Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

March 2015

In this issue

CMS conducts successful ICD-10 end-to-end testing week

From January 26 through February 3, 2015, Medicare fee-for-service (FFS) health care providers, clearinghouses, and billing agencies participated in the first successful ICD-10 end-to-end testing week with all Medicare administrative contractors (MACs) and the durable medical equipment (DME) MAC common electronic data interchange (CEDI) contractor.

CMS was able to accommodate all volunteers, which represented a broad cross-section of provider, claim, and submitter types.

Approximately 660 providers and billing companies submitted nearly 15,000 test claims. This successful week of testing continues to put us on course for successful implementation of this important initiative that better reflects modern practice of medicine by October 1, 2015.

Testing demonstrated that CMS systems are ready to accept ICD-10 claims. *View the results*.

Overall, participants in the January 26 to February 3 testing were able to successfully submit ICD-10 claims and have them processed through our billing systems. To the extent that some claims were rejected, most didn't meet the mark because of errors unrelated to ICD-9 or ICD-10.

Testing allows us to identify areas of improvement, and we will work with outside entities and stakeholders to improve those very small deficiencies identified. And, we will continue to do testing, especially in those areas we identify as needing improvement.

In addition to acknowledgement testing, which may be completed at any time, two more end-to-end testing weeks will be held before the October 1, 2015, compliance date for ICD-10:

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

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

General Information

Updates to the 'Medicare Internet-Only Manual' for skilled nursing facility providers

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries who are in a skilled nursing facility (SNF).

Provider action needed

Change request (CR) 8997 updates sections of the *Medicare Benefit Policy Manual* and the *Medicare Claims Processing Manual* in regards to SNF policy and billing. If you provide services to Medicare beneficiaries in a SNF stay, information in CR 8997 could impact your payments.

Background

CR 8997 updates two chapters of the *Medicare Claims Processing Manual* and one chapter of the *Medicare Benefit Policy Manual*. The following summarizes these manual updates:

'Medicare Benefit Policy Manual,' Chapter 8:

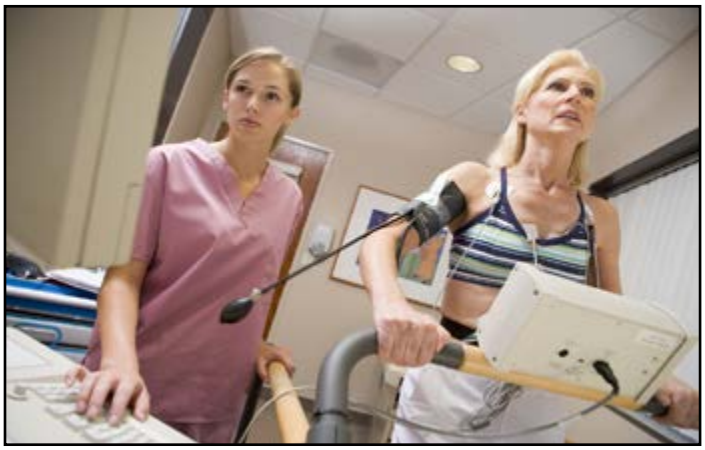
Section 20.2.3 (Readmission to SNF):

- If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days of the last covered skilled day, the 30-day transfer requirement is considered to be met; and
- The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the resumption of SNF coverage.

'Medicare Claims Processing Manual,' Chapter 6:

Section 20.1.1.2 - Hospital's "Facility Charge" in Connection with Clinic Services of a Physician

- When a beneficiary receives clinic services from a hospital-based physician, the physician in this situation would bill his or her own professional services directly to the Part B MAC and would be reimbursed at the facility rate of the Medicare physician fee schedule--which does not include overhead expenses.
- The hospital historically has submitted a separate



Part B "facility charge" for the associated overhead expenses to its Part A MAC. The hospital's facility charge does not involve a separate service (such as a diagnostic test) furnished in addition to the physician's professional service; rather, it represents solely the overhead expenses associated with furnishing the professional service itself.

- Accordingly, hospitals bill for "facility charges" under the physician evaluation and management (E&M) codes in the range of *99201-99245* and G0463 (for hospitals paid under the outpatient prospective payment system).
- E&M codes, representing the hospital's "facility charge" for the overhead expenses associated with furnishing the professional service itself, are excluded from SNF consolidated billing (CB). Effective for claims with dates of service on or after January 1, 2006, Medicare's common working file will bypass CB edits when billed with revenue code 0510 (clinic visit) with an E&M HCPCS code in the range of *99201-99245* and, effective January 1, 2014 with HCPCS code G0463.

