

# C Medicare A CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

July 2014



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## Clean Medicare claims start with good signatures

### Provider types affected

This *MLN Matters*® special edition article is intended for all Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order or provide Medicare-covered services to Medicare beneficiaries.

### Provider action needed

#### Stop – impact to you

Medicare requires that services provided/ordered be authenticated by the author. The method used should be a handwritten or electronic signature. Under certain circumstances, a rubber stamped signature is acceptable. If you do not have an acceptable signature on services provided/ordered, your Medicare payment may be impacted.

#### Caution – what you need to know

Medicare services provided/ordered must be authenticated by the author using an acceptable signature.

#### Go – what you need to do

Use this article as a reference to available educational

resources related to signature requirements for Medicare-covered services.

### Educational products for professionals

The *Medicare Learning Network*® (MLN®) offers a variety of educational products to help you understand signature requirements for Medicare-covered services.

#### 1. Medicare Quarterly Compliance Newsletter

- The *Medicare Quarterly Provider Compliance Newsletter (January 2014)* highlights comprehensive error rate testing (CERT) circumstances as a result of insufficient documentation.

#### 2. Articles

- **MM5971: “CR 5550 Clarification – Signature Requirements”** clarifies the instructions on signature requirements for the certification of terminal illness for hospice. It states that Medicare contractors will accept a facsimile of an original written or electronic signature in documenting the certification of terminal illness hospice.
- **MM6100: “Physician signature requirements for**

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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

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## Expand your knowledge of Medicare

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

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

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

General Information

**SIGNATURES**

From front page

**diagnostic tests**” notes that a physician’s signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

- **MM6261: “Signature and Date Stamps For Dme Supplies – Certificates Of Medical Necessity (CMNs) And Dme Mac Information Forms (Difs)”** alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions regarding signature requirements for CMNs and DIFs. It states signature and date stamps are not acceptable for use on CMNs and DIFs. Medicare contractors will only accept hand written, facsimiles of original written and electronic signatures and dates on medical documentation for medical review purposes on CMNs and DIFs.
- **MM6698: “Signature Guidelines For Medical Review Purposes”** outlines the new rules for signatures and adds language of e-Prescribing beginning on or after April 16, 2010. The article covers signature logs and attestation statements. A helpful table summarizing examples where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit a signature log or attestation statement.
- **MM7337: “Hospice Benefit Policy Manual Update: New Certification Requirements And Revised Conditions Of Participation”** states, if the narrative is part of the certification or recertification form it must be located immediately above the physician’s signature. If the narrative is an addendum to the form, (in addition to the physician’s signature on the certification or recertification form) the physician must also sign immediately following the narrative in the addendum. In addition, it must include a statement directly above the physician’s signature attesting that (by signing), the physician confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his or her examination of the patient.
- **MM8219: “Use Of Rubber Stamp For Signature”** highlights the exception for the use of rubber stamps in accordance with the Rehabilitation Act of 1973 in the case of the author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. Under this circumstance, by affixing the rubber stamp, the provider is certifying that they have reviewed the document.
- **SE1219: “A Physician’s Guide To Medicare’s Home**

**Health Certification, Including The Face-To-Face Encounter”** includes a short section on signature requirements for face-to-face documentation.

- **SE1308: “Physicians Delegation Of Tasks In Skilled Nursing Facilities (SNFs) and nursing facilities (NFs)”** addresses the authority of nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) to sign orders, certification, and recertification in SNFs and NFs.
- **SE1405: “Documentation requirements for home health prospective payment system (HH PPS) face-to-face encounter”** notes that the homebound status of the patient and his/her need for skilled services must be written in a brief narrative, signed by a physician, titled *Home health face-to-face encounter*, and dated.

**3. Fact sheets:**

- **ICN 905063: “Power mobility devices: complying with documentation and coverage requirements”** discusses the need for a signature on both the prescription and the detailed product description from the supplier by the treating physician.
- **ICN 905364: “Complying With Medicare signature requirements”** provides answers to questions, as well as a list of resources, about Medicare signature requirements.
- **ICN 905064: “Continuous and bi-level positive airway pressure (CPAP/BPAP) devices: complying with documentation and coverage requirements”** states the order/prescription must be signed by the treating physician who ordered the device. The description may be written by someone else, but the treating physician must sign the order.

**Additional information**

To review detailed Medicare signature requirements read Chapter 3 of *The Medicare Program Integrity* manual located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>.

For more information about provider compliance, visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>.

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## General Coverage

# National coverage determination for single chamber and dual chamber permanent cardiac pacemakers

**Note:** This article was revised July 11, 2014, to reflect the revised change request (CR) 8525 issued July 10. The CR was revised to state that the implementation of CR 8525 is delayed until further notice from the Centers for Medicare & Medicaid Services (CMS). As soon as an implementation date is established, this article will be updated accordingly. This information was previously published in the [February 2014 Medicare A Connection, Pages 20-22](#).

### Provider types affected

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

### Provider action needed

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

Make sure that your billing personnel know about these changes.

### Background

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

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

On August 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD). In this NCD, CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia



due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion).

The following indications are covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

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

The following indications are non-covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block.
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest.
5. Ineffective atrial contractions (e.g., chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia.
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes are prolonged or electrophysiological studies have demonstrated that the block is at or beyond the level of the His Bundle (a component of the electrical conduction system of the heart).

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## NCD

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7. Syncope of undetermined cause.
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block.
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.
11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia.
12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

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

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

### Other key notes for billing

- MACs will pay professional claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains at least one of the *CPT*<sup>®</sup> codes of 33206, 33207, or 33208 and one of the following ICD-9-CM/ICD-10-CM diagnostic codes, and only when the claim is submitted with the KX modifier:
      - 426.0/I44.2
      - 426.12/I44.1
      - 426.13/I44.1
      - 427.81/I49.5, or
      - 746.86/Q24.6
    - The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*<sup>®</sup> codes and at least one of the diagnosis codes listed above along with the KX modifier:
      - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
      - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia
    - Contractors will return claim lines if the KX modifier is not present using the following message:
      - **Claim adjustment reason code (CARC) 4:** The procedure code is inconsistent with the modifier used or a required modifier is missing.
      - **Remittance advice remarks code (RARC) N517:** Resubmit a new claim with the requested information.
  - Effective for claims with dates of service on or after August 13, 2013, MACs will pay outpatient institutional claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, (codes C1785, C1786, C2619, or C2620) provided the claim contains the KX modifier, and contains at least one of the *CPT*<sup>®</sup> codes 33206, 33207, or 33208, and one of the following ICD-9-CM/ICD-10-CM diagnostic codes :
    - 426.0/I44.2
    - 426.12/I44.1
    - 426.13/I44.1
    - 427.81/I49.5, or
    - 746.86/Q24.6
  - MACs will return outpatient institutional claims for implanted permanent cardiac pacemakers that do not meet the preceding requirements.
  - The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*<sup>®</sup> codes and diagnosis codes listed above:
    - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
    - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
    - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia
  - Effective for claims with dates of service on or after August 13, 2013, MACs will pay inpatient claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains one of the following ICD-9/ICD-10 diagnosis and procedure codes:
    - 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, or 37.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, and

