

# C Medicare A CONNECTION

medicare.fcso.com



A Newsletter for MAC Jurisdiction N Providers

November 2014



## In this issue

Response to additional documentation requests.....	4
2015 annual update to the therapy code list .....	6
Medicare shared systems modifications.....	17
October 2014 physician fee database update .....	22
ESRD PPS changes for 2015.....	31
Upcoming educational events .....	33

## Proper billing of outpatient drugs

Medicare uses an outpatient prospective payment system (OPPS) to pay certain outpatient claims. With this method of reimbursement, Medicare payment is not based on the amount the provider charges.

The billed charges generally do not affect the current Medicare prospective payment amounts. Billed charges usually exceed the Medicare payment amount. A Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

First Coast Service Options Inc. (First Coast) reminds providers that they are responsible for ensuring that the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and units of service are billed correctly for services rendered to Medicare beneficiaries, and claims are in accordance with coding guidelines.

Providers should use the appropriate HCPCS codes, and report units of service as the number of times that a service or procedure was performed or, if the HCPCS is associated with a drug, the number of units administered.

This article provides examples of payment errors that were identified during an audit for certain outpatient claims. Providers should carefully review this article to ensure their claims are submitted properly to Medicare.

### Errors that may result in overpayments

#### Incorrect number of units of service

In the audit review, a provider administered 720 micrograms of filgrastim to a patient and billed for eight units of service (2,400 micrograms).

Using the HCPCS description (injection, filgrastim 300 micrograms) the correct number of units to bill for 720 micrograms was three. On 19 separate occasions this type of error occurred, resulting in overpayments.

Prior to billing the claim, ensure the service is correctly represented by the true number of units. If you are unsure what constitutes one unit, per Medicare guidelines, review the [Medicare Part B drug average sales price \(ASP\) files](#). These files list the dosage per unit for most payable drugs.

See **OUTPATIENT**, Page 3



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

## General Information

New timeframe for response to additional documentation requests.....	4
Revised CMS-855R application - reassignment of benefits .....	5
2015 annual update to the therapy code list .....	6

## General Coverage

Screening for abdominal aortic aneurysms/fecal-occult blood tests.....	6
Coverage of items and services in investigational device exemption studies .....	7

## Local Coverage Determinations

Advance beneficiary notice.....	9
Paclitaxel (Taxol®) – revision to the Part A LCD.....	10
Visual field examination – revision to the Part A LCD.....	10
Alprolix™ [Coagulation Factor IX (Recombinant), Fc Fusion Protein].....	11
Cyramza™ (ramucirumab).....	11
Eloctate™ Antihemophilic Factor (Recombinant), Fc Fusion Protein .....	11
Entyvio™ (vedolizumab).....	12
Novoeight®, Antihemophilic Factor (Recombinant).....	12
Sylvant™ (siltuximab).....	13
Tretten®, Coagulation Factor XIII A-Subunit (Recombinant).....	13
J3590/C9399 Vimizim™ (elosulfase alfa).....	13

## Claims and Inquiry Summary Data

Top inquiries, rejects, and return to provider claims .....	14
Part A top rejects for August 2014 through October 2014 .....	15
Part A top return to providers August - October 2014.....	16

## Electronic Data Interchange

Medicare shared systems modifications.....	17
Remittance information when Medicare recodes HIPPS codes.....	18

## Reimbursement

October 2014 DMEPOS fee schedule update.....	19
Mass adjustment of selected SNF inpatient claims .....	20
Payment for G0101 and Q0091 in rural health clinics and FQHCs.....	21
Demand letters for polysomnography claims .....	21
Claim hold extended for FDG PET for solid tumors .....	21
October 2014 Medicare physician fee database update .....	22
Outpatient therapy cap values for 2015.....	23
Part B inpatient services payment policy update.....	24

## End-stage renal disease facilities

ESRD PPS July 2014 quarterly update.....	25
ESRD PPS October 2014 quarterly update.....	27
Clarification of low volume adjustment for ESRD PPS.....	28
Elimination of the 50/50 payment rule for laboratory services ESRD claims.....	30
Implementation of changes in the ESRD PPS for 2015 .....	31

## Educational Events

Provider outreach and educational events .....	33
CMS MLN Connects™ Provider eNews.....	34
MLN Connects™ Provider eNews for October 23, 2014.....	34
MLN Connects™ Provider eNews for October 30, 2014.....	35
MLN Connects™ Provider eNews for November 6, 2014.....	35
MLN Connects™ Provider eNews for November 13, 2014.....	36

## Contact information

First Coast Service Options contact information .....	37
---	----

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

### Publication staff:

Terri Drury  
Kathleen Cruz Fuentes  
Sofia Lennie  
Martin Smith  
Mark Willett  
Robert Petty

Fax comments about this publication to:

**Medicare Publications**  
**904-361-0723**

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

*CPT five-digit codes, descriptions, and other data only are copyright 2013 by American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. No fee schedules, basic units, relative values or related listings are included in CPT. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein.*

*ICD-9-CM codes and their descriptions used in this publication are copyright 2014 under the Uniform Copyright Convention. All rights reserved.*

*This document contains references to sites operated by third parties. Such references are provided for your convenience only. Florida Blue, Inc. and/or First Coast Service Options Inc. do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

*All stock photos used are obtained courtesy of a contract with www.shutterstock.com.*

## General Information

### OUTPATIENT

From front page

#### Billed separately for packaged services

For selected outpatient drugs that have multiple HCPCS codes, one provider billed Medicare on two line items using a HCPCS code that Medicare pays separately, instead of a HCPCS code that Medicare does not pay separately. These line items involved two different packaged outpatient drugs. In total, the provider was paid \$25,637 for packaged drugs when the provider should have been paid \$0.

Another provider billed Medicare for the chemotherapy drug melphalan hydrochloride (J9245) rather than the chemotherapy drug carboplatin (J9045) that was actually administered.

During the dates of service that the provider administered this drug, Medicare packaged carboplatin in the payment for other services and did not provide for separate reimbursement under the OPPS. As a result, the provider was paid \$16,617 when they should have been paid \$0.

Review the services being billed prior to the claim being submitted to determine if there are any packaged services being included.

It is the provider's responsibility to ensure the correct codes are being billed to represent the services being rendered and that the billing follows Medicare guidelines. For more information on packaged services, please review *CMS' Internet-only manual (IOM) 100-04 chapter 4 section 10.4*.

#### Lack of supporting documentation

Four providers billed Medicare for nine line items for which the providers did not provide any documentation to support that a patient had received the drug service billed.

The Centers for Medicare & Medicaid Services' IOMs can provide specifics on billing for services and documentation that may be required for the services. Specifically, CMS provides an IOM on *Drugs and Biologicals: IOM 100-04 chapter 17*.

#### Incorrect HCPCS codes

One provider used an incorrect HCPCS code on one line item, which resulted in an overpayment. The provider billed Medicare for two units of service for leuprolide acetate injections (J1950, 3.75 milligrams per unit), which is indicated for the treatment of endometriosis, uterine leiomyomas, and malignant neoplasms of the breast; however, the provider should have billed Medicare for two units of service for leuprolide acetate injection (J9217, 7.5



milligrams per unit), which is indicated for the treatment of prostate cancer and was the drug actually administered.

Again, it is the provider's responsibility to review the claim prior to submitting it to Medicare to ensure it is being billed properly.

First Coast recommends that providers establish a compliance and audit program that will allow them to set up necessary checks and balances to safeguard themselves against submitting incorrect claims, resulting in future overpayments. For more information on compliance programs, review the Office of Inspector General's (OIGs) webpage on *Compliance Education Materials*.

#### Provider education resources

The following resources provide information that will assist you with proper billing of outpatient services.

- *Medicare Claims Processing Manual Publication 100-04*
- Chapter 1 – General Billing Requirements, Section 80.3.2.2 FI Consistency Edits -- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>
- Chapter 12 – Physicians/Nonphysician Practitioners -- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>
- Chapter 17 – Drugs and Biologicals, Section 70 Claims Processing Requirements - General -- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>
- Chapter 23 – Fee Schedule Administration and Coding Requirements, Section 20.3 Use and Acceptance of HCPCS Codes and Modifiers – <https://www.cms.gov/manuals/downloads/clm104c23.pdf>

## New timeframe for response to additional documentation requests

*Note: This article was revised November 18, 2014, to make corrections in the article, especially to clarify ADR requirements related to pre-payment review.*

### 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 (DME) MACs, for services to Medicare beneficiaries.

### What you need to know

This article is based on change request (CR) 8583, which instructs MACs and zone program integrity contractors (ZPICs) to produce pre-payment review additional documentation requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

### Background

In certain circumstances, CMS review contractors (MACs, ZPICs, recovery auditors, the comprehensive error rate testing contractor and the supplemental medical review contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare's common working file (CWF).

In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an ADR. The requirements for additional documentation are as follows:

- The Social Security Act, Section 1833(e) – Medicare contractors are authorized to collect medical documentation. The Act states that no payment shall be made to any provider or other person for services

unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.

- According to the *Medicare Program Integrity Manual*, Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions), when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

### Additional information

The official instruction, CR 8583, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R554PI.pdf>.

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

*MLN Matters*® Number: MM8583 Revised  
Related Change Request (CR) #: CR 8583  
Related CR Release Date: November 14, 2014  
Effective Date: April 1, 2015  
Related CR Transmittal #: R554PI  
Implementation Date: April 6, 2015

*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.*

### Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. offers its exclusive E/M interactive worksheet, available at <http://medicare.fcso.com/EM/165590.asp> to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit.

This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders.

*Click here to read* how one innovative provider is using the E/M worksheet to improve communication in her office.



## Revised CMS-855R application - reassignment of benefits

### Provider types affected

This *MLN Matters*<sup>®</sup> special edition (SE) article is intended for physicians, non-physician practitioners, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) and who choose to reassign their benefits or accept reassigned benefits of those claims.

### Provider action needed

#### Stop – impact to you

Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS 855R (reassignment of benefits) application beginning June 1, 2015.

#### Caution – what you need to know

The revised CMS 855R application will be available for use on the CMS.gov website as of December 29, 2014. MACs may accept both the current and revised versions of the CMS 855R through May 31, 2015, after which the revised CMS 855R application will be required to be submitted.

After May 31, 2015, MACs will return any newly submitted CMS 855R applications on the previous version (07/11) to the provider/supplier with a letter explaining that the CMS 855R has been updated and the current version of the CMS 855R (11/12) must be submitted.

#### Go – what you need to do

Make sure that your billing staffs are aware of these changes.

### Background

Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS 855R application starting June 1, 2015. The revised CMS 855R has been streamlined and some sections have been re-ordered for clarity.

The revised form includes an optional section for primary practice location address. This information is shared with other programs such as physician compare to help



beneficiaries identify where their physicians are primarily practicing.

This address must be one that is affiliated with the individual/organization where the benefits are being reassigned.

### Additional information

Visit the Medicare provider supplier enrollment Web page for more information about Medicare enrollment, available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>.

*MLN Matters*<sup>®</sup> Number: SE1432  
Related Change Request (CR) #: NA  
Related CR Release Date: N/A  
Effective Date: June 1, 2015  
Related CR Transmittal #: N/A  
Implementation Date: May 31, 2015

*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>

## 2015 annual update to the therapy code list

### Provider types affected

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

### Provider action needed

Change request (CR) 8985 updates the therapy code list for 2015 by adding two “sometimes therapy” codes, and deleting two current codes. The update to the therapy code list reflects those made in the 2015 Healthcare Common Procedure Coding System and *Current Procedural Terminology*<sup>®</sup>, Fourth Edition (HCPCS/CPT<sup>®</sup>-4). Make sure your billing staff is aware of these changes.

### Background

The Social Security Act (Section 1834(k)(5)) (see [http://www.ssa.gov/OP\\_Home/ssact/title18/1834.htm](http://www.ssa.gov/OP_Home/ssact/title18/1834.htm)) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The HCPCS/CPT<sup>®</sup>-4, 2015 edition is the coding system used for the reporting of these services.

CR 8985 updates the list of codes that describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the 2014 and 2015 Healthcare Common Procedure Coding System and

*Current Procedural Terminology, Fourth Edition* (HCPCS/CPT<sup>®</sup>-4). The therapy code listing can be found at <http://www.cms.gov/Medicare/Billing/TherapyServices/index.html>.