Section 30.1 - Health Insurance Prospective Payment System (HIPPS) Rate Code:

- The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the "grouper" software program followed by a two digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the grouper. Providers may access the resident assessment instrument (RAI) manual located at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html*.

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue

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codes will continue to be shown, for example, 0250 - pharmacy, 042x – physical therapy, in conjunction with the appropriate entries in service units and total charges.

Section 30.2: Coding PPS bills for ancillary services

- SNFs are required to report the number of units based on the procedure or service.
- For therapy services, that is revenue codes 042x, 043x, and 044x, units represent the number of calendar days of therapy provided. For example, if the beneficiary received physical therapy, occupational therapy or speech-language pathology on May 1, that would be considered one calendar day and would be billed as one unit.
- SNFs are required to report the actual charge for each line item, in total charges.

Section 30.3: Adjustment requests

Adjustment requests based on corrected assessments must be submitted within 120 days of the service "through" date. The "through" date will be used to calculate the period during which adjustment requests may be submitted based on corrected RAI assessments.

The "through" date indicates the last day of the billing period for which the HIPPS code is billed. Adjustment requests based on corrected assessments must be submitted within 120 days of the "through" date on the bill. For HIPPS changes resulting from an MDS correction, providers must append a condition code D2 on their adjustment claim. An edit is in place to limit the time for submitting this type of adjustment request to 120 days from the service "through" date.

CMS expects that most HIPPS code corrections will be made during the course of the beneficiary's Medicare Part A stay. Therefore, providers that routinely submit corrections after the beneficiary's Part A stay has ended may be subject to focused medical review.

Adjustment requests to change a HIPPS code may not be submitted for any claim that has already been medically reviewed. This applies whether or not the medical review was performed either pre- or post-payment. All adjustment requests submitted are subject to medical review. Information regarding medical review is located in the *Medicare Program Integrity Manual*.

Section 40.3.5.2: Leave of absence:

- Leave of absence (LOA) days are shown on the bill with revenue code 018x and LOA days as units. However, charges for LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them except as specified in Chapter 1 of this manual at Section 30.1.1.1. Occurrence span code 74 is used to report the LOA from and through dates.
- Providers should review the RAI manual to clarify situations where an LOA is not appropriate, for example observation stays in a hospital lasting greater than 24 hours.

'**Medicare Claims Processing Manual**,' **Chapter 13:**

Section 90.5 (Transportation of Equipment Billed by a SNF to a MAC):

- When a SNF resident receives a portable x-ray service during the course of a Medicare-covered stay in the SNF, only the service's professional component (representing the physician's interpretation of the test results) is a separately billable physician service under Part B (see Section 20 of Chapter 6).
- By contrast, the technical component representing the procedure itself, including any associated transportation and setup costs, would be subject to consolidated billing (CB) (the SNF "bundling" requirement for services furnished to the SNF's Part A residents), and must be included on the SNF's Part A bill for the resident's covered stay (bill type 21x) rather than being billed separately under Part B.

Additional information

The official instruction for CR 8997 was issued to your MAC via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3216CP.pdf.* The second updates the *Medicare Benefit Policy Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R204BP.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: MM8997
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Related CR Release Date: March 13, 2015
Effective Date: June 15, 2015
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Implementation Date: June 15, 2015

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Incorporation of certain provider enrollment policies into 'Medicare Program Integrity Manual'

Provider types affected

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

Provider action needed

Change request (CR) 9065, on which this article is based, incorporates provisions in final rule CMS-6045-F into the *Medicare Program Integrity Manual* or PIM. CR 9065 also addresses several minor provider enrollment policy issues that have arisen recently. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) final rule (CMS-6045-F titled "Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment") was published in the *Federal Register*, Vol. 79 , No. 234 on December 5, 2014. See *http://www.gpo.gov/fdsys/pkg/FR-2014-12-05/html/2014-28505.htm*.

