364T</td>
<td>Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time</td>
<td>S</td>
<td>0322</td>
</tr>
<tr>
<td>0365T</td>
<td>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)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0366T</td>
<td>Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time</td>
<td>S</td>
<td>0325</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>0367T</td>
<td>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)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0368T</td>
<td>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</td>
<td>S</td>
<td>0322</td>
</tr>
<tr>
<td>0369T</td>
<td>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)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0370T</td>
<td>Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)</td>
<td>S</td>
<td>0324</td>
</tr>
<tr>
<td>0371T</td>
<td>Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)</td>
<td>S</td>
<td>0324</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>0372T</td>
<td>Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients</td>
<td>S</td>
<td>0325</td>
</tr>
<tr>
<td>0373T</td>
<td>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</td>
<td>S</td>
<td>0323</td>
</tr>
<tr>
<td>0374T</td>
<td>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)</td>
<td>N</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**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](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

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

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

<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Long descriptor</th>
<th>APC</th>
<th>Status Indicator effective 7/1/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9970*</td>
<td>Injection, ferric carboxymaltose, 1 mg</td>
<td>9441</td>
<td>G</td>
</tr>
<tr>
<td>Q9974**</td>
<td>Injection, Morphine Sulfate, Preservative-Free For Epidural Or Intrathecal Use, 10 mg</td>
<td>N/A</td>
<td>N</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Status indic.</th>
<th>APC Short desc.</th>
<th>Corr. pmt. rate</th>
<th>Corr. min. unadj. copmt</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2788</td>
<td>K</td>
<td>Rho d immune globulin 50 mcg</td>
<td>$25.15</td>
<td>$5.03</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Status indic.</th>
<th>APC Short desc.</th>
<th>Corr. pmt. rate</th>
<th>Corr. min. unadj. copmt</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0775</td>
<td>K</td>
<td>Collage-nase, clost hist inj</td>
<td>$38.49</td>
<td>$7.70</td>
</tr>
</tbody>
</table>

 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
Hospitals

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 OPPS-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 OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program.

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

Additional information

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.
Provider outreach and educational events
August - September 2014

Internet-based PECOs 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, logon to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event. **First-time user**?
   Set up an account by completing “Request a New Account” online. Providers with no national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 904-791-8103. Class materials will be faxed to you the day of the event.

Please note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant’s Name: __________________________________________________________________________
Registrant’s Title: __________________________________________________________________________
Provider’s Name: ____________________________________________________________________________
Telephone Number: ___________________________ Fax Number: __________________________________
Email Address: ______________________________________________________________________________
Provider Address: ____________________________________________________________________________
City, State, ZIP Code: ________________________________________________________________________

Keep checking the **Education** section of our website, medicare.fcso.com, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit medicare.fcso.com, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. Our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Explore our catalog of online courses and learn more at www.fcsouniversity.com.
CMS MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) MLN Connects™ Provider eNews is an official Medicare Learning Network® (MLN) – branded product that contains a week’s worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate.

To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to the latest e-News:

- CMS MLN Connects™ Provider eNews: May 29, 2014 – http://go.usa.gov/8PgC
- CMS MLN Connects™ Provider eNews: June 12, 2014 – http://go.usa.gov/8ugz
- CMS MLN Connects™ Provider eNews: June 26, 2014 – http://go.usa.gov/9m3B

Discover your passport to Medicare training

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- 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 30904-0660

Regional home health and hospice 
intermediary
Palmetto Government Benefit 
Administrators
Medicare Part A
P. O. Box 100238 
Columbia, SC 29202-3238

Florida/USVI 
phone numbers

Customer service/IVR
Providers:
888-664-4112
Speech and hearing impaired
877-660-1759

Beneficiaries:
800-MEDICARE (800-633-4227)
Speech and hearing impaired
800-754-7820

Credit balance report
Debt recovery
904-791-6281
Fax
904-361-0359

Electronic data interchange
888-670-0940

Option 1 – Transaction support
Option 2 – PC-ACE support
Option 3 – Direct data entry (DDE)
Option 4 – Enrollment support
Option 5 – 5010 testing
Option 6 – Automated response line

Provider audit and reimbursement
904-791-8430

Provider education and outreach 
Seminar registration hotline
904-791-8103
Seminar registration fax
904-361-0407

Provider enrollment
877-602-8816

Websites
First Coast Service Options Inc. 
(Florida, U.S. Virgin Islands Medicare 
contractor)
medicare.fcso.com

Centers for Medicare & Medicaid 
Services
Providers:
www.cms.gov

Beneficiaries:
www.medicare.gov

Contact CMS
The Region 4 office of the Centers for 
Medicare & Medicaid Services is located 
in Atlanta. The feedback email address is:
ROATLFM@CMS.HHS.GOV
Puerto Rico addresses

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

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

Debt recovery (except for MSP)
First Coast Service Options Inc.
P.O. Box 45096
Jacksonville, FL 32232-5096

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

Freedom of Information Act (FOIA*) related requests
First Coast Service Options Inc.
Attn: FOIA PARD 16T
P.O. Box 45268
Jacksonville, FL 32232-5028

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, auditoria, apelación de reporte de costo, porcentaje tentativo, rama de PS & R
First Coast Service Options Inc.
P.O. Box 45268
Jacksonville, FL 32232-0048

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
medicareespanol.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary
Centers for Medicare & Medicaid Services
www.medicare.gov