Specifically, CR 8985 updates the code list by adding HCPCS codes 97607 (Neg press wnd tx) and 97608 (Neg press wound tx >50 cm) to the “sometimes therapy” codes and deleting HCPCS codes G0456 and G0457 from the 2015 therapy code list. Code 97608 replaces current code G0457 effective January 1, 2015 and 97607 replaces current code G0456 effective January 1, 2015.

### Additional information

The official instruction, [CR 8985](#), issued to your MAC regarding this change, is available on the CMS website.

*MLN Matters*<sup>®</sup> Number: MM8985

Related Change Request (CR) #: CR 8985

Related CR Release Date: November 14, 2014

Effective Date: January 1, 2015

Related CR Transmittal #: R3121CP

Implementation Date: January 5, 2015

*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.*

## General Coverage

### Medicare coverage of ultrasound screening for abdominal aortic aneurysms and screening fecal-occult blood tests

#### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians, physician assistants, nurse practitioners, and clinical nurse specialists submitting claims to Medicare administrative contractors (MACs) for ultrasound screening for abdominal aortic aneurysms (AAA) and screening fecal-occult blood tests (FOBT) ordered for Medicare beneficiaries.

#### Provider action needed

Effective for dates of service on and after January 27, 2014, MACs shall pay claims for ultrasound screening for AAA and screening FOBTs, per the modified requirements in 42 *Code of Federal Regulations* (CFR) 410.19 and 410.37. See the details of the changes in the *Background* section below. Make sure that your billing staffs are aware of these changes.

#### Background

Medicare Part B coverage of screening FOBTs and ultrasound screening for AAA is covered for certain

beneficiaries that meet eligibility requirements as described in regulations.

As part of the 2014 physician fee schedule rule, the Centers for Medicare & Medicaid Services (CMS) revised the Medicare Part B coverage requirements for ultrasound screening for AAA (42 CFR 410.19) and screening FOBT (42 CFR 410.37). As a result of CR 8881, the following policy changes are effective for dates of service on and after January 27, 2014:

- Ultrasound screening for AAA:** Coverage of AAA screening is modified by eliminating the one year time limit with respect to the referral for this service. This modification allows coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the initial preventive physical examination (IPPE, also commonly known as the “Welcome to Medicare Preventive Visit”).

The beneficiary need only obtain a referral from their physician, physician assistant, nurse practitioner,

See **ULTRASOUND**, next page

# Medicare coverage of items and services in category A and B investigational device exemption studies

## Provider types affected

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

## Provider action needed

This article is based on change request (CR) 8921, which announces changes effective on and after January 1, 2015, to Medicare coverage requirements and review procedures related to items and services in Food and Drug Administration (FDA) approved Category A and B IDE studies. CR 8921 makes changes to the following Medicare manuals:

- *Medicare Benefit Policy Manual*, Chapter 14;
- *Medicare Benefit Policy Manual*, Chapter 16, Section 10; and
- *Medicare Claims Processing Manual*, Chapter 32, Section 68.

Make sure that your billing staffs are aware of these changes.

## Background

Section 1862(m) of the Social Security Act and regulations

at 42 CFR 405 Subpart B allows for payment of routine costs of care furnished to Medicare beneficiaries in Category A IDE studies and authorizes the Secretary to establish criteria to ensure that Category A IDE studies conform to appropriate scientific and ethical standards. Additionally, the regulations allowed Medicare contractors to make coverage decisions for Category B IDE devices and routine care services in their review of claims for payment for these items and services.

Category A (Experimental) device refers to a device for which “absolute risk” of the device type has not been established (that is, initial questions of safety and effectiveness have not been resolved) and the FDA is unsure whether the device type can be safe and effective.

Category B (Non-experimental/investigational) device refers to a device for which the incremental risk is the primary risk in question (that is, initial questions of safety and effectiveness of that device type have been resolved), or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained FDA premarket approval or clearance for that device type.

The FDA notifies the Centers for Medicare & Medicaid Services (CMS) when it notifies the IDE study sponsor

See **STUDIES**, next page

## ULTRASOUND

From previous page

or clinical nurse specialist. All other coverage requirements for this service remain unchanged, per 42 CFR 410.19.

- **Screening FOBTs:** In addition to the beneficiary’s attending physician, the beneficiary’s attending physician assistant, nurse practitioner, or clinical nurse specialist may furnish written orders for screening FOBTs, per section 42 CFR 410.37(b). All other coverage requirements for this service remain unchanged, per 42 CFR 410.37.

## Additional information

The official instruction, CR 8881, consists of three transmittals issued to your MAC. These transmittals update the *Medicare Claims Processing Manual*, the *Medicare Benefit Policy Manual*, and the *Medicare National Coverage Determinations Manual*.

These transmittals are available at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3096CP.pdf>, or <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R196BP.pdf>,

and <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R176NCD.pdf>, respectively.

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: MM8881  
 Related Change Request (CR) #: CR 8881  
 Related CR Release Date: October 17, 2014  
 Effective Date: January 27, 2014  
 Related CR Transmittal #: R3096CP, R176NCD, and R196BP  
 Implementation Date: November 18, 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.*

## STUDIES

From previous page

(i.e. manufacturer) that the device is categorized as either Category A or Category B.

As part of the 2014 physician fee schedule rule, CMS modified its regulations at *42 CFR 405 Subpart B*, related to Medicare coverage of routine care items and services in Category A and B IDE studies and Medicare coverage of Category B IDE devices, effective January 1, 2015.

For purposes of Medicare coverage in Category A and B IDE studies, these regulatory modifications define Medicare coverage requirements, Medicare coverage IDE study criteria, and establish a centralized review process for approval of Category A and B IDE studies.

Effective for Category A and B IDE studies approved by the FDA on or after January 1, 2015, interested parties (i.e. study sponsors) that wish to seek Medicare coverage must submit a request for review and approval to CMS.

Revised Chapter 14 of the *Medicare Benefit Policy Manual* contains detailed instructions on seeking CMS approval of Category A and B IDE studies for purposes of Medicare coverage. Additional information regarding submission of Category A and B IDE study review requests, along with the list of CMS-approved studies is available on the CMS coverage website at <http://www.cms.gov/Medicare/Coverage/IDE/index.html>.

Medicare claims for routine care items and services related to Category A or B IDE studies and Category B IDE devices should be submitted to MACs that will identify routine costs for which Medicare payment is made for each related claim.

**Note:** IDE studies approved by MACs prior to January 1, 2015, will continue to be administered by the MAC. Study

sponsors do not have to submit the protocol to CMS if the participating study investigator sites have already received approval from their MAC. Study sponsors should continue to follow the process established by the MAC for any site additions or protocol changes.

### Additional information

The official instruction, CR 8921, issued to your MAC regarding this change, via two transmittals. The first updates the *Medicare Claims Processing Manual*. It is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3105CP.pdf>. The second updates the *Medicare Benefit Policy Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R198BP.pdf>.

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

MLN Matters® Number: MM8921  
 Related Change Request (CR) #: CR 8921  
 Related CR Release Date: November 6, 2014  
 Effective Date: January 1, 2015  
 Related CR Transmittal #: R3105CP and R198BP  
 Implementation Date: January 5, 2015

*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.*

## Get ready for ICD-10

On October 1, 2015, the health care industry will transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures.

This transition is going to change how you do business—from registration and referrals to superbills and software upgrades. But that change doesn't have to be overwhelming.

The Centers for Medicare & Medicaid Services has the following resources to help your practice prepare for the transition.

*Online ICD-10 guide*

*ICD-10 basics for large medical practices*





# 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.

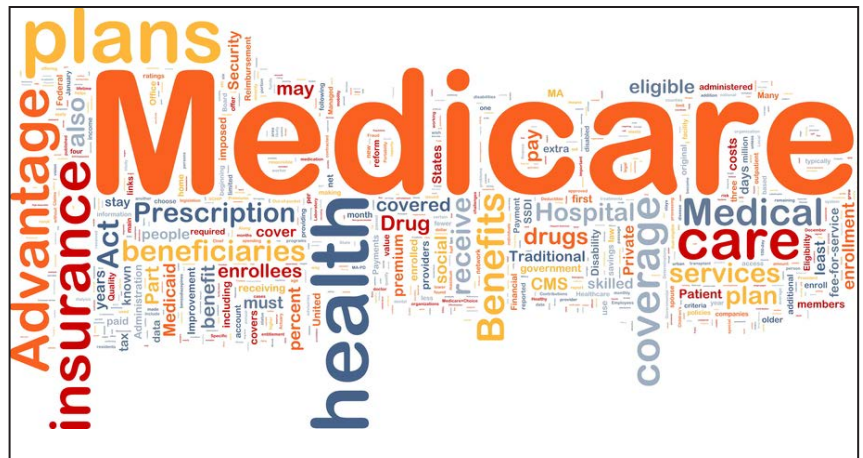
### Effective and notice dates

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

## Paclitaxel (Taxol®) – revision to the Part A LCD

**LCD ID number: L28943 (Florida)**

**LCD ID number: L28964 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for paclitaxel (Taxol®) has been revised based on a reconsideration request. Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, for off-labeled indications, anaplastic thyroid carcinoma was added. Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, ICD-9-CM code 193 (Malignant neoplasm of thyroid gland) was added. 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 November 17, 2014.**

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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

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

## Visual field examination – revision to the Part A LCD

**LCD ID number: L29006 (Florida)**

**LCD ID number: L29038 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for visual field examination was revised based on the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Edits, Chapter XI, medically unlikely edits.

The “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD was updated. Additionally, a “Coding Guideline” has been developed and attached to the LCD.

### Effective date

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

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

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

### Take the time to ‘chat’ with the website team

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast’s Live Chat service.

Live chat is available Monday-Friday, from 10 a.m.-2 p.m. ET.



**Additional information**

## Alprolix™ [Coagulation Factor IX (Recombinant), Fc Fusion Protein]

Alprolix™ [Coagulation Factor IX (Recombinant), Fc Fusion Protein] Lyophilized powder for solution for intravenous injection is a recombinant DNA derived, coagulation Factor IX concentrate indicated in adults and children with hemophilia B for: control and prevention of bleeding episodes, perioperative management, and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. Alprolix™ was approved by the Food and Drug Administration (FDA) on March 28, 2014.

Alprolix™ is supplied as a lyophilized powder in a single use vial containing nominally 500, 1000, 2000, or 3000 international units (IU.). As approved by the FDA the recommended dose and duration of treatment depend on

## Cyramza™ (ramucirumab)

Cyramza™ (ramucirumab) injection, for intravenous use is a human vascular endothelial growth factor receptor 2 (VEGFR2) antagonist indicated for the treatment of advanced gastric cancer or gastro-esophageal junction adenocarcinoma, as a single agent after fluoropyrimidine or platinum-containing chemotherapy.

Cyramza™ was approved by the Food and Drug Administration (FDA) April 21, 2014. Cyramza™ is supplied in a single-dose vial as a sterile, preservative-free solution as a concentrated solution for infusion in a 5mg/5ml (1mg/mL) single-use vial requiring dilution. As approved by the FDA the recommended dose is eight mg/kg every two weeks administered as an intravenous infusion over 60-minutes.

## Eloctate™ Antihemophilic Factor (Recombinant), Fc Fusion Protein

Eloctate™, Antihemophilic factor (Recombinant) Fc Fusion Protein, Lyophilized powder for solution for intravenous injection is a recombinant DNA derived, Antihemophilic factor indicated for use in adults and children with hemophilia A (congenital factor VIII deficiency ) for: Control and prevention of bleeding episodes; perioperative management and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. Eloctate™ is not indicated for the treatment von Willebrand disease.

Eloctate™ was approved by the Food and Drug Administration (FDA) June 6, 2014.

Eloctate™ is supplied as a lyophilized powder in single use vials of containing nominally, 250, 200, 1000, 1500, 2000, and 3000 international units pf Factor VIII potency. As approved by the FDA the recommended dose and

the severity of the Factor XI deficiency, the location and extent of bleeding, and the patient's clinical condition.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The patient's medical record must support the diagnosis hemophilia B disorder using the appropriate ICD-9-CM code 286.1 (congenital L factor XI disorder), when provided by a supplier a valid prescription, a valid invoice, shipment ticket and FDA guidance for use as well as the administration.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting.