As mentioned, CR 9065 incorporates provisions in CMS-6045-F into the PIM in Chapter 15 (Medicare Enrollment), which is included as an attachment to CR 9065. One such change outlined in CR 9065 is that if a supplier submits a corrective action plan (CAP) for a revocation based in part on 42 CFR § 424.535(a)(1), the MAC shall (A) only consider the portion of the CAP pertaining to (a)(1); and (B) notify the supplier in its decision letter (or, if the MAC wishes, via letter or e-mail prior to issuing the decision letter) that under 42 CFR § 405.809, the CAP was/will be reviewed only with respect to the (a)(1) revocation reason. See the full manual revision attached to CR 9065 for details on other updates.

Additional information

The official instruction, CR 9065, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R582PI.pdf.*

If you have questions please contact your MAC at their toll-free number. The 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: MM9065
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Related CR Release Date: March 4, 2015
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Implementation Date: May 28, 2015

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SUCCESSFUL

From front page

- April 27 through May 1: Volunteers have been selected
- July 20 through July 24: Volunteer forms will be available March 13 on the MAC and CEDI websites
- Testers who participated in the January testing are automatically eligible to test again in April and July.

For more information

- *MLN Matters® article #MM8867*, "ICD-10 Limited End-to-End Testing with Submitters for 2015
- *MLN Matters® special edition article #SE1435*, "FAQs – ICD-10 End-to-End Testing"
- *MLN Matters® special edition article #SE1409*, "Medicare FFS ICD-10 Testing Approach"

Incorporation of revalidation policies into the 'Program Integrity Manual'

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 9011 to incorporate various existing Medicare enrollment revalidation policies into Chapter 15 of the *Program Integrity Manual* (PIM).

Background

CR 9011 incorporates various existing revalidation policies into the PIM. As these policies were previously established via business requirements, those business requirements are not being repeated in this article. The new polices announced in CR 9011 are as follows:

- When processing a voluntary termination of a reassignment, the MAC will contact the group to confirm that the group member's provider transaction access number (PTAN) is being terminated from all locations and, if multiple group member PTANs exist for multiple group locations, each PTAN is terminated.
- Many enrolled providers may actually be subparts of other enrolled providers, and some of those subparts entered their "doing business as name" as their LBN when applying for their NPIs. Once a contractor determines for certain that this situation exists, the contractor shall ask the provider to correct its NPPES information. The provider can (1) change its LBN in NPPES to read in accordance with the IRS CP-575, and (2) report its "doing business as" name in NPPES as an "other name" and indicate the type of other name as a "doing business as" name.

Additional information

The official instruction for CR 9011 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R578PI.pdf*.

If you have questions please contact your MAC at their toll-free number, which 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: MM9011
Revised Related Change Request (CR) #: CR 9011
Related CR Release Date: February 25, 2015
Effective Date: May 15, 2015
Related CR Transmittal #: R578PI
Implementation Date: May 15, 2015

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Requesting duplicate remittance advice

First Coast sometimes receives requests for duplicate Medicare remittance notices (MRNs), also known as Medicare summary notices (MSNs).

Trading partners who are directly submitting through the EDI Gateway using their own submitter number and receive electronic remittance advices (ERAs) may use the *Remittance reload request for X12 v5010*.

Providers who are sending/receiving files through a clearinghouse should contact the clearinghouse for any reload requests. Providers may also download free software to retrieve ERAs.

How do I get the free software?

- For Part A providers, download *PC-Print Software*.
- For Part B providers, download *MREP software*.

What if I receive paper remittance notices?

Medicare contractors do not routinely provide duplicate paper remits (standard paper remittance or SPR). Providers who receive SPR may contact customer service for duplicates if the originals were never received or were lost due to natural disaster.

(**Note**: Customer service can only send the duplicates to the address printed on the SPR. In addition, Part A requests must be made within 30 days of the remit date; otherwise, there is a $25 fee for duplicates.)

Please be sure to submit the request along with the $25 fee to the following address:

First Coast Service Options
Attn: Finance Control
P.O. Box 406443
Atlanta, GA 30384-6443

We recommend using ERA. *Click here* for answers to concerns you may have regarding ERA, or *click here* to view ERA FAQs.

Healthcare provider taxonomy code set update

Provider types affected

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

Provider action needed

Change request (CR) 8993 instructs MACs to obtain the most recent healthcare provider taxonomy code (HPTC) set and use it to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (x12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use;
2. Terminated codes are not approved for use after a specific date;
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears; and
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR 8993 implements the NUCC HPTC code set that is effective on April 1, 2015, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at *http://www.wpc-edi.com/codes*.