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## NCD

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- 426.0/I44.2, 426.12/I44.1,
- 426.13/I44.1, 427.81/I49.5, or
- 746.86/Q24.6
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*<sup>®</sup> codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia

In addition, be aware of the following:

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

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

- **CARC 96:** Non-covered charge(s).
- **RARC N569:** Not covered when performed for the reported diagnosis.

## Delay in implementing NCD for single chamber and dual chamber cardiac pacemakers

On August 13, 2013, the Center for Medicare & Medicaid Services (CMS) issued a final decision memorandum regarding coverage of implanted permanent cardiac pacemakers, single chamber or dual chamber, and determined they are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block.

On February 6, 2014, CMS directed Medicare

- **Group code CO** (contractual obligation), if claim received with GZ modifier indicating no signed advance beneficiary notice (ABN) is on file or group code PR (patient responsibility) if occurrence code 32 indicating a signed ABN is on file or occurrence code 32 with modifier GA is present.

NCDs are binding on all MACs and contractors with the federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See the Social Security Act, Section 1869(f)(1)(A)(i), at [http://www.ssa.gov/OP\\_Home/ssact/title18/1869.htm](http://www.ssa.gov/OP_Home/ssact/title18/1869.htm)).

### Additional information

The official instruction, CR 8525, was issued to your MACs regarding this change via two transmittals. The first is the transmittal that updates the *NCD* manual and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R170NCD.pdf>. The second transmittal updates the *Medicare Claims Processing* manual and it is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2986CP.pdf>.

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

*MLN Matters*<sup>®</sup> Number: MM8525 *Revised*  
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 Implementation Date: To be determined

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administrative contractors to implement national coverage determination (NCD) 20.8.3 July 7, 2014, for claims with dates of service on and after August 13, 2013, for those beneficiaries who meet the specific coverage criteria. See *MLN Matters*<sup>®</sup> article MM8525.

There is a temporary delay in implementing NCD 20.8.3. CMS will advise you of the new implementation date in the near future.

# Invalidation of transsexual surgery coverage determination

**Effective date: May 30, 2014**

**Implementation date: June 29, 2014**

## Summary of changes

The purpose of this change request (CR) is to implement the Departmental Appeals Board decision consistent with 42 CFR §426.560(b)(2) by removing section 140.3 (Transsexual Surgery) from Pub. 100-03, *Medicare National Coverage Determinations* manual.

Additionally, references to transsexual surgery have been removed from Pub. 100-02, *Medicare Benefit Policy* manual.

## General information

### Background

The purpose of this CR is to inform you that the Department of Health and Human Services Departmental Appeals Board (DAB) has invalidated National Coverage Determination (NCD) 140.3 "Transsexual Surgery" pursuant to Section 1869(f)(1)(A)(iii) of the Social Security Act (SSA).

(Docket #A-13-47, Decision #2576) dated May 30, 2014. As a consequence of this decision, NCD 140.3 is no longer valid. Implementation of this decision shall be June 29, 2014.

### Policy

Because **the NCD is no longer valid** as of the effective date, its provisions are no longer a basis for denying claims for Medicare coverage of "transsexual surgery" under 42 CFR §405.1060.

Moreover, any local coverage determinations used to adjudicate such claims may not be based on or rely on the provisions or reasoning from Section 140.3 of Pub. 100-03, *Medicare NCD* manual.

In the absence of an NCD, contractors and adjudicators should consider whether any Medicare claims for these services are reasonable and necessary under §1862(a)(1)(A) of the SSA consistent with the existing guidance for making such decisions when there is no NCD.

Therefore, the Centers for Medicare & Medicaid Services will implement the DAB decision with this CR consistent with 42 CFR §426.560(b)(2). **Section 140.3 has been removed from the Medicare NCD manual.**

## Medicare Benefit Policy Manual

### Chapter 1 – Inpatient Hospital Services Covered under Part A

## 120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

(Rev. 189, Issued: 06-27-14, Effective: 05-30-14, Implementation: 06-29-14)

Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons.

Services "related to" non-covered services (e.g., cosmetic surgery, noncovered organ transplants, non-covered artificial organ implants, etc.), including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay in which the noncovered service was performed, are not covered services under Medicare. Services "not related to" non-covered services are covered under Medicare.

Following are examples of services "related to" and "not related to" non-covered services while the beneficiary is an inpatient:

- A beneficiary was hospitalized for a non-covered service and broke a leg while in the hospital. Services related to care of the broken leg during this stay is a clear example of "not related to" services and are covered under Medicare.

- A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a non-

covered transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a recommendation for a non-covered transplant or implant, the services related to the admitting condition would be covered.

- A beneficiary was admitted to the hospital for covered services related to a condition which ultimately led to identification of a need for transplant and receipt of a transplant during the same hospital stay. If, on the basis of the nature of the services and a comparison of the date they are received with the date on which the beneficiary is identified as a transplant candidate, the services could reasonably be attributed to preparation for the non-covered transplant, the services would be "related to" non-covered services and would also be non-covered.

Following is an example of services received subsequent to a non-covered inpatient stay:



See **COVERAGE**, next page

## COVERAGE

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After a beneficiary has been discharged from the hospital stay in which the beneficiary received non-covered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior non-covered services may be covered when they are reasonable and necessary in all other respects.

Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous non-covered procedure.

Some examples of services that may be found to be covered under this policy are the reversal of intestinal

bypass surgery for obesity, complications from cosmetic surgery, removal of a non-covered bladder stimulator, or treatment of any infection at the surgical site of a non-covered transplant that occurred following discharge from the hospital.

However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered."