The medical record must clearly document the patient's prior chemotherapy regimens and must also support the diagnosis of advanced gastric cancer or gastro-esophageal junction adenocarcinoma using the appropriate ICD-9-CM code(s) of 150.0-150.9 (Malignant neoplasm of esophagus), 151.0-151.9 (Malignant neoplasm of stomach), 235.5 (Other and unspecified digestive organs) and FDA guidance for use as well as the administration.

duration of treatment depend on the severity of the Factor VIII deficiency, the location and extent of bleeding, and the patient's clinical condition. Careful monitoring of replacement therapy is necessary in cases of major surgery or life-threatening bleeding episodes.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The patient's medical record must support the diagnosis of congenital factor VIII deficiency using the appropriate ICD-9-CM code 286.0. (Congenital deficiency of other clotting factors), when provided by a supplier a valid prescription, a valid invoice, shipment ticket and FDA guidance for use as well as the administration.

## Entyvio™ (vedolizumab)

Entyvio™ (vedolizumab) injection, for intravenous use is an integrin receptor antagonist indicated for the treatment of adult patients with moderately to severely active ulcerative colitis (UC) who have had an inadequate response with, lost response to, or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator; or had an inadequate response with, were intolerant to, or demonstrated dependence or corticosteroids:

- Inducing and maintaining clinical response
- Inducing and maintaining clinical remission
- Improving endoscopic appearance of the mucosa
- Achieving corticosteroid-free remission

Entyvio™ is also indicated for treatment of adult patients with moderately to severely active Crohn's disease (CD) who have had an inadequate response with, lost response to, or were intolerant to a TNF blocker or immunomodulator; or had an inadequate response with, were intolerant to; or demonstrated dependence on corticosteroids:

- Achieving clinical response
- Achieving clinical remission
- Achieving corticosteroids-free remission

Entyvio™ was approved by the Food and Drug Administration (FDA) May 20, 2014.

## Novoeight®<sup>®</sup>, Antihemophilic Factor (Recombinant)

Novoeight®<sup>®</sup>, Antihemophilic factor (Recombinant), Lyophilized powder for solution for intravenous injection is indicated for use in adults and children with hemophilia A (congenital factor VIII deficiency or classic hemophilia) for: Control and prevention of bleeding episodes; perioperative management and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. Novoeight®<sup>®</sup> is not indicated for the treatment von Willebrand's disease.

Novoeight®<sup>®</sup> was approved by the Food and Drug Administration (FDA) October 15, 2013. Novoeight®<sup>®</sup> is supplied as a lyophilized powder in single use vials of 250, 200, 1000, 1500, 2000, and 3000 international units.

As approved by the FDA the recommended dose is determined using the following formula: Dosage required (IU)= Body Weight(kg) x Desired Factor VIII increase (IU/dl

Entyvio™ is supplied in sterile 20 mL single-use glass vials, containing 300mg of vedolizumab as a white to off-white cake.

As approved by the FDA the recommended dose in patients with ulcerative colitis and Crohn's disease is 300 mg infused intravenously over approximately 30 minutes at zero, two, and six weeks, then every eight weeks thereafter. Entyvio™ should be discontinued in patients who do not show evidence of therapeutic benefit by week 14.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting.

The medical record must clearly document the patient's inadequate response, loss of response or intolerant to a TNF blocker or immunomodulator or had an inadequate response, intolerance or demonstrated dependence on corticosteroids.

The medical record must clearly document evidence that the patients has had therapeutic benefit the record must also support the diagnosis of UC or CD .a (using the appropriate ICD-9-CM code(s) of 556.0-556.3 or 556.5-556.9 (Ulcerative colitis), 555.0-555.9 (Regional enteritis) and FDA guidance for use as well as the administration.

or percent normal) x 0.5 (IU/dl).

Frequency of Novoeight®<sup>®</sup> administration is determined by the type of bleeding episode and recommendation of the treating physician. In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting.

The patient's medical record must support the diagnosis of congenital factor VIII deficiency using the appropriate ICD-9-CM code 286.0 (Congenital deficiency of other clotting factors), when provided by a supplier a valid prescription, a valid invoice, shipment ticket and FDA guidance for use as well as the administration.

## Sylvant™ (siltuximab)

Sylvant™ (siltuximab) injection, for intravenous use is an interleukin-6(IL-6) antagonist indicated for the treatment of patients with multicentric Castleman's disease (MCD) who is human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV) negative. Sylvant™ was approved by the Food and Drug Administration (FDA) April 22, 2014.

Sylvant™ is supplied in a single-use vial containing 100mg or 400mg of lyophilized powder.

As approved by the FDA the recommended dose is 11mg/kg given over one hour by intravenous infusion every three weeks until treatment failure.

In the absence of a national coverage determination

(NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting.

The medical record must clearly document the patient's HIV and HHV-8 status; the medical record must include the patient's hematology laboratory test for the first 12 months of treatment and every three dosing cycles thereafter.

The record must also support the diagnosis of Multicentric Castleman's disease using the appropriate ICD-9-CM code(s) of 785.6 (Enlargement of lymph nodes), 229.0 (Benign neoplasm of other and unspecified sites) 238.79 (Other lymphatic and hematopoietic tissues) and FDA guidance for use as well as the administration.

## Tretten®, Coagulation Factor XIII A-Subunit (Recombinant)

Tretten®, [Coagulation Factor XIII A-Subunit (Recombinant), Lyophilized powder for solution for intravenous injection is indicated for routine prophylaxis of bleeding in patients with congenital factor XIII-A-Subunit deficiency.

Tretten® was approved by the Food and Drug Administration (FDA) December 24, 2013. Tretten® is supplied as a lyophilized powder in a single use vial along with the diluent (Sterile Water for injection) vial. As approved by the FDA the recommended doses 35 international units per kilogram body weight once monthly

to achieve target trough level of FXIII activity at or above 10 percent using a validated assay. In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting.

The patient's medical record must support the diagnosis of congenital factor XIII A-Subunit deficiency using the appropriate ICD-9-CM code 286.3 and FDA guidance for use as well as the administration.

## Vimizim™ (elosulfase alfa)

Vimizim™ (elosulfase alfa) injection, for intravenous use is a hydrolytic lysosomal glycosaminoglycan (GAG) specific enzyme indicated for patients with Mucopolysaccharidosis type IVA (MPS IVA: Morquio A syndrome). Vimizim™ was approved by the Food and Drug Administration (FDA) February 14, 2014.

Vimizim™ is supplied as a concentrated solution for infusion in a 5mg/5ml (1mg/mL) single-use vial requiring dilution.

As approved by the FDA the recommended dose is 2mg per kg administered intravenously over a minimum range of 3.5 to 4.5 hours, based on infusion volume, once every week.

Pre-treatment with antihistamines with or without antipyretics is recommended 30-60 minutes prior to the start of the infusion.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting.

The patient's medical record must also support the diagnosis of Mucopolysaccharidosis, type IVA (MPS IVA; Morquio A syndrome using the appropriate ICD-9-CM code(s) of 277.5 (Mucopolysaccharidosis) and FDA guidance for use as well as the administration.