When reviewing the health care provider taxonomy code set online, you can identify revisions made since the last release by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

Additional information

The official instruction, CR 8993, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3201CP.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: MM8993
Related Change Request (CR) #: CR 8993
Related CR Release Date: February 20, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R3201CP
Implementation Date: As soon as April 1, 2015, but no later than July 6, 2015

Guidance on the PQRS for rural health clinics, federally qualified health centers, and critical access hospitals

Provider types affected

This article is intended for rural health clinics (RHCs), federally qualified health centers (FQHCs), and critical access hospitals (CAHs) who submit claims to Medicare administrative contractors (MACs) for services furnished to Medicare beneficiaries.

What you need to know

In this informational article the Centers for Medicare & Medicaid Services (CMS) provides answers to some frequently asked questions raised by staff at RHCs, FQHCs, and CAHs.

Frequently asked questions - RHCs & FQHCs

Question: If I furnish professional Medicare Part B services only at an RHC or an FQHC, are the services eligible for PQRS?

Answer: No, if you furnish Medicare Part B professional services **only** at an RHC or an FQHC, such services are not eligible for either the PQRS incentive payment or for the PQRS negative payment adjustment.

Question: I'm an eligible professional (EP) and I furnish professional Medicare Part B services at an RHC/FQHC and also furnish services at a non-RHC/FQHC setting. Are the non-RHC/FQHC services eligible for the 2015 PQRS incentive payment or for the PQRS negative payment adjustment?

Answer: Yes, for an EP who furnishes professional Medicare Part B services at an RHC/FQHC and also furnishes services at a non-RHC/FQHC setting, the non-RHC/FQHC services may be eligible for the PQRS incentive payment or the negative payment adjustment. The PQRS program applies a negative payment adjustment to practices with EPs, identified on claims by their individual national provider identifier (NPI) and tax identification number (TIN), or group practices participating via the group practice reporting option (GPRO) (referred to as PQRS group practices) who do **not** satisfactorily report data on quality measures for covered Medicare physician fee schedule services furnished to Medicare Part B fee-for-service beneficiaries. A negative payment adjustment may be triggered in future year(s) if an EP furnishes services, but does not report them.

Question: Under what circumstances are professional Medicare Part B services furnished by an EP at a setting outside an RHC/FQHC subject to the 2015 PQRS 1.5 percent negative payment adjustment if he or she has not satisfactorily reported 2013 PQRS quality measures?

Answer: There are two circumstances under which professional Medicare Part B services furnished by an EP at a setting outside an RHC/FQHC may be subject to the 2015 PQRS negative payment adjustment if he or she has not satisfactorily reported 2013 PQRS quality measures:

1. The non-RHC/FQHC services furnished by the EP are billed under his or her own TIN/NPI combination as reported via Provider Enrollment, Chain, and Ownership System (PECOS). The 2015 PQRS payment adjustment applies to the EP as an individual, **not** to the clinic or the facility; and
2. The non-RHC/FQHC services an EP furnished are billed under a group practice's TIN, which may be registered to participate in the 2013 PQRS under the GPRO registration or self- nomination. The 2015 PQRS payment adjustment applies to the EP under the group practice's TIN, which applies to the entire group practice.

For more information about how the 2015 PQRS 1.5 percent negative payment adjustment applies to RHC/FQHC providers, refer to "Listserv 2015 PQRS Payment Adjustment and Providers who Rendered Services at RHCs/FQHCs," located at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/CMS_listserv_2015_PQRS_PA_RHC_FQHC_final.pdf* and "FAQ on 2015 PQRS Payment Adjustment and Providers who Render Services at RHCs/FQHCs," located at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/CMS_FAQ_2015_PQRS_PA_RHC_FQHC_final.pdf*.

To find timeline information, refer to "2015 – 2017 Physician Quality Reporting System (PQRS) Timeline" located at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015-17_CMS_PQRS_Timeline.pdf*.

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FAQs

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To find general PQRS information, including information about payment adjustments, visit *http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html*.

For additional questions, contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via *qnetsupport@hcqis.org*. The Help Desk is available from 7:00 a.m. to 7:00 p.m. central time Monday through Friday.