**Source:** CR 8825, *transmittal 169* & *transmittal 189*

## Learn the secrets to billing Medicare correctly

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





## Local Coverage Determinations

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

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

### Effective and notice dates

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

### More information

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

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



## Advance beneficiary notice

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

First Coast Service Options Inc provides current and draft local coverage determinations (LCDs), when they exist, for Medicare-covered procedure codes.

Not every procedure code is covered by an LCD. [Click here](#) to look up current LCDs



## Revised LCDs

### Polysomnography and sleep testing – revision to Part A LCD

**LCD ID number: L29905 (Florida)**

**LCD ID number: L29907 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for polysomnography and sleep testing was revised to include Accreditation Commission for Health Care (ACHC) as an acceptable accreditor for sleep labs.

The “Indications and Limitations of Coverage and /or Medical Necessity” and “Documentation/Credentialing Requirements” sections of the LCD were revised to add this language. In addition, the “Sources of Information and

Basis for Decision” section of the LCD was updated.

#### Effective date

This LCD revision is effective for services rendered **on or after July 8, 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>.

**Note:** To review active, future, and retired LCDs, please [click here](#).

### Dialysis (AV fistula and graft) vascular access maintenance – revision to the Part A LCD

**LCD ID number: L32830**

**(Florida, Puerto Rico/U.S. Virgin Islands)**

Based on the 2014 American Medical Association (AMA) Errata, the descriptors for *Current Procedural Terminology*® (CPT®) codes 37236 and 37237 were revised. Therefore, the “CPT®/HCPCS codes” section of the dialysis (AV fistula and graft) vascular access maintenance local coverage determination (LCD) was updated to reflect the revised descriptors for CPT® codes 37236 and 37237.

#### Effective date

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

**Note:** To review active, future, and retired LCDs, please [click here](#).

### Molecular pathology procedures – revision to the LCD

**LCD ID number: L33703**

**(Florida, Puerto Rico/U.S. Virgin Islands)**

Based on the 2014 American Medical Association (AMA) Errata, the descriptor for *Current Procedural Terminology*® (CPT®) code 81405 was revised. Therefore, the “CPT®/HCPCS codes” section of the molecular pathology procedures local coverage determination (LCD) was updated to reflect the revised descriptor for CPT® code 81405.

#### Effective date

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

**Note:** To review active, future, and retired LCDs, please [click here](#).

## Online Medicare refreshers

The *Medicare Learning Network*® (MLN) Products Web-Based Training (WBT) courses are designed for self-paced training via the Internet.

These WBT courses provide information on a broad range of Medicare topics for health care professionals and their staff. Many of these courses offer continuing education credits.

[Click here](#) to explore the wide array of training opportunities.



## Electronic Data Interchange

# Medically unlikely edits and bilateral procedures

### Provider types affected

This *MLN Matters*® special edition article is intended for all Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare administrative contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries.

### Provider action needed

#### Stop – impact to you

Claims filed using noncompliant coding for bilateral surgical procedures may have been paid in the past. The purpose of this article is to inform providers that MUE changes may now render those claim lines unpayable.

#### Caution – what you need to know

Providers and suppliers, other than ambulatory surgical centers (ASCs), are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a -50 modifier and one unit of service (UOS).

#### Go – what you need to do

Make sure your billing staffs examine their process for filing claims for bilateral procedures and services to ensure the -50 modifier is used in accordance with Medicare correct coding and claims submission instructions.

### Background

There are several ways that claims for bilateral procedures could be coded, but different methods are only correct in specific situations. The most common methods involve reporting

- a single UOS on one line using the -50 modifier;
- one UOS on each of two lines using modifiers RT and LT; and
- two UOS on a single line with no modifier.

For Medicare claims, when reporting bilateral surgical procedures using codes where the term bilateral is not included in the descriptor, both the *Medicare Claims Processing Manual* and the National Correct Coding Initiative (NCCI) manual specify that these bilateral surgical procedures should be reported using a single UOS and the -50 modifier. The NCCI manual goes on to

warn that MUE edits are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently many bilateral procedures have an MUE value of 1, and have had that MUE value for some time.

At the recommendation of the Office of the Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS) has examined its claims data relative to MUE levels and has confirmed a pattern of inappropriate billing using multiple lines to bypass the MUEs. Agreeing with the OIG that this practice overcharges both beneficiaries and the Medicare program,

CMS is converting most MUEs into per day edits. The MUE adjudication indicator (MAI) indicates the type of MUE and its basis. Effective with the July 1, 2014, update, published per day edits are identified on the CMS NCCI website (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>) by their MAI value of two or three.



#### MAI of three

An MAI of three, the most common per day edit, indicates an edit for which the MUE is based on clinical information such as:

- billing patterns;
- prescribing instructions; or
- other information.

It acknowledges that exceptions could occur but they would be sufficiently rare that the abnormally high units of service value should be considered to be a billing error.

Providers should carefully assess any denials based on these edits and consider the denial to be an indication of incorrect reporting due to such things as clerical errors or errors in the interpretation or application of coding instructions. It is also possible some provider reporting errors could be associated with a lack of medical necessity for the excess units, although the MUE itself does not address medical necessity, but only the medically unlikely nature of the reported value.

In the rare instance where the provider has verified all information, including the correct interpretation of coding

See **EDITS**, next page

## EDITS

From previous page

instructions, and still believes that the correctly coded medically necessary service exceeds the MUE, the provider should submit a clearly supported appeal.

### MAI of two

An MAI of two indicates an edit for which the MUE is based on regulation or subregulatory instruction (“policy”), including the instruction that is inherent in the code descriptor or its applicable anatomy.

### Examples:

1. The MUE of a “per cervical vertebra” code cannot exceed seven based on anatomic considerations, that is, the number of cervical vertebrae. The MUE of seven is therefore inherent in the code descriptor, an integral part of the code set specified for use by Health Insurance Portability & Accountability Act of 1996 (HIPAA).
2. The MUE of a “first 15 minutes” session code for a practitioner cannot exceed one since any time beyond that would require a different “subsequent” code, and that limitation is inherent in the code descriptor and its annual incorporation by CMS.

CMS expects all claims reporting services in excess of the MUE for edits with an MAI of two will represent either clerical errors or errors in the interpretation of instructions. CMS has not identified any instances in which a higher value would be correct and payable. MACs have therefore been instructed that this subregulatory instruction is binding on the MAC for both initial determinations and redeterminations, as is all subregulatory instruction.