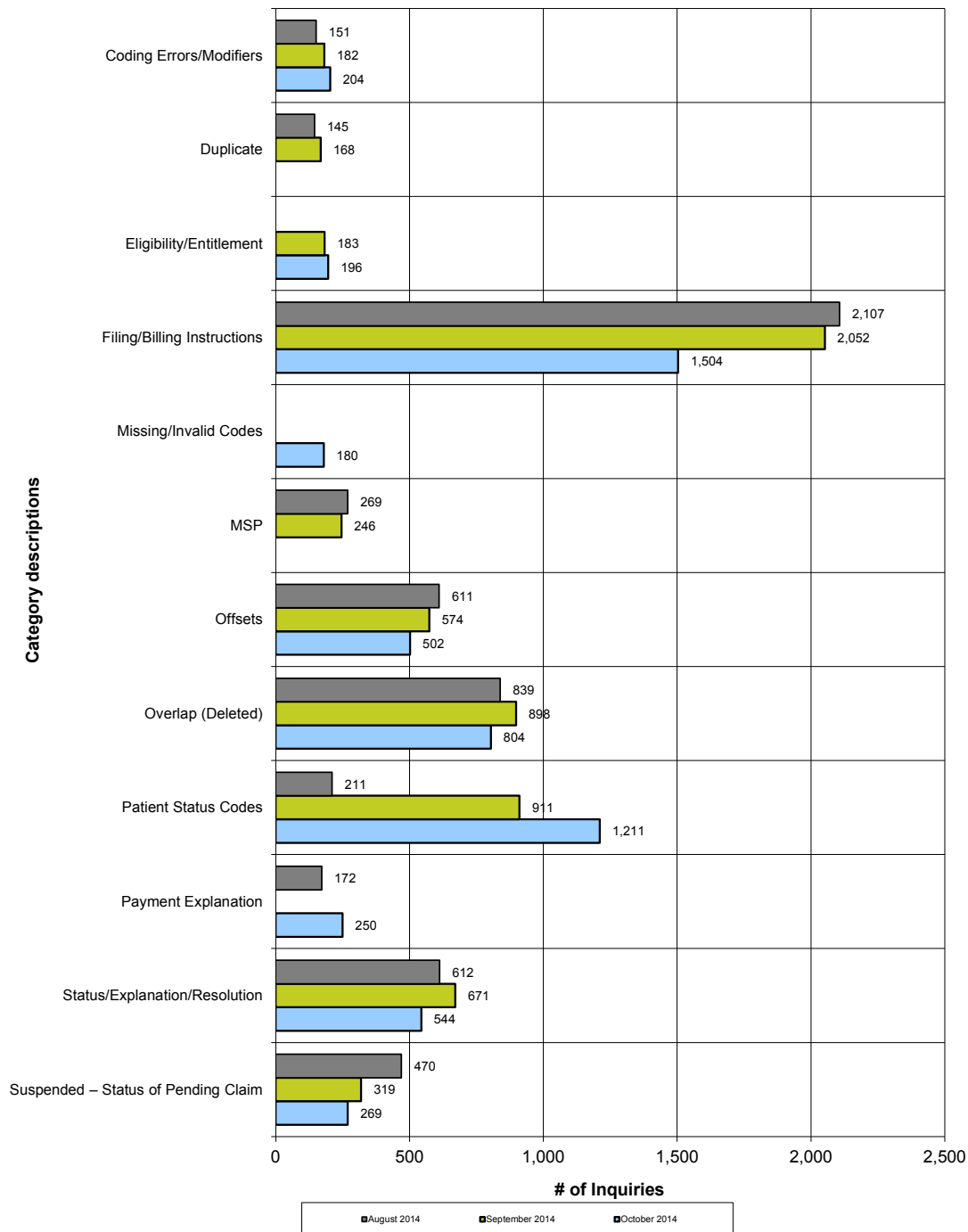
## Claims and Inquiry Summary Data

### 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 August 2014 through October 2014.

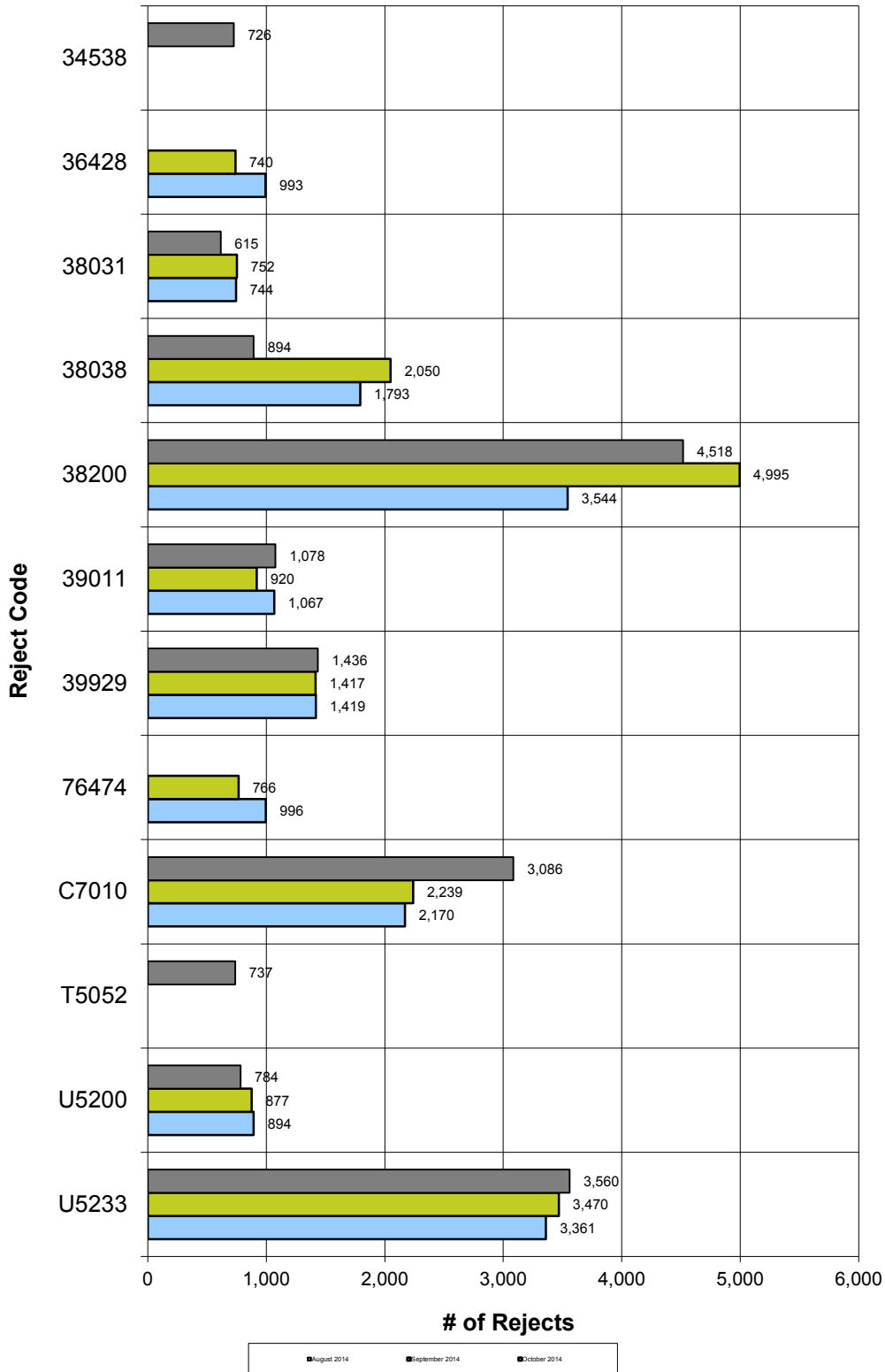
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at [http://medicare.fcso.com/Inquiries\\_and\\_denials/index.asp](http://medicare.fcso.com/Inquiries_and_denials/index.asp).

#### Top inquiries for August-October 2014



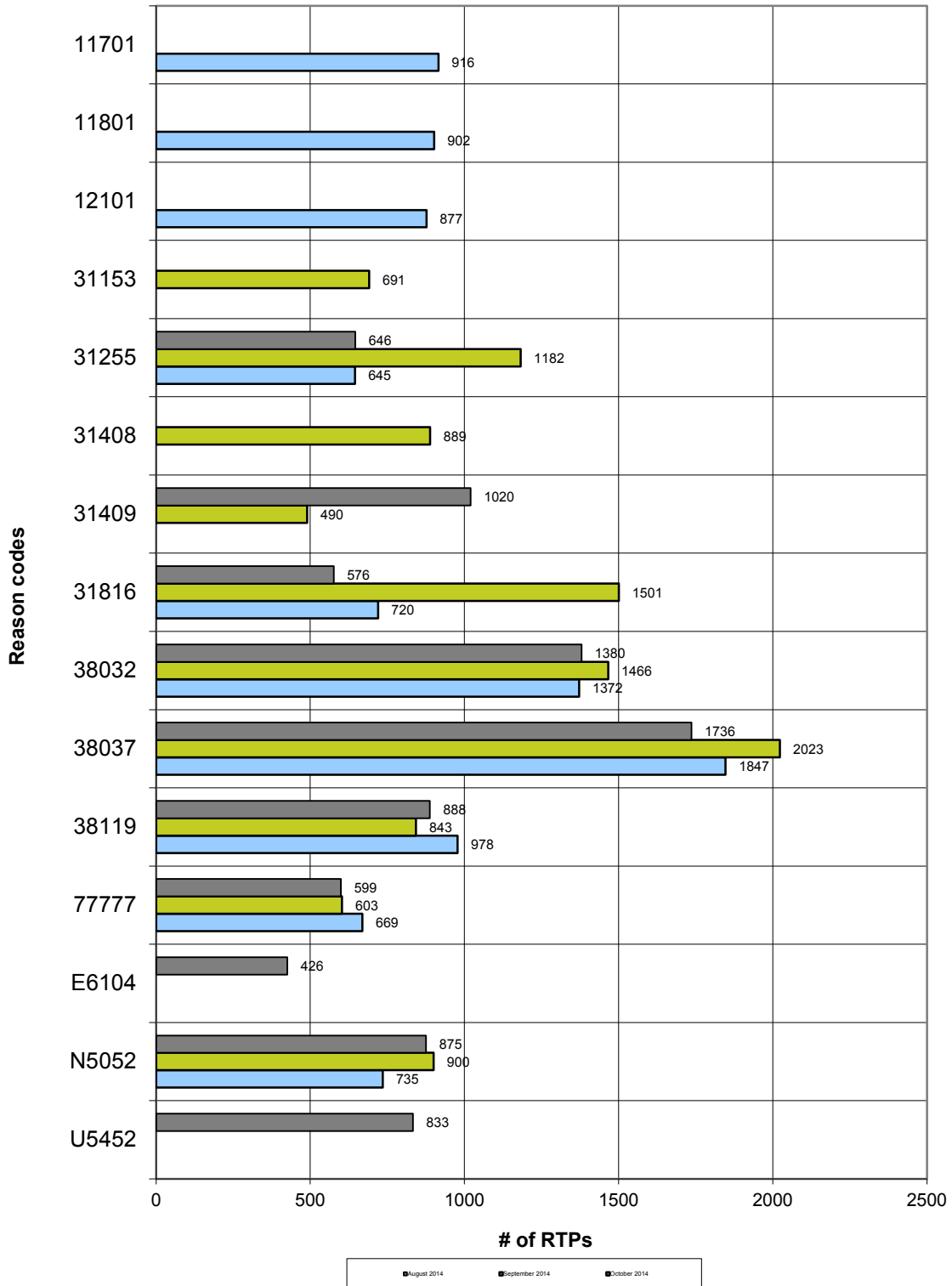
# Part A top rejects for August 2014 through October 2014

Top rejects for August-October 2014



## Part A top return to providers August - October 2014

Top RTPs for August-October 2014





## Electronic Data Interchange

# Medicare shared systems modifications necessary to capture various HIPAA compliant fields

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for hospitals, other providers, and suppliers submitting institutional claims to Medicare administrative contractors (MACs) for services paid under the Medicare physician fee schedule (MPFS).

### Provider action needed

This article is based on change request (CR) 8384 which informs MACs that the Centers for Medicare & Medicaid Services (CMS) needs to expand institutional claim processing fields and to update items on the version 5010 837I flat files. Specifically, CMS is:

Updating the direct data entry (DDE) screens to allow entry of three patient reason for visit codes;

- Updating the DDE screens to allow entry of a nine-digit ZIP code for the service facility;
- Editing to ensure that when a patient reason for visit code is received that the 5010 requirements for claims are enforced (that is to say that the services billed involve unscheduled outpatient visits type of bill (TOB) 013x or 085x together with priority of visit/type of admission codes 1, 2 or 5 and revenue codes 045x, 0516, or 0762).

Claims failing this edit will return to the provider (RTP). Medicare outpatient service providers report the nine-digit ZIP code of the service facility location in the 2310E loop of the 837 Institutional claim transaction.

Direct data entry submitters also are required to report the nine-digit ZIP code of the service facility location for off-site or multiple satellite office outpatient facilities. DDE submitters should key the 9-digit service facility's ZIP code in the "FAC.ZIP" field found on MAP 1711.

Paper submitters shall report this information in form locator (FL) 01 on the paper claim form. Medicare systems use this service facility ZIP code to determine the applicable payment locality whenever it is present. Make sure that your billing staffs are aware of these changes.

### Background

Services that are paid subject to the Medicare physician fee schedule (MPFS) are adjusted based on the applicable payment locality. Medicare systems determine which locality applies using ZIP codes. In cases where the provider has only one service location, the payment locality used to calculate the fee amount is determined using

the ZIP code of the master address contained in the Medicare contractors' provider file.

Increasingly, hospitals operate off-site outpatient facilities and other institutional outpatient service providers operate multiple satellite offices. In some cases, these additional locations are in a different payment locality than the parent provider. In order for MPFS payments to be accurate, the nine-digit ZIP code of the satellite facility is used to determine the locality in these cases.

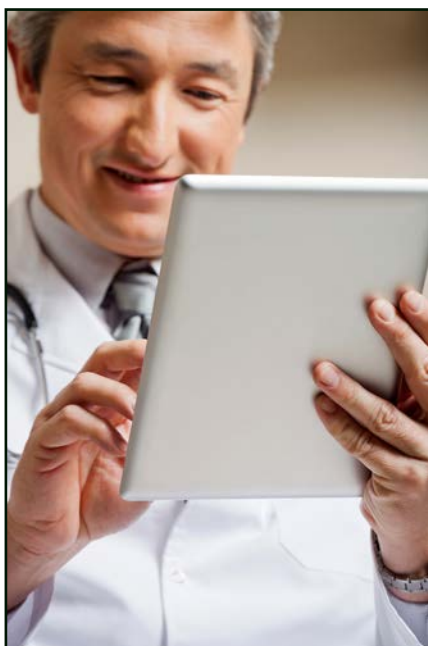
### Additional information

The official instruction, CR 8384 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3107CP.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: MM8384 Revised  
Related Change Request (CR) #: CR 8384  
Related CR Release Date: November 6, 2014  
Effective Date: April 1, 2015  
Related CR Transmittal #: R3107CP  
Implementation Date: April 6, 2015

*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.*



## Remittance information when Medicare systems recodes health insurance prospective payment system codes

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for inpatient rehabilitation facilities (IRFs), home health agencies (HHAs), and skilled nursing facilities (SNFs) submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs, for services provided to Medicare beneficiaries.

### Provider action needed

Change request (CR) 8950 contains no new payment policy. CR 8950 improves the implementation of existing policies. CR 8950:

1. Provides approved remittance advice code pairs to apply to claims in which only a remittance advice remark code (RARC) is currently used. This correction is required for compliance with operating rules of the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE).
2. Reflects changes to the home health (HH) pricer logic that were implemented as part of the 2015 home health prospective payment system (HH PPS) payment update.

Make sure that your billing personnel are aware of these changes.

### Background

The Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set was implemented by January 1, 2014, as the Affordable Care Act required. In order to be compliant with these operating rules, the processing of Medicare claims must use remittance advice code combinations that are included in this list that CAQH CORE developed.

Recently, MACs informed the Centers for Medicare & Medicaid Services (CMS) of two situations in which past instructions specified only a single code for a payment adjustment, rather than a compliant pair.

1. Since 2000, Medicare systems have re-coded the health insurance prospective payment system (HIPPS) code submitted on home HH PPS claims in various circumstances. Under prior instructions, Medicare systems applied only RARC N69 (PPS code changed by claims processing system) without a corresponding claim adjustment reason code (CARC).
2. In 2012, CR 7760 began the implementation of a process to validate HIPPS codes against the assessment records submitted to the quality improvement evaluation system (QIES). This process currently applies to inpatient rehabilitation facility claims and will be expanded to HH and skilled



Patient:	01608034780	
Claim Number:	06/09/10	
Date Claim Received:		
DATES OF SERVICE	PROCEDURE CODE	
05/21/10-05/21/10	82272	
05/21/10-05/21/10	94010	PULM
05/21/10-05/21/10	94375	PULM
05/21/10-05/21/10	93000	CARDIOVASCULAR SERV
05/21/10-05/21/10	36410	VENIPUNCTURE
		Total:

nursing facility claims in the future. CR 7760 only required Medicare systems to apply RARC N69 to claims recoded based on QIES data, also without a corresponding claim adjustment reason code (CARC).

You can find the associated *MLN Matters*<sup>®</sup> article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7760.pdf>.