Frequently asked questions - CAHs

Question: I'm an EP who furnishes professional Medicare Part B services at a CAH and the CAH is paid under the Optional Payment Method (Method II). Are my services eligible for PQRS?

Answer: Not in 2013. An EP who furnishes Medicare Part B services at a CAH and the CAH is paid under Method II is not eligible for the 2013 PQRS incentive payment or for the 2015 PQRS negative payment adjustment if he or she has not satisfactorily reported 2013 PQRS quality measures. Please note that this applies only to Tax ID and the rendering NPI used for Medicare billings on UB-04 claims.

An EP who furnishes Medicare Part B services at a CAH and the CAH is paid under Method II may be eligible for PQRS beginning in 2014 for the 2014 PQRS incentive payment and will be subject to the 2016 PQRS negative adjustment payment if he or she does not report by the deadline specified for each reporting method.

Any physician-reported NPI, at either the claim level or the line level of a UB-04 claim, is considered eligible to participate in PQRS.

Question: I'm a CAH provider paid under Method II. Am I required to report line item rendering NPI information?

Answer: Yes, a CAH provider paid under Method II is required to report the rendering NPI at the line level **if** it is different than the rendering NPI at the claim level. For more information about this billing standard requirement, refer to *MLN Matters*® MM7578 titled "Fiscal Intermediary Shared System (FISS) and Common Working File (CWF) System Enhancement for Storing Line Level Rendering Physicians/Practitioners National Provider Identifier (NPI) Information," located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7578.pdf*.

Additional information

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

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Mandatory payment adjustment of 2 percent extended for Medicare FFS claims (sequestration)

For the Medicare fee-for-service (FFS) program claims with dates of service or dates of discharge on or after April 1, 2013, will continue to incur a 2 percent reduction in Medicare payment through March 31, 2016 (sequestration).

Claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), including claims under the DMEPOS Competitive Bidding Program, will continue to be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

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

Although beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. CMS encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries on the impact of sequestration on Medicare's reimbursement.

Questions about reimbursement should be directed to your Medicare administrative contractor (*http://go.usa.gov/3xtCC*).

General Coverage

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

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for single chamber and dual chamber permanent cardiac pacemaker services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9078 informs MACs that the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) and concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Make sure that your billing staffs are aware of these changes.

Background

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

On August 13, 2013, CMS issued an NCD, in which CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible, symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion).

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

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

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

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block. *(exception)
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest. *(exception)
5. Ineffective atrial contractions (for example, chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia. *(exception)
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes are prolonged or electrophysiological studies have demonstrated that the block is at or beyond the level of the His Bundle (a component of the electrical conduction system of the heart).
7. Syncope of undetermined cause. *(exception)
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block. *(exception)
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.
11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia. *(exception)
12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

MACs will determine coverage under section 1862(a)(1)(A) of the Social Security Act for any other indications

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for the implantation and use of single chamber or dual chamber cardiac pacemakers that are not specifically addressed in this NCD. **Notes**: MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia (symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion).

Note: The final decision memorandum addresses Medicare policy specific to implanted permanent cardiac pacemakers, single chamber or dual chamber, for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block.

Medicare coverage of removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber, for the above-noted indications, were not addressed in the final decision. Therefore, it is expected that MACs will continue to apply the reasonable and necessary standard in determining local coverage within their respective jurisdictions for removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber.

Cardiac pacemaker Healthcare Common Procedure Coding System (HCPCS) and *Current Procedural Terminology* (*CPT*®) codes