### Request for reopening of a claim

For all MUE edit denials, including both MAI of two and three, if the provider identifies a clerical error and

the correct value is equal to or less than the MUE, the provider may request a reopening to correct its billing of the claim as an alternative to filing an appeal. Providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral service because it was billed with two UOS instead of being billed with one UOS and a -50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the -50 modifier to avoid future denials and delays in 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: SE1422  
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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## Updated EDI enrollment form will not allow ERA future date requests

Effective July 21, 2014, the EDI enrollment form will be updated to no longer allow future date requests for 835 (electronic remittance advice) changes. Once the form has been received and processed the remittance request will be effective the next business day. The current form will be retired as of July 20, 2014, and only the current form will be accepted on and after July 21, 2014.

Please remember that the authorized official original signature and title must be included on all applications, and signing this section confirms that you have read and agree with the agreement, the Centers for Medicare &

Medicaid Services (CMS) obligations, and attestation sections on pages 3 and 4.

### Reminders

- It is highly recommended that you keep a copy of your completed enrollment form(s) for your records.
- EDI forms are processed in the order in which they are received.
- All forms received after 2:00 p.m. ET, will have the date of the receipt of the next business day.

## Implementation of phase III CORE 360 CARCs and RARCs rule – version 3.1.0

**Note:** This article was revised July 9, 2014, to reflect the revised change request (CR) 8711 issued June 25. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are changed. Also, the CAQH CORE version number in the above title is revised to 3.1.0. All other information remains the same. This information was previously published in the [May 2014 Medicare A Connection, Page 17](#).

### Provider types affected

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

### What you need to know

This article is based on CR 8711, which instructs the MACs to update the Committee on Operating Rules for Information Exchange (CORE) 360 uniform use of claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) rule. If you use Medicare's PC Print or Medicare Remit Easy Print (MREP) software, you will need to obtain the new version after it is updated October 6, 2014. Make sure that your billing staffs are aware of these changes.

### Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act.

Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C – Administrative Simplification – to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions.

This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE will publish the next version of the code combination list on or about June 1, 2014. This update is



based on March 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. (Visit <http://www.wpc-edi.com/> reference for CARC and RARC updates and <http://www.caqh.org/CORECodeCombinations.php> for CAQH CORE defined code combination updates.)

**Note:** Per the Affordable Care Act mandate, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of four business scenarios.

Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

### Additional information

The official instruction, CR 8711, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1392OTN.pdf>.

*MLN Matters*<sup>®</sup> Number: MM8711 Revised  
Related Change Request (CR) #: CR 8711  
Related CR Release Date: June 25, 2014  
Effective Date: September 2, 2014  
Related CR Transmittal #: R1392OTN  
Implementation Date: September 2, 2014

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## Introduction to PC Print for Medicare Part A

**Note:** PC-Print versions 4.3.0 and higher are no longer compatible with Windows XP. If you receive an error message when accessing Help, please go to this [Microsoft Support page](#) and follow the directions.

The PC-based ANSI ASC X12.835 translator program, PC Print, is an interactive program. It allows the viewing and printing of the Medicare Part A ERA received by the provider in the form of an ANSI ASC X12.835 Electronic Remittance Advice. This program does not retrieve electronic remittances or store them within PC Print.

The primary purpose of the program is to produce a paper remittance advice containing all of the data residing within the ANSI ASC X12.835 5010 electronic remittance advice transmission. The intent of the paper remittance advice is to facilitate accounts receivable processing for the end-user, a provider, who does not have access to sophisticated data processing facilities. Also, the purpose is to produce a paper remittance advice acceptable for subsequent payers processing when electronic links capable of ANSI ASC X12.835 transmission do not exist.

Medicare Part A does not send a standard paper remittance (SPR) to entities that receive an electronic remittance advice (ERA). Entities submitting a new request for enrollment of ERA will be allowed to receive the SPR in addition to the ERA for a limited 30-day period.

JSM-412 instructed fiscal intermediaries to terminate issuance of SPRs to those entities (such as a provider, billing agent, clearinghouse, or other entity representing a provider) currently receiving or who begin to receive electronic remittance advices (ERAs), effective the 31st day after initial issuance of the ERA in production. If a Medicare Part A provider uses a billing agent, clearinghouse, or other entity to obtain the ERA, the same guidelines will apply. If a provider number is set up to generate an ERA, First Coast Service Options will not generate a paper remit.

### Benefits of the PC Print program

- The Segment List allows you to view the actual ANSI 835 data in a list format. If the file contains multiple

remittances, they can be viewed separately by choosing a GS segment shown in the first column.

- Viewing facilities exist to display a *Single Claim*. A compressed font is incorporated in order to display the detail line item activity of a claim.
- The All Claims display will allow the operator to view all of the claims in a 25 claim count increment, within the transmission in an abbreviated format. The *All Claims* display allows for left and right scrolling in order to view the entire header and detail of each claim displayed.
- A *Summary Subtotal/Total Bill Type, Bill Summary*, will display the sub-totals for each payment category, per provider fiscal year and the total remittance found within the single claim display, accumulated and displayed by TOB (Type of Bill).

A *Payment Summary, Provider Summary*, identifies the total paid to the provider for this billing cycle/transmission. It also indicates the total claims within the billing cycle/transmission. Non-claim payment adjustments are displayed when applicable. These adjustments allow for provider payments when claims are not present, for example, periodic interim payments, cost report settlements, etc. The adjustments also allow for various other financial transactions required between fiscal intermediaries and providers. The PC Print program allows the end user to view or print all of the above displays. These displays can be used selectively in all situations.

### Comments

The PC Print environment has limitations on the size of a data file used. It has been determined that a data file with greater than approximately 80,000 segments will not appropriately process in this PC Print software. Medicare does not recommend using files greater than 80,000 segments.

This program does not retrieve electronic remittances or store them within PC Print. This program only allows you to view and print an 835 ERA.

### Find fees faster:

### Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at [http://medicare.fcso.com/Fee\\_lookup/fee\\_schedule.asp](http://medicare.fcso.com/Fee_lookup/fee_schedule.asp)

This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.



## Clarification of billing instructions related to the home health benefit

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians, home health agencies, and suppliers of durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) submitting claims to Medicare administrative contractors (MACs) for services and supplies to Medicare beneficiaries in a home health period of coverage.

### Provider action needed

This article is based on change request (CR) 8775, which updates the *Medicare Claims Processing* manual, to specify the physician specialty codes that are excluded from home health consolidated billing, to make conforming changes related to the retirement of the home health advance beneficiary notice, and to make miscellaneous changes to conform term and code usage to national standards. This CR contains no new policy. Make sure your billing staffs are aware of these updates.