CR 8950 seeks to correct these oversights. However, CAQH CORE has not yet assigned approved code pairs for RARC N69. Medicare will request the approval of RARC N69 to be paired with CARC 169 (Alternate benefit has been provided); and in the interim, Medicare systems will apply CARC 169 with RARC N69 in both situations described above. Your MAC will:

1. Apply the following remittance advice codes on claims with type of bill (TOB) 032x (Home Health Services under a Plan of Treatment) when the output HIPPS code returned by the HH pricer is different from the input HIPPS code:
  - Group code: CO
  - CARC: 169
  - RARC: N69
2. Apply the following remittance advice codes on claims with TOBs 011x (Hospital Inpatient (Part A) with CMS certification numbers (CCNs) XX3025 - XX3099, XXTXXX, or XRXXXX, or TOBs 018x (Hospital Swing Bed), 021x (SNF Inpatient) or 032x (Home Health) when a HIPPS code is changed due to response file information received from QIES:
  - Group code: CO
  - CARC: 169
  - RARC: N69

HIPPS codes changed on the basis of validation with QIES data are not currently displayed to providers on direct

See **REMITTANCES**, next page

Reimbursement

## October 2014 update for durable medical equipment, prosthetics, orthotics, and supplies fee schedule

*Note: This article was revised November 17, 2014, to reflect the revised change request (CR) 8865 issued November 13. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This article was previously published in the August 2014 edition of Medicare A Connection, Pages 64-65.*

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including hospice & home health MACs, and durable medical equipment MACs (DME MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

### Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 8865 to alert providers and suppliers that CMS issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2014. Make sure your billing staffs are aware of these changes.

### Background

CMS updates DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies.

The quarterly update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>.

### Key points of CR 8865

Splints, casts, and certain intraocular lenses (IOLs) As part of this update, the splint and cast (SC) payment category indicator will be added to the file for the following SC Healthcare Common Procedure Coding System (HCPCS) codes reflecting payment calculated in accordance with the regulations in 42 *Code of Federal Regulations (CFR)*, Section 414.106 for splints and casts:

A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010, Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021, Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032, Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041, Q4042, Q4043, Q4044, Q4045, Q4046, Q4047, Q4048, Q4049

The 'IL' payment category indicator will be added to the file for V2630, V2631, and V2632 HCPCS codes for IOLs inserted in a physician's office reflecting payment calculated in accordance with the IOL payment regulations at 42 *CFR*, Section 414.108. You may want to review *MLN Matters*<sup>®</sup> article MM8645, "April Quarterly Update for 2014

See **DMEPOS**, next page

## REMITTANCES

From previous page

data entry (DDE) screens and are not being sent to the remittance advice.

CR 8950 also reflects changes to the HH pricer logic that were implemented as part of the 2015 HHPPS payment update. You can find these changes in the updated *Medicare Claims Processing Manual*, Chapter 10 (Home Health Agency Billing), Section 70.4 (Decision Logic Used by the Pricer on Claims), which is attached to CR 8950.

### Additional information

The official instruction, CR 8950 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3104CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number.

That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How Does It Work*.

*MLN Matters*<sup>®</sup> Number: MM8950  
 Related Change Request (CR) #: CR 8950  
 Related CR Release Date: November 6, 2014  
 Effective Date: April 1, 2015  
 Related CR Transmittal #: R3104CP  
 Implementation Date: April 6, 2015

*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.*

## DMEPOS

From previous page

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule” at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8645.pdf>, which includes additional discussion on the establishment of national fee schedule amounts for codes for splints, casts, and IOLs.

### Off-the-shelf (OTS) orthotics

Effective October 1, 2014, the following two new codes are added to the HCPCS file to describe prefabricated knee orthoses that are furnished OTS:

1. K0901 – Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf; and
2. K0902 – Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf.



Since these two orthotic OTS codes represent a coding explosion of the prefabricated knee orthosis codes L1843 and L1845, the fees for the above codes will be added to the DMEPOS fee schedule file and established by applying the fees for codes L1843 and L1845 to the new OTS codes K0901 and K0902, respectively.

The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the *Medicare Claims Processing Manual*, Chapter 23, Section 60.3.1. at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>.

Further information on the development of new OTS orthotic codes can be found at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS\\_Orthotics.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html).

## Mass adjustment of selected SNF inpatient claims

Since August 25, 2014, the Medicare claims processing system has been incorrectly calculating the expenses subject to deductible for skilled nursing facility (SNF) inpatient claims (type of bill (TOB) 22x with Healthcare Common Procedure Code (HCPC) 97116).

### Specific coding and pricing issues

1. This update also notifies that HCPCS codes K0734, K0735, K0736, and K0737 found in Attachment B of CR 6270, were discontinued; and
2. Cross walked to HCPCS codes E2622, E2623, E2624, and E2625, respectively, effective January 1, 2011.

Billing instructions for these wheelchair seat cushion items may refer to any of these codes.

### Additional information

The official instruction, CR 8865 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3123CP.pdf>.

You may review Attachment B (page 19) of CR 6270 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1630CP.pdf>.

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

MLN Matters® Number: MM8865 Revised  
 Related Change Request (CR) #: CR 8865  
 Related CR Release Date: November 13, 2014  
 Effective Date: October 1, 2014  
 Related CR Transmittal #: R3123CP  
 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.*

As a result, these claims have been overpaid. Once the system is fixed, Medicare administrative contractors (MACs) will adjust affected claims received on or after August 25, 2014. All claim adjustments were completed December 4, 2014.

## Payment for G0101 and Q0091 in rural health clinics and FQHCs that bill under the all-inclusive rate system

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for rural health clinics (RHCs) and federally qualified health centers (FQHCs) who are authorized to bill under the all-inclusive rate (AIR) system and submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

### Provider action needed

Change request (CR) 8927 adds Healthcare Common Procedure Coding System (HCPCS) code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and code Q0091 (screening Papanicolaou smear) to the list of preventive services paid based on the all-inclusive rate (AIR) for RHCs and FQHCs. Make sure your billing staffs are aware of this change.

### Background

The Centers for Medicare & Medicaid Services (CMS) has determined that HCPCS codes G0101 and Q0091 are billable visits when furnished by a RHC or FQHC practitioner to a RHC or FQHC patient.

CR 8927 instructs MACs to allow HCPCS codes G0101 and Q0091 to be billed as a standalone encounter/visit. These services will be paid the AIR on RHC and FQHC claims for 71x and 77x types of bills (TOBs), effective for dates of service on or after January 1, 2014.

Please note that deductible and coinsurance are NOT to be applied to G0101 or Q0091. If other billable visits are furnished on the same day as G0101 or Q0091, only one visit will be paid.

G0101 or Q0091 are payable annually for women at high risk for developing cervical or vaginal cancer, and women

## Demand letters for polysomnography claims

In June, Medicare administrative contractors (MACs) began to demand and recover what the Centers for Medicare & Medicaid Services (CMS) initially considered to be identified overpayments associated with an Office of Inspector General study on polysomnography claims.

## Claim hold extended for FDG PET for solid tumors

Claims for fluorodeoxyglucose (FDG) positron emission tomography (PET) for solid tumors submitted October 6 through November 30 will be held to ensure Medicare systems can accurately calculate payments.

Specifically, these are claims containing Healthcare Common procedure Coding System (HCPCS) A9552

of childbearing age who have had an abnormal Pap test within the past three years. It is payable every two years for women at normal risk. For FQHCs billing under the PPS, G0101 and Q0091 are qualifying visits when billed with FQHC payment HCPCS codes G0466 or G0467.

Your MAC will not search for claims that have been denied with HCPCS code G0101 or Q0091 prior to the implementation of CR 8927, but will adjust any claims that you bring to their attention.

### Additional information

The official instruction, CR 8927 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1434OTN.pdf>.

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

*MLN Matters*<sup>®</sup> Number: MM8927  
Related Change Request (CR) #: CR 8927  
Related CR Release Date: November 6, 2014  
Effective Date: January 1, 2014  
Related CR Transmittal #: R1434OTN  
Implementation Date: April 6, 2015

*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.*

In August, this activity was suspended.

Providers should not appeal these overpayments, as all claim denials will be reversed. Any recouped money will be refunded, including interest. No action is required by providers.

for all oncologic conditions. See *MLN Matters*<sup>®</sup> article [MM8739](#) for additional information.

The common working file (CWF) will disable the edits that were to be implemented with CR 8739. All claims have been reprocessed.

# October 2014 Medicare physician fee database update

*Note: This article was revised October 24, 2014, to reflect revised change request (CR) 8888. The CR was revised to correct the type of service indicator of HCPCS code G0471 to "5." In this article, the CR release date, transmittal number and the Web address for accessing CR 8888 are revised. All other information remains the same. This article was previously published in the [September 2014 edition of Medicare A Connection, Page 42.](#)*

## Provider types affected

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

## Provider action needed

CR 8888 informs MACs about changes to payment files that were originally issued to contractors based upon the 2014 Medicare physician fee schedule (MPFS) final rule. This change request amends those payment files, effective October 1, 2014. Make sure that your billing staffs are aware of these changes.

## Background

Payment files were issued to MACs based upon rates in the 2014 Medicare physician fee schedule (MPFS) final rule, published in the *Federal Register* December 10, 2013, which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSchedule/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html> on the Centers for Medicare & Medicaid Services (CMS) website, as modified by Section 101 of the "Pathway for SGR Reform Act of 2013" to be effective for services furnished between January 1, 2014, and March 31, 2014. On April 1, 2014, the President signed the "Protecting Access to Medicare Act of 2014," which extends those rates through December 31, 2014.

In order to reflect appropriate payment policy as included in the 2014 MPFS final rule, the Medicare physician fee schedule database (MPFSDB) has been updated with October changes. These rates are effective through December 31, 2014. The table below summarizes the addition of federally qualifying health centers (FQHCs) Healthcare Common Procedure Coding System (HCPCS) codes G0466, G0467, G0468, G0469, and G0470.

HCPCS	Short descriptor	Procedure status
G0466	FQHC visit, new patient	X
G0467	FQHC visit, estab pt	X
G0468	FQHC visit, IPPE or AWW	X
G0469	FQHC visit, MH new pt	X
G0470	FQHC visit, MH estab pt	X

In addition, note the following changes:

- For HCPCS codes 55970 and 55980, CMS will change their procedure status codes from "N"= "Noncovered service by Medicare" to "C"= "carrier priced", and their global surgery codes from "XXX" to "YYY", effective May 30, 2014 (All other indicators should remain the same.).
- For HCPCS code A9586, CMS will change its procedure status code changed from "N"= "Noncovered service by Medicare" to "C"= "carrier priced", and its global surgery code from "XXX" to "YYY", effective September 27, 2013 (All other indicators should remain the same. See CR 8526.).
- HCPCS code G0471 "Ven blood coll SNF/HHA" is added to the MPFS with a procedure status code of X, effective April 1, 2014.
- HCPCS code 0275T "Perq lamot/lam lumbar" is revised to the 2014 physician fee schedule with a procedure status code of "R"="Restricted", effective January 9, 2014 (See CR 8757).
- CMS is changing the short descriptor for G9361 to read "Med Ind for induction", effective January 1, 2014.

Note that MACs need not search their files to either retract payment for claims already paid or to retroactively pay claims and which were impacted by the above changes. However, they will adjust claims that you bring to their attention.

## Additional information

The official instruction, CR 8888 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3097CP.pdf>.

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

*MLN Matters*<sup>®</sup> Number: MM8888 Revised  
 Related Change Request (CR) #: CR 8888  
 Related CR Release Date: October 20, 2014  
 Effective Date: October 1, 2014  
 Related CR Transmittal #: R3097CP  
 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.*

# Outpatient therapy cap values for 2015

## Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians, therapists, and other providers, submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs, for outpatient rehabilitation services provided to Medicare beneficiaries.

## Provider action needed

Change request (CR) 8970 informs MACs about changes to outpatient therapy caps for 2015. For physical therapy and speech-language pathology combined, the therapy cap will be \$1,940. For occupational therapy, the cap for 2015 will be \$1,940. Make sure that your billing staffs are aware of these changes.

## Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as "therapy caps."

The therapy caps are updated each year based on the Medicare economic index. An exceptions process to the therapy caps for reasonable and medically necessary services was required by section 5107 of the Deficit Reduction Act of 2005. The exceptions process for the therapy caps has been continuously extended several

times through subsequent legislation. Most recently, section 103 of the Protecting Access to Medicare Act of 2014 extended the therapy caps exceptions process through March 31, 2015.



## Additional information

The official instruction, CR 8970, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3120CP.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](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

**MLN Matters<sup>®</sup> Number:** MM8970  
**Related Change Request (CR) #:** CR 8970  
**Related CR Release Date:** November 14, 2014  
**Effective Date:** January 1, 2015  
**Related CR Transmittal #:** R3120CP  
**Implementation Date:** January 5, 2015

*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.*



## Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency?

You do – visit the *Tools to improve your billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

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

## Implementing the payment policies related to patient status from the CMS-1599-F

### Provider types affected

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

### What you need to know

Change request (CR) 8959 incorporates changes to the *Medicare Claims Processing Manual* related to the payment policies regarding patient status from final rule CMS-1599-F. This includes payment of Medicare Part B inpatient services, and admission and medical review criteria for payment of hospital inpatient services under Medicare Part A. Make sure that your billing staffs are aware of these changes.