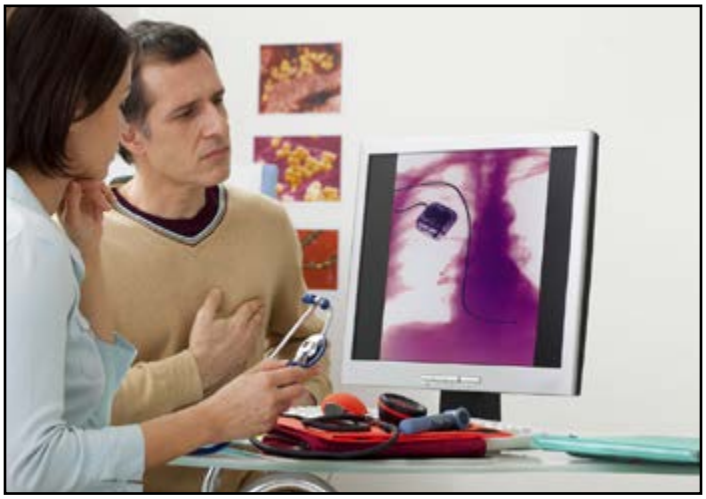
Professional claims

Effective for claims with dates of service on or after August 13, 2013, MACs shall pay for implanted permanent cardiac pacemakers, single chamber or dual chamber, for one of the following *CPT*® codes if the claim contains at least one of the designated diagnosis codes in addition to the –KX modifier:

- *33206* - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial;
- *33207* - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – ventricular; or
- *33208* - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial and ventricular.

Institutional claims

Effective for claims with dates of service on or after August 13, 2013, MACs shall pay for implanted permanent cardiac pacemakers, single chamber or dual chamber, for the following HCPCS codes if the claim contains at least one of the designated *CPT*® codes, and at least one of



the designated diagnosis codes, in addition to the –KX modifier:

- C1785 – *Pacemaker, dual chamber, rate-responsive (implantable);*
- C1786 – *Pacemaker, single chamber, rate-responsive (implantable);*
- C2619 – *Pacemaker, dual chamber, nonrate-responsive (implantable);*
- C2620 – *Pacemaker, single chamber, nonrate-responsive (implantable)*;
- *33206 – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial*
- *33207 – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – ventricular*
- *33208 – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial and ventricular*

MACs have discretion to cover or not cover the following *CPT*® codes:

- *33227 – Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system*; or
- *33228* – Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system.

Cardiac pacemaker ICD-9/ICD-10 diagnosis codes

Professional claims

Claims with dates of service on and after August 13, 2013, for implanted permanent cardiac pacemakers, single chamber or dual chamber, are covered if submitted with one of the following *CPT*® codes: *33206, 33207, or 33208*, and that contain at least one of the following ICD-9/ICD-10 diagnosis codes (upon ICD-10 implementation) listed below in addition to the –KX modifier:

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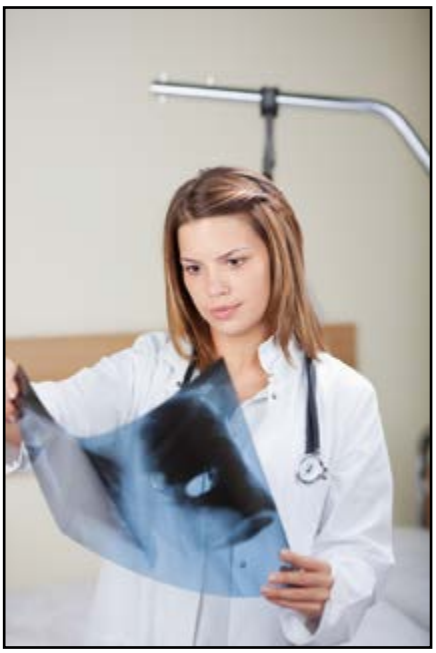
- 426.0 Atrioventricular block, complete/ I44.2 Atrioventricular block, complete;
- 426.12 Mobitz (type) II atrioventricular block/ I44.1 Atrioventricular block, second degree;
- 426.13 Other second degree atrioventricular block/ I44.1 Atrioventricular block, second degree;
- 427.81 Sinoatrial node dysfunction/ I49.5 Sick sinus syndrome; or
- 746.86 Congenital heart block/ Q24.6 – Congenital heart block.
- The following diagnosis codes can be covered at your MACs discretion if submitted with at least one of the *CPT*® codes and diagnosis codes listed above in addition to the –KX modifier:
- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;
- 426.11 First degree atrioventricular block/ I44.0 Atrioventricular block first degree;
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block/ I45.19 Other right bundle-branch block;
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia;
- 427.31 Atrial fibrillation/ I48.1 Persistent atrial fibrillation/ I48.91, Unspecified atrial fibrillation;
- 427.32 Atrial flutter/ I48.3 Typical atrial flutter/ I48.4 Atypical atrial flutter or I48.91 Unspecified atrial fibrillation; or
- 780.2 Syncope and collapse/R55 Syncope and collapse (R55 is the ICD-10 dx code but is not payable upon implementation of ICD-10 and is only included here for information purposes).