### Background

CR 8775 makes a variety of small changes to the *Medicare Claims Processing* manual. These changes do not reflect any new policy. These changes fall into one of three categories.

1. Clarification to home health consolidated billing (HH CB) instructions: In 2003, CR 2705 made changes to Medicare systems to bypass services from home health consolidated billing (HH CB) editing when provided by a physician. CR 2705 provided a list of physician specialty codes that are used in this bypass, but the list was never included in the *Medicare Claims Processing* manual. CR 8775 adds the list to the HH CB section of Chapter 10 of the manual. It also makes some wording clarifications to better reflect how Medicare system edits currently enforce HH CB. The modifications to the manual are attached to CR 8775, and you will find a link to that CR in the *Additional information* section of this article.
2. Removal of references to the home health advance beneficiary notice (HHABN): CR 8404 described the use of the advance beneficiary notice of noncoverage (ABN) as a replacement for the HH ABN. CR 8775 makes conforming changes to Chapter 10 to remove references to the HHABN.
3. Conforming to national standards: CR 8775 makes detailed changes throughout many sections of Chapter 10 to ensure that references to type of bill and revenue code values mirror the way these values are used in the National Uniform Billing Committee's Official



UB-04 Data Specifications Manual. Additionally, one remittance advice code pair is updated to comply with the Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules for code usage on remittance advices.

**Note:** MACs use claim adjustment reason code 97 when rejecting or denying claims due to HH CB.

### Additional Information

The official instruction, CR 8775, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2977CP.pdf>.

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

*MLN Matters*<sup>®</sup> Number: MM8775  
Related Change Request (CR) #: CR 8775  
Related CR Release Date: June 20, 2014  
Effective Date: September 23, 2014  
ICD-10: Upon Implementation of ICD-10  
Related CR Transmittal #: R2977CP  
Implementation Date: September 23, 2014, ICD-10: Upon Implementation of ICD-10

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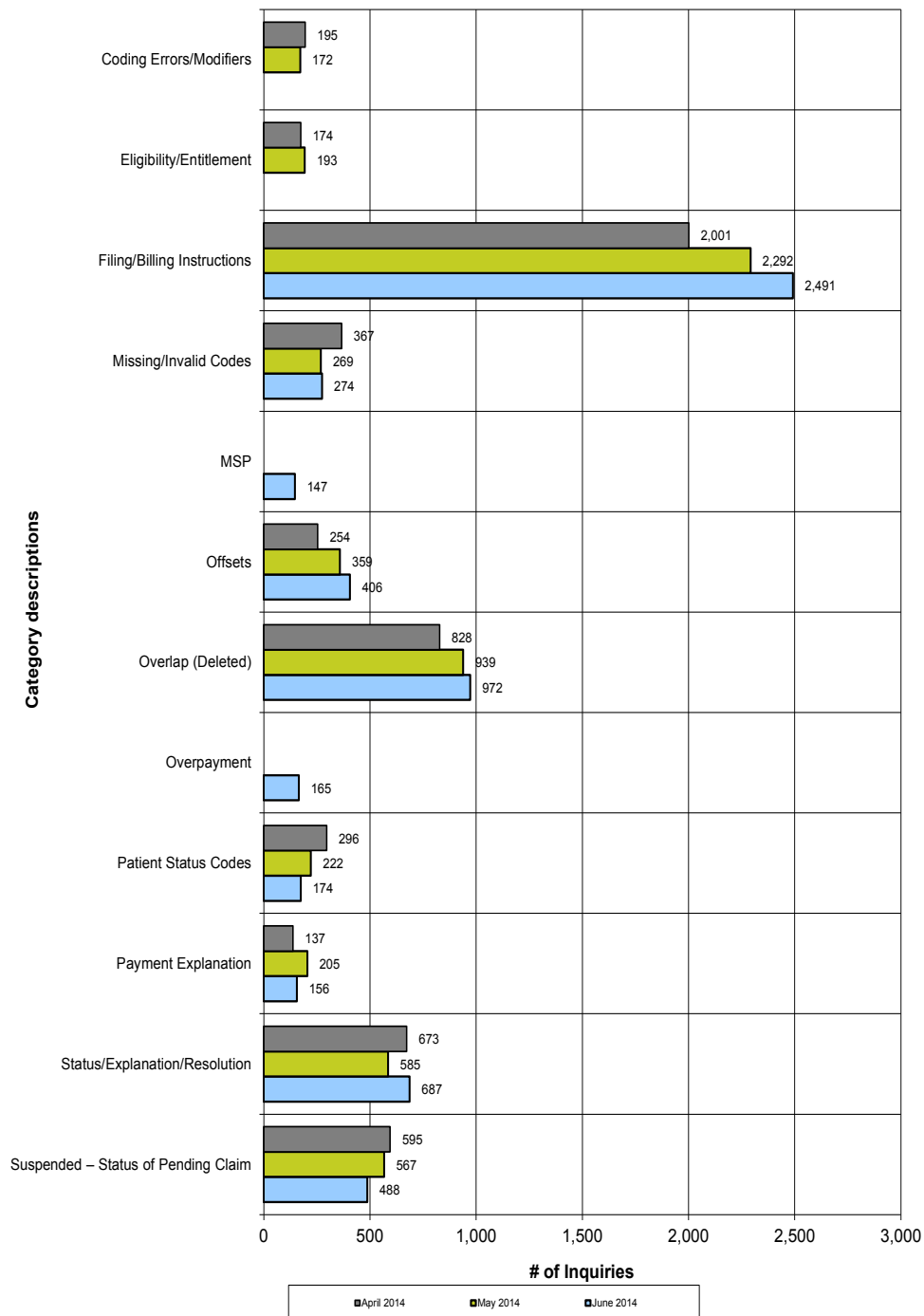
Claims and Inquiry Summary Data