### Background

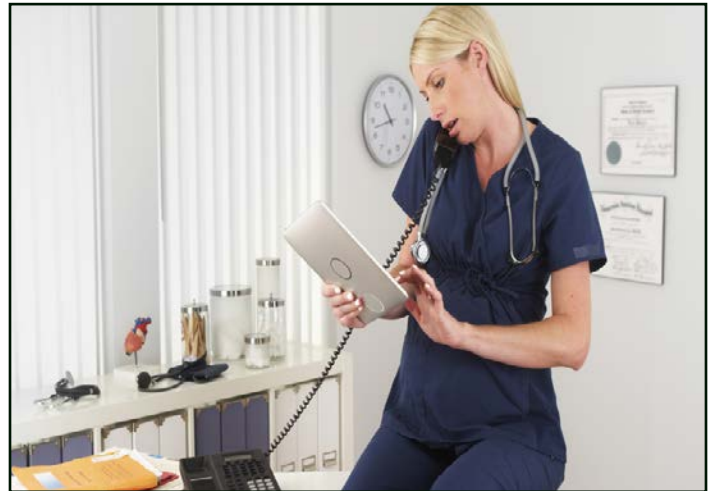
When an inpatient admission is found to be not reasonable and necessary, Medicare will allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, provided the allowed timeframe for submitting claims is not expired. Medicare will not allow payment for services that specifically require an outpatient status, such as outpatient visits, emergency department visits, and observation services that are, by definition, provided to hospital outpatients and not inpatients.

Specific changes to the *Medicare Claims Processing Manual* as a result of CR 8959 involve Chapter 240 of that manual. Specifically, inpatient routine services in a hospital generally are those services included by the provider in a daily service charge—sometimes referred to as the “Room and Board” charge.

They include the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made to Medicare Part A.

Many nursing services provided by the floor nurse (such as IV infusions and injections, blood administration, and nebulizer treatments, etc.) may or may not have a separate charge established depending upon the classification of an item or service as routine or ancillary among providers of the same class in the same state. Some providers established customary charging practice resulting in separate charges for these services following the *Provider Reimbursement Manual* (PRM-1) instructions.

However, in order for a provider’s customary charging practice to be recognized it must consistently follow those instructions for all patients and this must not result in an inequitable apportionment of cost to the program. If the PRM-1 instructions have not been followed, a provider cannot bill these services as separate charges.



Additionally, it is important that the charges for services rendered and documentation meet the definition of the Healthcare Common Procedure Coding System (HCPCS) in order to separately bill.

All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the inpatient prospective payment system (IPPS), hospitals paid under the outpatient prospective payment system (OPPS), long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, critical access hospitals (CAHs), children’s hospitals, cancer hospitals, and Maryland waiver hospitals.

Hospitals paid under the OPPS would continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in *42 Code of Federal Regulations (CFR) 419.20(b)* would be eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies.

Beneficiaries are liable for their usual Part B financial liability. Beneficiaries would be liable for Part B copayments for each hospital Part B inpatient service and for the full cost of drugs that are usually self-administered. If the beneficiary’s liability under Part A for the initial claim submitted for inpatient services is greater than the beneficiary’s liability under Part B for the inpatient services they received, the hospital must refund the beneficiary the difference between the applicable Part A and Part B amounts. Conversely, if the beneficiary’s liability under Part A is less than the beneficiary’s liability under Part B for the inpatient services they received, the beneficiary may face greater cost sharing.

Timely filing restrictions will apply for Part B inpatient services. Claims that are filed beyond one (1) calendar year from the date of service will be rejected as untimely and will not be paid.

See **PATIENT**, next page



# Quarterly update to the end-stage renal disease prospective payment system

## Provider types affected

This *MLN Matters*® article is intended for end-stage renal disease (ESRD) facilities that submit claims to Medicare administration contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

## Provider action needed

This article is based on change request (CR) 8698 which provides the **July 2014 quarterly update** to the ESRD prospective payment system (PPS).

See the *Background* and *Additional information* sections of this article for further details regarding this ESRD PPS update, and make sure that your billing staff are aware of these changes.

## Background

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b); see <http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf>) required the implementation of an ESRD PPS effective January 1, 2011.

The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment, and it includes consolidated billing requirements for limited Part B services included in the ESRD facility's bundled payment.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. The ESRD PPS provides:

- Payment adjustments for comorbid conditions identified by specific diagnostic codes. The diagnostic codes are updated annually and effective each October 1st; and
- Outlier payments, if applicable, for high cost patients due to unusual variations in the type or amount of medically necessary care.

## ESRD-related drugs and biologicals subject to the ESRD PPS consolidated billing requirements

CR 8698 provides instructions for the following new code in the table below which is being added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management treatment effective July 1, 2014:

HCPCS code	Description
Q9970	Injection, Ferric Carboxymaltose, 1mg

Ferric carboxymaltose is used for anemia management which is a category of drugs and biologicals that are always considered to be ESRD-related.

See **ESRD PPS**, next page

## PATIENT

From previous page

Remember that when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for the limited set of Part B inpatient services specified in the *Medicare Benefit Policy Manual*, Chapter 6, Section 10, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf>.

Note: You may view CMS-1599-F at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Regulations.html> on the Centers for Medicare & Medicaid Services (CMS) website.

## Additional information

The official instruction, CR 8959, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3106CP.pdf>.

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

*MLN Matters*® Number: MM8959  
 Related Change Request (CR) #: CR 8959  
 Related CR Release Date: November 6, 2014  
 Effective Date: October 1, 2013  
 Related CR Transmittal #: R3106CP  
 Implementation Date: February 10, 2015

*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.*

## ESRD PPS

From previous page

ESRD facilities will not receive separate payment for Q9970 with or without the AY modifier, and line items with this code will process as covered with no separate payment under the ESRD PPS effective July 1, 2014.

In accordance with 42 CFR 413.237(a)(1), Q9970 Injection, ferric carboxymaltose is considered to be an eligible outlier service, and it will be included in the outlier calculation when CMS provides a fee amount on the average sales price fee schedule.

You can review 42 CFR 413.237(a)(1) at <http://www.ecfr.gov/cgi-bin/text-idx?SID=e88efd0cc8ec3b503b30016e5463d95c&node=42:2.0.1.2.13&rgn=d iv5#42:2.0.1.2.13.8.59.27>.

The updated list of ESRD-related items and services that are subject to the ESRD PPS consolidated billing requirements is available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated\\_Billing.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html).

### Diagnosis coding updates

Effective July 1, 2014, the following International Classification of Diseases (ICD)-10-CM codes were removed from the comorbidity list:

- D89.2 Hypergammaglobulinemia, unspecified; and
- K52.81 Eosinophilic gastritis or gastroenteritis.

These two codes will not be eligible for the comorbidity payment adjustment with the implementation of the ICD-10-CM coding scheme.

### Additional information

The official instruction, CR 8698 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2949CP.pdf>.

For the latest information regarding the implementation of ICD-10, please go to <http://www.cms.gov/Medicare/Coding/ICD10/index.html>.

For more information regarding ESRD co-morbidity conditions, please go to [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Comorbidity\\_Conditions.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Comorbidity_Conditions.html).

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: MM8698  
 Related Change Request (CR) #: CR 8698  
 Related CR Release Date: May 7, 2014  
 Effective Date: July 1, 2014  
 Related CR Transmittal #: R2949CP  
 Implementation Date: July 7, 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.*

## 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.



# Quarterly update to the end-stage renal disease prospective payment system

## Provider types affected

This *MLN Matters*® article is intended for end-stage renal disease (ESRD) facilities submitting claims to Medicare administrative contractors (MACs) for ESRD services provided to Medicare beneficiaries.

## Provider action needed

Change request (CR) 8841 provides the **October 2014 quarterly update** to the end-stage renal disease (ESRD) prospective payment system (PPS) and adds a new Healthcare Common Procedure Coding System (HCPCS) code to the drugs subject to the ESRD consolidated billing list. Make sure your billing staffs are aware of these changes.

## Background

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b); see <http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf>) required the implementation of an ESRD PPS effective January 1, 2011.

The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment, and it includes consolidated billing requirements for limited Part B services included in the ESRD facility's bundled payment.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

### ESRD-related drugs and biologicals subject to the ESRD PPS consolidated billing requirements

CR 8841 provides instructions for the following new code added to the Healthcare Common Procedure Coding System (HCPCS) file effective October 1, 2014:

Added HCPCS code	Long description
Q9972	Injection, Epoetin Beta (For ESRD On Dialysis), 1 microgram

This drug is used for anemia management which is a category of drugs and biologicals that are always considered to be ESRD-related. ESRD facilities would not receive separate payment for Q9972 with or without the AY modifier, and the MACs will process the claims' line item as covered with no separate payment under the ESRD PPS, effective October 1, 2014.

In accordance with 42 CFR 413.237(a)(1) (See <http://www.ecfr.gov/cgi-bin/text-idx?SID=9a236dd4ead112b7a8a24bf752c36b60&node=42:2.0.1.2.13&rgn=d iv5#42:2.0.1.2.13.8.59.27>), Q9972 is considered to be an



eligible outlier service and will be included in the outlier calculation when CMS provides a fee amount on the average sales price (ASP) fee schedule.

The updated list of ESRD-related items and services subject to the ESRD PPS consolidated billing requirements is available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated\\_Billing.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html).

**Note:** There is also a new HCPCS code Q9973 for the same drug for non-ESRD use. This code will not be permitted on the ESRD type of bill 072x.

## Additional information

The official instruction, CR 8841, issued to your MAC regarding this is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2995CP.pdf>.

You can find additional ESRD resources at the ESRD center at <http://www.cms.gov/Center/Special-Topic/End-Stage-Renal-Disease-ESRD-Center.html>.

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: MM8841  
 Related Change Request (CR) #: CR 8841  
 Related CR Release Date: July 25, 2014  
 Effective Date: October 1, 2014  
 Related CR Transmittal #: R2995CP  
 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.*

## Clarification of the end stage renal disease prospective payment system low volume adjustment

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for end-stage renal disease (ESRD) facilities that submit claims to Medicare administrative contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

### What you need to know

Change request (CR) 8898 provides clarification for two criteria required for the validation of the ESRD PPS low volume payment adjustment (LVPA). Specifically, CR 8898 clarifies the criteria required for the validation of the ESRD PPS LVPA related to:

1. The treatment count requirements for hospital-based ESRD facilities using cost report data and other supporting documents, and
2. When a change of ownership for any ESRD facility does not result in a new provider access transaction number (PTAN) but does result in a new cost reporting period.

CR 8898 also revises the *Medicare Benefit Policy Manual*, Chapter 11 (End Stage Renal Disease (ESRD), Section 60 (ESRD PPS Case-Mix Adjustments)) to reflect these clarifications. Make sure that your billing staff are aware of the clarifications and revisions.

### Background

For an ESRD facility to qualify for the LVPA, certain criteria must be attested to by the ESRD facility and validated by its MAC. The qualifying criteria include:

- Furnishing less than 4,000 dialysis treatments in each of the three cost reporting years preceding its payment year;
- The facility must not have opened, closed, or received a new provider number due to change in ownership in the three years preceding the payment year; and
- The facility must not be located within 25 road miles of another ESRD facility under common ownership.

The geographic proximity criterion is only applicable to ESRD facilities that are Medicare certified on or after January 1, 2011, to furnish outpatient maintenance dialysis treatments.

CR 8898 clarifies two criteria required for the validation of the LVPA. The two criteria needing clarification are:

1. The treatment count requirements for hospital-based ESRD facilities using cost report data and other supporting documents, and

2. When a change of ownership for any ESRD facility does not result in a new PTAN but does result in a new cost reporting period.

The first criteria needing clarification relates to hospital-based ESRD facilities meeting the requirement of furnishing less than 4,000 dialysis treatments in each of the three cost reporting years preceding the payment year. In the situation where a hospital has multiple locations of a hospital-based ESRD facility under its governing body, the aggregate cost and treatment data of all of the locations (not just the treatment count of one of the sub-units or satellite entities) are reported on the hospital's cost report.

In the case where a hospital has multiple locations reported on its cost report, the MAC may consider other supporting data in addition to the total treatments reported in each of the 12-consecutive month cost reports, including other supporting documentation which may include individual facility treatment counts, rather than the hospital's cost report alone.