Top inquiries, rejects, and return to provider claims

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

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

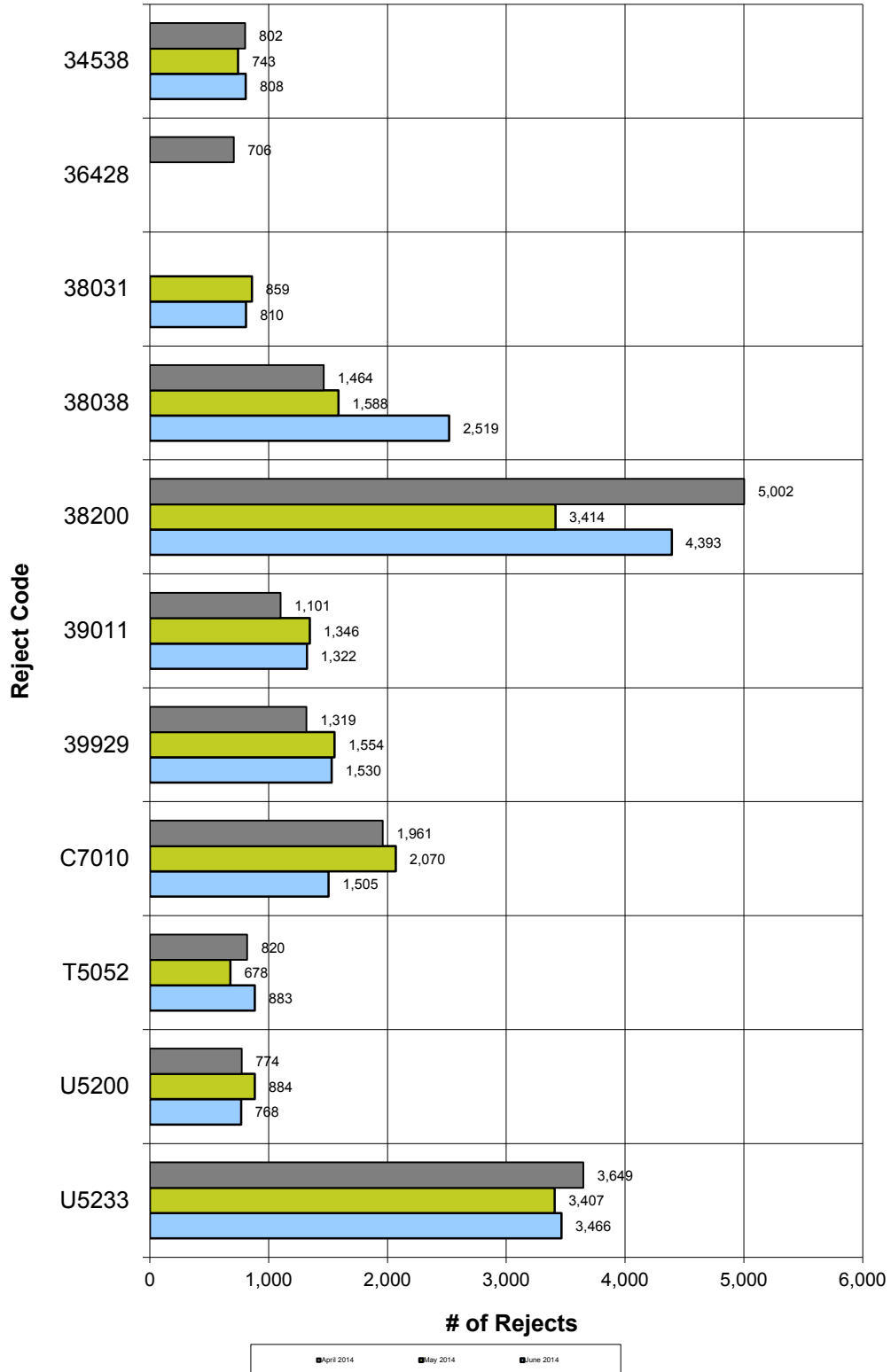
Top inquiries for April-June 2014





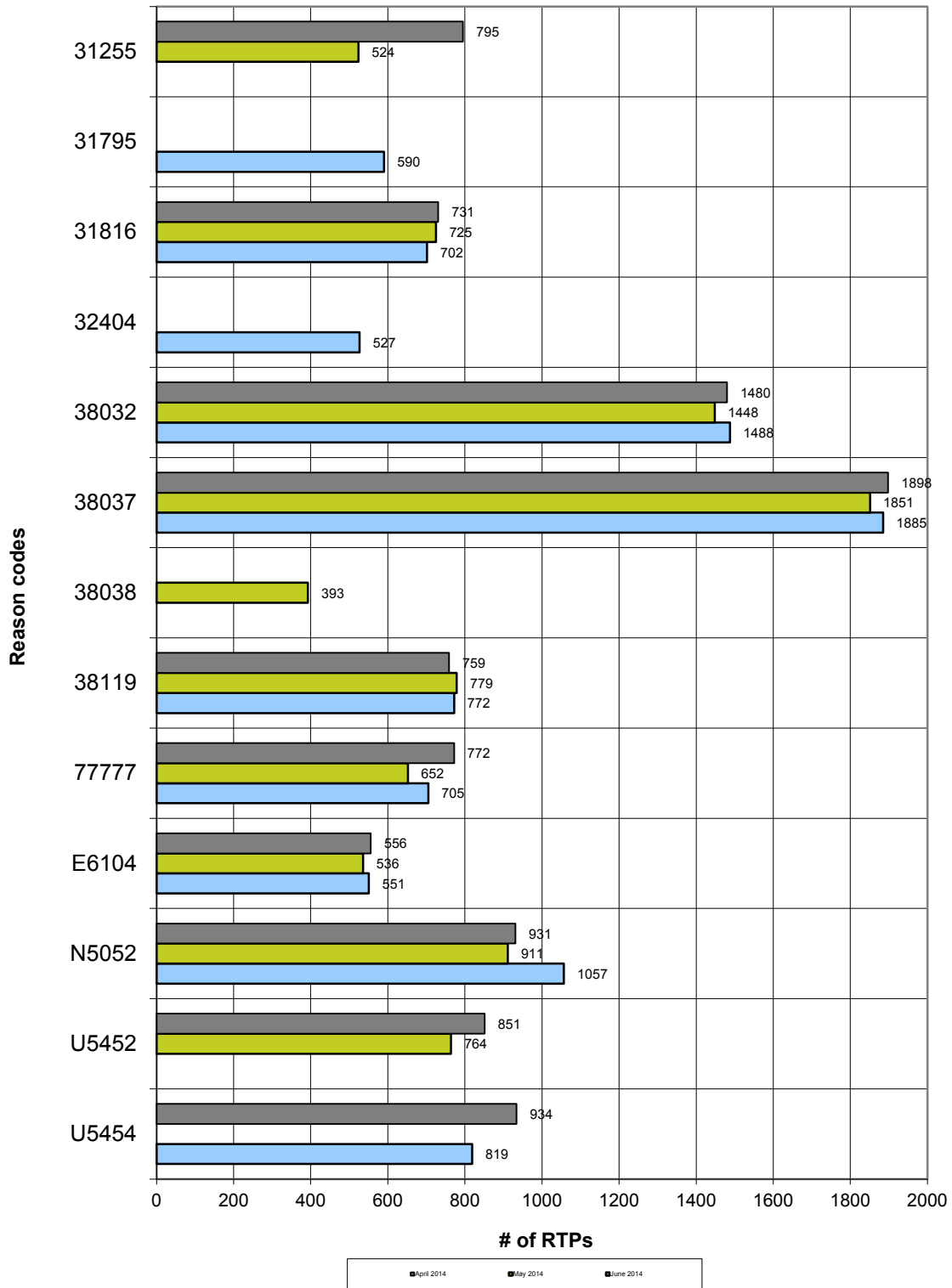
## Part A top rejects for April 2014 through June 2014