The hospital must provide the documentation to support the total treatment count for all the facilities that make up the total treatment count on the cost report for the MAC to review, even if not all the facilities are applying for the low volume adjustment.

The second criteria needing clarification is related to any ESRD facility that has a change of ownership (CHOW),

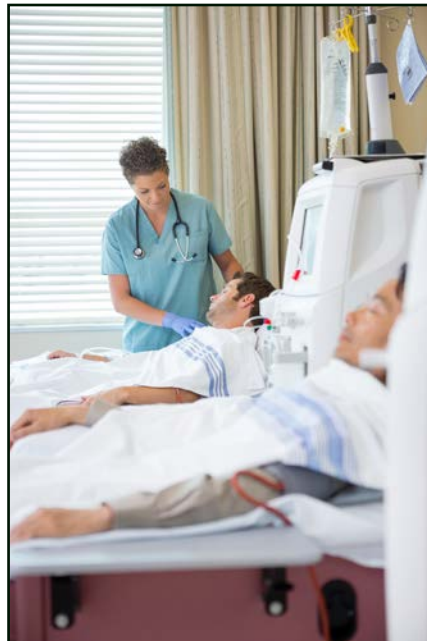
but does not obtain a new provider transaction access number (PTAN). If there is a change in ownership that does not result in a change in provider number but does cause a change in the original fiscal year to that of the new provider, resulting in two non-standard cost reporting periods, then the MAC should either:

- Combine the two non-standard cost reports that equals 12 consecutive months, or
- Where the two non-standard cost reporting periods in combination exceed 12 consecutive months, prorate the data to equal a full 12 consecutive month period.

For example, prior to a CHOW, Facility A had a cost reporting period that spanned January 1 through December 31.

Facility A had a CHOW mid-year that did not result in a new PTAN but caused a break in the cost reporting period. The MAC would add Facility A's cost report that spanned January 1 through May 31 to its cost report that spanned June 1 through December 31 to verify the total treatment count.

See **CLARIFICATION**, next page



## CLARIFICATION

From previous page

The other situation that could occur is when a CHOW results in a change of the original fiscal period. For example, prior to a CHOW, Facility B had a cost reporting period that spanned January 1 through December 31 and, based on its cost reports for 2012 and 2013, it met the LVPA eligibility criteria. Then, Facility B had a CHOW in the beginning of 2014 that did not result in a new PTAN, but changed its cost reporting period to that of its new owner, October 1, 2014, through September 30, 2015.

This scenario would create a short and a long cost report that would not total 12 months that the MAC would need to review for verification. That is, Facility B would have a cost report that spanned January 1, 2014, through July 31, 2014 (seven months) and a cost report that spanned August 1, 2014, through September 30, 2015 (14 months). In this situation, the MAC should combine the two non-standard cost reporting periods that in combination may exceed 12-consecutive months and prorate the data to equal a full 12-consecutive month period.

CMS realizes that these two clarifications may change the outcome for some ESRD facilities requesting the LVPA. As a result, ESRD facilities that wish to attest for the LVPA may submit attestations for each year applicable between 2011 and 2015.

The timeframe for submission of these attestations will be extended until December 31, 2014. MACs will review the attestations and determine applicability for each previous year submitted by the facility. If the MAC validation results in applying the LVPA to a facility (facilities) that has (have) had claims paid without the adjustment, the MAC will adjust all claims during the applicable payment year(s) within six months of approving the attestation. CMS

believes these clarifications will impact less than 1 percent of ESRD facilities that have less than 4,000 treatments in any given year.

In addition, CMS reiterates the long-standing policy that allows for a maximum of 13 treatment payments per 30-day month, 14 treatment payments per 31 day month for all ESRD claims. MACs may consider additional documentation to support the medical justification for payment of additional treatments.

### Additional information

The official instruction, CR 8898, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R197BP.pdf>.

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

MLN Matters® Number: MM8898  
Related Change Request (CR) #: CR 8898  
Related CR Release Date: October 24, 2014  
Effective Date: January 1, 2011  
Related CR Transmittal #: R197BP  
Implementation Date: January 5, 2015

*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.*

## Got a success story using First Coast Web tools?

With its *Tools Center*, First Coast Service Options offers medical providers an abundance of self-service tools to improve their Medicare billing practices.

**Provider profiles** - [Click here](#) to read about how providers are making innovative use of Web tools to grow their bottom line.

**Success story?** - If you have a success story you would like to share with First Coast, let us know by [clicking here](#). Check the "Success Story" button on the form and let us know how First Coast's Tools Center is helping to improve your practice.



# Elimination of the 50/50 payment rule for laboratory services on end stage renal disease claims

## Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for laboratories and end stage renal disease (ESRD) facilities that submit claims to Medicare administrative contractors (MACs) for ESRD-related tests provided to Medicare beneficiaries.

## Provider action needed

With the implementation of the ESRD prospective payment system (PPS), ESRD laboratory services are no longer paid in accordance with the 50/50 rule. Change request (CR) 8957 instructs that for ESRD claims with dates of service on or after April 1, 2015, ESRD facilities will no longer be required to submit the 50/50 rule modifiers CD, CE, and CF. The ESRD PPS requires that renal dialysis laboratory services be paid in the ESRD facility bundled payment and therefore may only be billed by the ESRD facility.

## Background

The Medicare end-stage renal disease (ESRD) benefit previously provided payment for dialysis and some dialysis related services under a per treatment composite rate. Separate payment for automated multi-channel chemistry (AMCC) laboratory tests was determined according to the 50/50 rule where separate payment for the laboratory services was subject to whether 50 percent or more of the tests performed were in excess of the composite rate. ESRD facilities were required to report the following modifiers:

- CD to indicate if the laboratory test was included in the composite rate;
- CE to indicate the laboratory tests exceeded the frequency of the composite rate; or
- CF to indicate the laboratory test was not included in the composite rate.

In addition, ESRD facilities were required to itemize on the claim the individual laboratory *Current Procedural Terminology*<sup>®</sup> (CPT<sup>®</sup>) codes rather than reporting disease panel codes.

CR 8957 instructs that ESRD laboratory services are no longer paid in accordance with the 50/50 rule. The ESRD PPS requires that all renal dialysis laboratory services be paid in the ESRD facility bundled payment and therefore may only be billed by the ESRD facility.

For ESRD claims with dates of service on or after April 1, 2015, ESRD facilities will no longer be required to submit the 50/50 rule modifiers CD, CE, and CF. In addition, ESRD facilities should report organ or disease-oriented panel codes on type of bill 072x for codes listed in the following table when performed for an ESRD beneficiary if:

- These codes best describe the laboratory services provided to the beneficiary, which are paid under the ESRD PPS; or



- The test is not related to the treatment of ESRD, in which case the ESRD facility would append modifier “AY” and the service may be paid separately from the ESRD PPS.

HCPCS/CPT <sup>®</sup>	Code description
80047	METABOLIC PANEL IONIZED CA
80048	METABOLIC PANEL TOTAL CA
80051	ELECTROLYTE PANEL
80053	COMPREHEN METABOLIC PANEL
80061	LIPID PANEL
80069	RENAL FUNCTION PANEL
80076	HEPATIC FUNCTION PANEL

## Additional information

The official instruction, CR 8957 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3116CP.pdf>.

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

*MLN Matters*<sup>®</sup> Number: MM8957  
 Related Change Request (CR) #: CR 8957  
 Related CR Release Date: November 6, 2014  
 Effective Date: April 1, 2015  
 Related CR Transmittal #: R3116CP  
 Implementation Date: April 6, 2015

*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.*

# Implementation of changes in the end-stage renal disease prospective payment system for 2015

## Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for end stage renal disease (ESRD) facilities submitting claims to Medicare administration contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

## Provider action needed

This article is based on change request (CR) 8978 which implements the 2015 rate updates for the ESRD prospective payment system (PPS). Make sure that your billing staffs are aware of these changes for 2015.

## Background

In accordance with the Medicare Improvements for Patients and Providers Act (MIPPA; section 153(b)), the Centers for Medicare & Medicaid Services (CMS) implemented the end stage renal disease (ESRD) prospective payment system (PPS) effective January 1, 2011. You may review MIPPA (section 153(b)) at <http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf>.

The Affordable Care Act (section 3401(h) amended MIPPA (section 153(b)); see <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>), and states that for 2012 and each subsequent year, CMS will reduce the ESRD bundled (ESRDB) market basket increase factor by a productivity adjustment described in the Social Security Act (section 1886(b) (3)(B)(xi)(II)); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1886.htm](http://www.ssa.gov/OP_Home/ssact/title18/1886.htm)). The ESRDB market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate.

For 2015, CMS rebased and revised the ESRDB market basket so that the cost weights and price proxies reflect the mix of goods and services that underlie ESRD bundled operating and capital costs for 2012.

A payment provision for 2015 that is affected by the rebase and revision is an increase in the labor-related share, which is used when adjusting payments for geographic locality. CMS is implementing a two-year transition under which a 50/50 blended labor-related share will apply to all ESRD facilities.

In addition, the Protecting Access to Medicare Act of 2014 (PAMA; section 217; see <http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf>) includes several provisions that apply to the ESRD PPS.

The most significant provisions for 2015 are the elimination of the drug utilization adjustment transition, a 0.0 percent update to the ESRD PPS base rate, and a delay in the inclusion of oral-only drugs used for the treatment of ESRD into the bundled payment until January 1, 2024.

The 2015 ESRD PPS final rule adopts the most recent core-based statistical area (CBSA) delineations as described in the February 28, 2013, Office of Management and Budget (OMB) Bulletin No. 13-01.

In addition, CMS is implementing a two-year transition under which a 50/50 blended wage index will apply to all ESRD facilities. As a result, several counties now have new CBSA numbers.

In addition, for 2015 only, there are several special wage index values that need to be sent to the ESRD PPS pricer in order to apply correct payments to certain ESRD facilities. ESRD facilities can confirm their 2015 CBSA delineation status and wage index value at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment>.

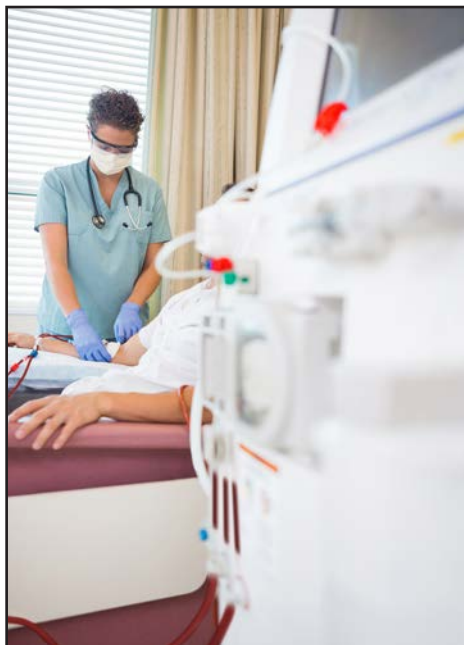
The consolidated billing requirements for drugs and biologicals included in the ESRD PPS will be updated to include Health Care Procedure Coding System (HCPCS) code J3480 (Injection, potassium chloride, per two meq). It is a composite rate drug and therefore, is not eligible for outlier consideration.

Regarding the calculation for outlier payments, there is a correction to the mean unit cost associated with the oral equivalent drug, Hectorol (doxercalciferol) 0.5 mcg capsule and one mcg capsule, applicable to claims with dates of service in 2014.

Facilities that believe the mean unit cost corrections may impact their outlier payments for claims in 2014, should submit adjustments to their claims within six months from the effective date of CR 8978. MACs will be instructed to override timely filing if necessary.

Finally, in an effort to enhance the ESRD claims data for possible future refinements to the ESRD PPS, CMS is requiring ESRD facilities to begin reporting composite rate drugs and biologicals on the claim.

Specifically, ESRD facilities should only report the composite rate drugs identified on the consolidated billing drug list provided in Attachment B of CR 8978. The ESRD PPS payment policy remains the same for composite rate drugs, therefore, no separate payment is made and these drugs will not be included in the outlier policy.



See **PROSPECTIVE**, next page

## PROSPECTIVE

From previous page

### 2015 ESRD PPS updates:

#### ESRD PPS base rate:

A zero percent update to the payment rate results in a 2015 ESRD PPS base rate of \$239.02 in accordance with section 217(b)(2) of PAMA. With a wage index budget neutrality adjustment factor of 1.001729, the 2015 ESRD PPS base rate is \$239.43 ( $\$239.02 \times 1.001729 = \$239.43$ ).

#### Wage index:

The wage index adjustment will be updated to reflect the latest available wage data. New CBSA delineations are being implemented with a 50/50 blend of wage indices and the wage index floor will be reduced from 0.45 to 0.40.

#### Labor-related share:

The revised labor-related share is 50.673 percent, an increase from 41.737 percent. CMS will implement the revised labor-related share with a 50/50 blend under a 2-year transition which results in a labor-related share value of 46.205 percent for 2015.

#### Outlier policy:

CMS will make the following updates to the adjusted average outlier service Medicare allowable payment (MAP) amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is \$51.29.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is \$43.57.

CMS will make the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:

1. The fixed dollar loss amount is \$86.19 for adult patients.
2. The fixed dollar loss amount is \$54.35 for pediatric patients.

CMS will make the following changes to the list of outlier services:

1. Renal dialysis drugs, that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the *Medicare Prescription Drug Plan Finder*, will be updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. See Attachment A of CR 8978 which provides a list of *2015 Oral and Other Equivalent Forms of Injectable Drugs*.
2. The mean dispensing fee of the national drug codes

(NDC) qualifying for outlier consideration is revised to \$1.15 per NDC per month for claims with dates of service on or after January 1, 2015. See Attachment A of CR 8978.

#### Claims reporting:

ESRD facilities shall begin reporting the composite rate drugs itemized on the consolidated billing list (see Attachment B of CR 8978) when provided, on ESRD claims with dates of service on or after January 1, 2015.

CR 8978 also revises the *Medicare Benefit Policy Manual* (Chapter 11 (End Stage Renal Disease (ESRD), sections 10, 20, 30, 40, 50, and 60) and the *Medicare Claims Processing Manual* (Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), section 50.3 (Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS). These manual revisions are included as attachments to CR 8978.

As part of the manual changes, ESRD facilities are required, effective January 1, 2015, to report on the claim the composite rate drugs identified on the consolidated billing list provided at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDPayment/Consolidated\\_Billing.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDPayment/Consolidated_Billing.html). No other composite rate drugs, items, or services are to be reported on the claim.

#### Additional information

The official instruction, CR 8978, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R199BP.pdf>.

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

MLN Matters® Number: MM8978

Related Change Request (CR) #: CR 8978

Related CR Release Date: November 14, 2014

Effective Date: January 1, 2015

Related CR Transmittal #: R199BP

Implementation Date: January 5, 2015

*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.*



Educational Events

Provider educational events – December 2014

File forms faster on the 'SPOT'

When: Tuesday, December 16
Time: 11:00 a.m. - 12:00 p.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/276321.asp

Medicare provider enrollment process

When: Wednesday, December 17
Time: 11:30 a.m. - 1:00 p.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/274624.asp

Modifier 59 subsets: "Ask-the-contractor" teleconference

When: Thursday, December 18
Time: 11:30 a.m. - 1:00 p.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/274441.asp

Two easy ways to register

- 1. Online – Visit www.fcsoniversity.com, logon to your account and select the course you wish to register.
2. Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 904-791-8103.

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.fcsoniversity.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 articles link to recent *MLN Connects™* e-News:

## MLN Connects™ Provider eNews for October 23, 2014

*MLN Connects™ Provider eNews for October 23, 2014*  
[View this edition as a PDF](#)

### In this edition:

#### MLN Connects™ National Provider Calls

- CMS 2014 Certified EHR Technology Flexibility Rule – Last Chance to Register
- Transitioning to ICD-10 – Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

#### CMS Events

- Webinar for Comparative Billing Report on Podiatry: Debridement of Ulcers and Wounds

#### Announcements

- Protect Your Patients Against Influenza and Pneumonia
- Updated CDC Resource Available on Ebola
- New Affordable Care Act Initiative to Support Care Coordination Nationwide
- Extension of Shared Savings Program Fraud and Abuse Waivers Interim Final Rule
- IRF Quality Reporting Program: NHSN Quality Data Submission Deadline Extended to November 15
- LTCH Quality Reporting Program: NHSN Quality Data Submission Deadline Extended to November 15

- Open Payments Search Tool Now Available
- Open Payments: Start Preparing for the 2014 Reporting Year
- Comparative Billing Report on Podiatry: Debridement of Ulcers and Wounds
- EHR Incentive Programs: Protect Electronic Health Information Core Objective?

#### Claims, Pricers, and Codes

- FQHC PPS Issue with Claims Containing Both Preventive and Non-Preventive Services
- Hold on FQHC Medicare Advantage PPS Claims – Update
- Use of HCPCS X Modifiers for Distinct Procedural Services
- Mass Adjustment of Selected SNF Inpatient Claims
- October 2014 Outpatient Prospective Payment System Pricer File Update

#### Medicare Learning Network® Educational Products

- “Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 1]” Educational Tool – Released
- Medicare Learning Network® Web-Based Training Programs
- Updated MLN Matters® Search Indices

## MLN Connects™ Provider eNews for October 30, 2014

*MLN Connects™ Provider eNews for October 30, 2014*  
[View this edition as a PDF](#)

### In this edition:

#### MLN Connects™ National Provider Calls

- Transitioning to ICD-10 – Register Now

#### Announcements

- HHS Secretary Announces \$840 Million Initiative to Improve Patient Care and Lower Costs
- Hospital Appeals Settlement: Act by October 31
- Get Ready for DMEPOS Competitive Bidding
- SNF PPS Payment Reform Research Project
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Third Quarter Hospice Item Set Question and Answer Document Available
- EHR Incentive Program: Hardship Exception Applications Due November 30
- PQRS: Submission Engine Validation Tool is Now Available for Testing

## MLN Connects™ Provider eNews for November 6, 2014

*MLN Connects™ Provider eNews for November 6, 2014*  
[View this edition as a PDF](#)

### In this edition:

#### MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Registration Opening Soon
- National Partnership to Improve Dementia Care in Nursing Homes – Registration Now Open
- Certifying Patients for the Medicare Home Health Benefit – Registration Opening Soon

#### MLN Connects™ Videos

- Monthly Spotlight: Medicare Preventive Services

#### Announcements

- CY 2015 Policy and Payment Changes to the Medicare Physician Fee Schedule
- CY 2015 Policy and Payment Changes for ESRD Facilities and Implementation of Competitive Bidding-Based Prices for DMEPOS
- CY 2015 Payment and Policy Changes for Hospital Outpatient and Ambulatory Surgical Centers
- CY 2015 Payment Changes for Medicare Home Health Agencies

#### Claims, Pricers, and Codes

- Physicians, Providers, and Suppliers Must Use Revised CMS 855R Starting May 31
- Demand Letters for Polysomnography Claims

#### Medicare Learning Network® Educational Products

- “ICD-10-CM/PCS Billing and Payment Frequently Asked Questions” – Revised
- “ICD-10-CM/PCS The Next Generation of Coding” – Revised
- “ICD-10-CM/PCS Myths and Facts” -- Revised
- “ICD-10-CM Classification Enhancements” – Revised
- “General Equivalence Mappings Frequently Asked Questions” – Revised
- Medicare Learning Network® Web-Based Training Course with Continuing Education Credits
- Medicare Learning Network® Products Available in Electronic Publication Format

- Raising Awareness of Diabetes in November
- Final Rule Changes for Open Payments
- Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the Affordable Care Act
- CMS is Accepting Suggestions for Potential PQRS Measures
- Comparative Billing Report on Modifier 25: Family Practice

#### Claims, Pricers, and Codes

- Physicians, Providers, and Suppliers Must Use Revised CMS 855R Starting May 31
- Demand Letters for Polysomnography Claims

#### Medicare Learning Network® Educational Products

- “Medicare Appeals Process” Podcast – New
- “Skilled Nursing Facility Prospective Payment System” Fact Sheet – Revised
- “Inpatient Rehabilitation Facility Prospective Payment System” Fact Sheet – Revised
- Medicare Learning Network® Products Available in Electronic Publication Format

## MLN Connects™ Provider eNews for November 13, 2014

*MLN Connects™ Provider eNews for November 13, 2014*  
View this edition as a PDF

### In this edition:

#### MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Registration Now Open
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Certifying Patients for the Medicare Home Health Benefit – Registration Now Open
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

#### CMS Events

- Participate in ICD-10 Acknowledgement Testing Week: November 17 through 21, 2014

#### Announcements

- Recognizing Lung Cancer Awareness Month and the Great American Smokeout
- Dialysis Facility Compare Star Ratings and Data Release for January 2015
- Coverage of Speech Generating Devices
- Clinical Laboratory Improvement Amendments Proposed Rule
- PQRS Negative Payment Adjustment
- FY 2016 IRF Quality Reporting Program Submission Deadline: November 15
- FY 2016 LTCH Quality Reporting Program Submission Deadline: November 15

- OASIS Updates for Home Health Agencies
- Get Ready for DMEPOS Competitive Bidding
- EHR Incentive Program: Deadlines for 2014 Hospital Reporting on November 30
- Changes to Medicare EHR Incentive Program Hardship Exceptions
- ICD-10 Resources for Small Physician Practices on Medscape

#### Claims, Pricers, and Codes

- ICD-10 MS-DRG v32 Definitions Manual and Medicare Code Editor Files Available
- 2015 HCPCS Annual Update
- Acute Inpatient PPS FY 2015.2 Software Release Available
- FDG PET for Solid Tumors: Claims Hold Extension

#### Medicare Learning Network® Educational Products

- “Safeguarding Your Medical Identity” Web-Based Training Course – Revised
- “Medicare Enrollment and Claim Submission Guidelines” Booklet – Revised
- “Medicaid Program Integrity: Understanding and Preventing Provider Medical Identity Theft” Booklet – Revised
- “Medicaid Program Integrity: Preventing Provider Medical Identity Theft” Fact Sheet -- Revised
- “Medicaid Program Integrity: Safeguarding Your Medical Identity Using Continuing Medical Education (CME)” Educational Tool -- Revised
- Medicare Learning Network® Products Available in Electronic Publication Format

FIRST COAST UNIVERSITY

#### 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*



## First Coast Service Options Phone Numbers

*(Note: Specific geographic contact information is noted when phone numbers and addresses are different for providers in Florida, U.S. Virgin Islands or Puerto Rico.)*

### Customer service

Monday to Friday  
8:00 a.m. to 4:00 p.m

**888-664-4112** (FL/USVI)  
**877-908-8433** (Puerto Rico)  
**877-660-1759** (TDD-FL/USVI)  
**888-216-8261** (TDD-Puerto Rico)

### Electronic data interchange

**888-670-0940** (FL/USVI)  
**888-875-9779** (Puerto Rico)

### Interactive Voice Response

**877-602-8816**

### Provider education/outreach

**Event registration hotline**  
904-791-8103

### Overpayments

904-791-6281

### SPOT Help Desk

FCSOSPOTHelp@fcso.com  
855-416-4199

### Websites

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

## First Coast Service Options Addresses

### Claims/correspondence Florida/ U.S. Virgin Islands

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

### Puerto Rico

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

### Medicare EDI 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

### FOIA requests

#### Provider audit/reimbursement

(relative to cost reports and audits)  
Attn: FOIA PARD – 16T  
P. O. Box 45268  
Jacksonville, FL 32232-5268

#### General Inquiries

[Online Form \(Click here\)](#)

**Email:** AskFloridaA@fcso.com

#### Local coverage determinations

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

#### Medicare secondary payer (MSP)

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

#### Hospital audits

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

#### MSPRC DPP debt recovery, auto accident settlements/lawsuits, liabilities

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

#### Overpayment collections and debt recovery

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

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

#### Credit balance reports

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

#### 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

#### Redetermination (cont'd)

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

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

##### Puerto Rico

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

#### Special delivery/courier services

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

#### Other Medicare carriers and intermediaries

##### DME regional carrier (DMERC)

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

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

##### Railroad Medicare

Palmetto GBA  
P. O. Box 10066  
Augusta, GA 30999-0001

##### Regional home health/hospice intermediary

Palmetto GBA  
Medicare Part A  
34650 US HWY 19N  
Palm Harbor, FL 34684

## Contact CMS

### Centers for Medicare & Medicaid Services (CMS) ([www.cms.gov](http://www.cms.gov))

Centers for Medicare & Medicaid Services,  
Division of Financial Management and Fee  
for Service Operations

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

##### Office of Inspector General (OIG)

Medicare fraud hotline  
800-HHS-TIPS (800-447-8477)

##### Medicare beneficiary customer service

1-800-MEDICARE  
1-800-633-4227

##### Hearing and speech impaired (TDD)

1-800-754-7820