Top rejects for April-June 2014



## Part A top return to providers (RTPs) for April 2014 through June 2014

### Top RTPs for April-June 2014



## Reimbursement

### Prompt payment interest rate revision

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

The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2014, must be paid before the end of business March 31, 2014.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page <http://fms.treas.gov/prompt/rates.html> for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 2 percent is in effect through December 31, 2014.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

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

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

### SNF claims rejecting with reason code C7123 in error

#### Issue

Skilled nursing facility (SNF) claims are receiving C7123 in error when the patient is being transferred to the SNF from other than an acute care hospital.

#### Resolution

The Centers for Medicare & Medicaid Services (CMS) recently resolved an issue concerning the common working file (CWF) qualifying stay edit C7123 to allow skilled nursing facility (SNF) claims that contain an accurate qualifying hospital stay to bypass edit C7123.

#### Status/date resolved

As of July 16, 2014, CMS is working on a permanent coding fix that will address all possible bypass scenarios for the edit. SNF providers should contact their MAC with any questions or concerns.

#### Provider action

SNF providers that have received this edit in error may adjust their affected claims or contact their Medicare administrative contractor (MAC) in order to have their claims adjusted.

### Mass adjustment of OPPS claims

Due to a publication error of the national unadjusted copayment associated with ambulatory payment classification (APC) 0066, outpatient prospective payment system (OPPS) claims with a payment associated with APC 0066 were not processed correctly.

The problem has been corrected in the July 2014 OPSS Addendums A and B, as well as in the release of the July 2014 OPSS Pricer, for claims with dates of service on or after July 1, 2014.

For claims with dates of service of January 1, 2014, through June 30, 2014, Medicare administrative contractors (MACs) will be mass adjusting any claims processed in error by September 1, 2014, to issue corrected payments for all impacted OPSS claims.

Providers shall reimburse beneficiaries for any overpayment of beneficiary copayment received that was created by the correction of the national unadjusted copayment associated with APC 0066.

## Medicare Part A skilled nursing facility prospective payment system pricer update

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for skilled nursing facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries paid under the SNF prospective payment system (PPS).

### Provider action needed

Change request (CR) 8828 describes the updates to the payment rates used under the PPS for SNFs, for fiscal year (FY) 2015, as required by statute. Make sure that your billing staffs are aware of these changes.

### Background

Annual updates to the SNF PPS rates are required by the Social Security Act (Section 1888(e); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1888.htm](http://www.ssa.gov/OP_Home/ssact/title18/1888.htm)), as amended by the Medicare, Medicaid, and the State Children's Health Insurance Plan (SCHIP) Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

Each July, the Centers for Medicare & Medicaid Services (CMS) publishes the SNF payment rates for the upcoming fiscal year (October 1, 2014 through September 30, 2015) in the *Federal Register*, available online at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/List-of-SNF-Federal-Regulations.html>.

The update methodology is identical to that used in the

previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds 0.5 percentage point. The statute mandates an update to the federal rates using the latest SNF full market basket adjusted for productivity. The payment rates will be effective October 1, 2014.

### Additional Information

The official instruction, CR 8828, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2985CP.pdf>.

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

*MLN Matters*<sup>®</sup> Number: MM8828  
 Related Change Request (CR) #: CR 8828  
 Related CR Release Date: July 11, 2014  
 Effective Date: October 1, 2014  
 Related CR Transmittal #: R2985CP  
 Implementation Date: October 6, 2014

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## Hold and adjustments to method II CAH claims that include services for a surgical assistant – update

### Issue

#### Provider types affected

Method II critical access hospital (CAH) claims that include services for a surgical assistant will be held until the system is fixed July 28, 2014. No action is required by providers.

#### Resolution

Beginning July 28, claims that were processed incorrectly from April 1 through July 28, 2014, will be adjusted based on the following criteria:

- Type of bill (TOB) = 85x
- CAHs method II (optional Method = 'J') - Page 10,

PROVIDER REIM METH = J

- Revenue code = 96x, 97x, or 98x, excluding 963 and 964
- Modifier = AS, 80, 81 and/or 82 with covered charges greater than zero
- Healthcare Common Procedure Coding (HCPC) = 10000 – 69999

#### Status/date resolved

Claims will be adjusted beginning July 28, 2014.

#### Provider action

None.

## Educational Events

# Provider outreach and educational events September 2014

### 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>

### Medicare Part B changes and regulations

**When:** Wednesday, September 17  
**Time:** 11:30 a.m. - 1:00 p.m. ET – Delivery language: English  
**Type of Event:** Webcast  
<http://medicare.fcso.com/Events/271657.asp>

### Two easy ways to register

- Online** – Visit [www.fcsouniversity.com](http://www.fcsouniversity.com), logon to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event. **First-time user?** Set up an account by completing “Request a New Account” online. Providers with no national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.
- Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 904-791-8103. Class materials will be faxed to you the day of the event.

### Please note:

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

Registrant’s Name: \_\_\_\_\_

Registrant’s Title: \_\_\_\_\_

Provider’s Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

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

### Never miss a training opportunity

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

### Take advantage of 24-hour access to free online training

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



## CMS MLN Connects™ Provider eNews

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

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

- CMS MLN Connects™ Provider eNews: July 3, 2014 – <http://go.cms.gov/1mKmUD3>
- CMS MLN Connects™ Provider eNews: July 10, 2014 – <http://go.usa.gov/Xn9x>
- CMS MLN Connects™ Provider eNews: July 17, 2014 – <http://go.cms.gov/1wviJAT>
- CMS MLN Connects™ Provider eNews: July 24, 2014 – <http://go.usa.gov/5UTw>
- CMS MLN Connects™ Provider eNews: July 31, 2014 – <http://go.cms.gov/1nTYqxJ>



### Discover your passport to Medicare training

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



## Florida/USVI addresses

### First Coast Service Options

#### American Diabetes Association certificates

Medicare Provider Enrollment – ADA  
P. O. Box 2078  
Jacksonville, FL 32231-0048

#### Claims/correspondence

##### Florida:

Medicare Part A Customer Service  
P. O. Box 2711  
Jacksonville, FL 32231-0021

##### U.S. Virgin Islands:

First Coast Service Options Inc.  
P. O. Box 45071  
Jacksonville, FL 32232-5071

#### Electronic claim filing

Direct Data Entry  
P. O. Box 44071  
Jacksonville, FL 32231-4071

#### Fraud and abuse

Complaint Processing Unit  
P. O. Box 45087  
Jacksonville, FL 32232-5087

#### Freedom of Information Act requests

(relative to cost reports and audits)

Provider Audit and Reimbursement (PAR)  
Attn: FOIA PARD – 16T  
P. O. Box 45268  
Jacksonville, FL 32232-5268

#### Local coverage determinations

Medical Policy and Procedures – 19T  
P.O. Box 2078  
Jacksonville, FL 32231-0048

#### Medicare secondary payer (MSP)

##### General information, conditional payment

Medicare Secondary Payer  
P. O. Box 2711  
Jacksonville, FL 32231-0021

##### Hospital protocols, admission questionnaires, audits

MSP – Hospital Review  
P. O. Box 45267  
Jacksonville, FL 32232-5267

##### MSPRC DPP debt recovery, automobile accident cases, settlements/lawsuits, liabilities

Auto/Liability – 17T  
P. O. Box 44179  
Jacksonville, FL 32231-4179

#### Overpayment collections

Repayment plans, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, interim rate determinations, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement  
P. O. Box 45268  
Jacksonville, FL 32232-5268

#### Post-pay medical review

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

#### Provider enrollment

CMS-855 Applications  
P. O. Box 44021  
Jacksonville, FL 32231-4021

#### Redetermination

##### Florida:

Medicare Part A Redetermination/Appeals  
P. O. Box 45053  
Jacksonville, FL 32232-5053

##### U.S. Virgin Islands:

First Coast Service Options Inc.  
P. O. Box 45097  
Jacksonville, FL 32232-5097

#### Special delivery mail & courier services

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

### Other Medicare carriers and intermediaries

#### Durable medical equipment regional carrier (DMERC)

DME, orthotic and prosthetic device, take-home supply, and oral anti-cancer drug claims

CGS Administrators, LLC  
P. O. Box 20010  
Nashville, Tennessee 37202

#### Railroad Medicare

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

#### Regional home health and hospice intermediary

Palmetto Government Benefit Administrators  
Medicare Part A  
P.O. Box 100238  
Columbia, SC 29202-3238

## Florida/USVI phone numbers

#### Customer service/IVR

##### Providers:

888-664-4112

##### Speech and hearing impaired

877-660-1759

##### Beneficiaries:

800-MEDICARE (800-633-4227)

##### Speech and hearing impaired

800-754-7820

#### Credit balance report

##### Debt recovery

904-791-6281

##### Fax

904-361-0359

#### Electronic data interchange

888-670-0940

Option 1 – Transaction support

Option 2 – PC-ACE support

Option 3 – Direct data entry (DDE)

Option 4 – Enrollment support

Option 5 – 5010 testing

Option 6 – Automated response line

#### Provider audit and reimbursement

904-791-8430

#### Provider education and outreach

##### Seminar registration hotline

904-791-8103

##### Seminar registration fax

904-361-0407

#### Provider enrollment

877-602-8816

## Websites

**First Coast Service Options Inc.**  
(Florida, U.S. Virgin Islands Medicare contractor)

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

#### Centers for Medicare & Medicaid Services

##### Providers:

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

##### Beneficiaries:

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

## Contact CMS

The Region 4 office of the Centers for Medicare & Medicaid Services is located in Atlanta. The feedback email address is:

[ROATLFM@CMS.HHS.GOV](mailto:ROATLFM@CMS.HHS.GOV)

## Puerto Rico addresses

### Claims

#### Additional documentation General mailing Congressmen mailing

First Coast Service Options Inc.  
P.O. Box 45003  
Jacksonville, FL 32232-5003

### Redeterminations

#### Redeterminations on overpayments

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

### Debt recovery (except for MSP)

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

### Post-payment medical exams

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

### Freedom of Information Act (FOIA\*) related requests

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

### Medicare fraud and abuse

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

### Provider enrollment

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

### Electronic Data Interchange (EDI\*)

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

### MSPRC DPP debt collection – Part A

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

### Credit balance

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

### Audit and reimbursement department

Reporte de costo, auditoría,  
apelación de reporte de costo,  
porcentaje tentativo, rama de PS &R

First Coast Service Options Inc.  
P.O. Box 45268  
Jacksonville, FL 32231-0048

### Overnight mail and other special handling postal services

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

### Other Medicare carriers and intermediaries

#### Durable Medical Equipment Regional Carrier (DMERC)

CGS Administrators, LLC  
P. O. Box 20010  
Nashville, Tennessee 37202

#### Regional Home Health &

#### Hospice Intermediary

Palmetto Government Benefit  
Administrators  
Medicare Part A  
P.O. Box 100238  
Columbia, SC 29202-3238

#### Railroad Medicare

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

## Puerto Rico phone numbers

### Providers

#### Customer service (free of charge)

Monday to Friday  
8:00 a.m. to 4:00 p.m.  
1-877-908-8433

#### For the hearing and speech impaired (TDD)

1-888-216-8261

#### Interactive voice response (IVR)

1-877-602-8816

### Beneficiary customer service

(free of charge)  
1-800-MEDICARE  
1-800-633-4227

#### For the hearing and speech impaired (TDD)

1-800-754-7820

### Electronic Data Interchange

1-888-875-9779

### Educational Events Enrollment

1-904-791-8103

### Fax number

1-904-361-0407

### Audit and Reimbursement Department

Fax number 1-904-361-0407

### Websites

#### Providers

#### First Coast – MAC Jurisdiction N

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

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

#### Centers for Medicare & Medicaid Services

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

#### Beneficiary

#### Centers for Medicare & Medicaid Services

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