Institutional claims

For coverage of claims with dates of service on and after August 13, 2013, for implanted permanent cardiac pacemakers, single chamber or dual chamber, using HCPCS codes: C1785, C1786, C2619, C2620, 33206, *33207*, or *33208*, the claim must contain at least one of the following procedure codes:

- 37.81 Initial insertion of single chamber device, not specified as rate responsive
- 37.82 Initial insertion of single chamber device, rate responsive
- 37.83 Initial insertion of single chamber device
- and at least one of the following diagnosis codes in addition to the –KX modifier:
- 426.0 Atrioventricular block, complete;
- 426.12 Mobitz (type) II atrioventricular block;
- 426.13 Other second degree atrioventricular block;
- 427.81 Sinoatrial node dysfunction; or
- 746.86 Congenital heart block.



The following diagnosis codes can be covered, at the MAC's discretion, if submitted with at least one of the diagnosis codes listed above in addition to the –KX modifier:

- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;
- 426.11 First degree atrioventricular block/ I44.0 Atrioventricular block first degree;
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block/ I45.19 Other right bundle-branch block;
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia;
- 427.31 Atrial fibrillation/ I48.1 Persistent atrial fibrillation/ I48.91, Unspecified atrial fibrillation;
- 427.32 Atrial flutter/ I48.3 Typical atrial flutter/ I48.4 Atypical atrial flutter or I48.91 Unspecified atrial fibrillation; or
- 780.2 Syncope and collapse/R55 Syncope and collapse (R55 is the ICD-10 dx code but is not payable upon implementation of ICD-10 and is only included here for information purposes).

Professional claims

MACs shall return claims lines for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following *CPT*® codes: *33206*, *33207*, or *33208*, as unprocessable when the -KX modifier is not present. When returning such claims, MACs shall use the following messages:

- Claim adjustment reason code (CARC) 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.
- Remittance advice remarks code (RARC) N517 - Resubmit a new claim with the requested information.

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Institutional claims

MACs shall return to providers claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, when any of the following are not present on the claim:

At least one HCPCS code: C1785, C1786, C2619, or C2620, at least one *CPT*® code: *33206, 33207, 33208, 33227, 33228*, at least one diagnosis code: 426.0/I44.2, 426.12/I44.1, 426.13/I44.1, 427.81/I49.5, 746.86/Q24.6, at least one procedure code: 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, 38.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, and the -KX modifier is not present on the claim.

Cardiac pacemaker non-covered ICD-10 diagnosis code

For claims with dates of service on or after implementation of ICD-10, for implanted permanent cardiac pacemakers, single chamber or dual chamber, using one of the following HCPCS and/or *CPT*® codes: *C1785*, *C1786*, *C2619*, *C2620, 33206, 33207*, or *33208*, ICD-10 diagnosis code R55 is not covered even if the claim contains one of the valid diagnosis codes listed above.

MACs will use the following messages when denying claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following HCPCS and/or *CPT*® codes: *C1785, C1786, C2619, C2620, 33206, 33207, or 33208*, and ICD-10 diagnosis code R55 with the following messages:

- CARC 96: Non-covered charge(s).
- RARC N569: Not covered when performed for the reported diagnosis.
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed advance beneficiary notice (ABN) is on file.
- Group code PR assigning financial liability to the beneficiary, if a claim is received with occurrence code 32 indicating a signed ABN is on file, or occurrence code 32 is present with modifier GA.

Additional information

The official instruction, CR 9078, was issued to your MAC via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3204CP.pdf*.

The second updates the Medicare *National Coverage Determination Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179NCD.pdf*.

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

MLN Matters® Number: MM9078
Related Change Request (CR) #: CR 9078
Related CR Release Date: February 20, 2015
Effective Date: August 13, 2013
Related CR Transmittal #: R3204CP and R179NCD
Implementation Date: July 6, 2015

Removal of multiple national coverage determinations using an expedited process

Provider types affected

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

Provider action needed

Effective December 18, 2014, change request (CR) 9095 removes Sections 50.6 – Tinnitus masking, 160.4 – Stereotactic Cingulotomy as a Means of Psychosurgery, 160.6 – Carotid Sinus Nerve Stimulator, 160.9 – Electroencephalographic (EEG) Monitoring During Open – Heart Surgery, 190.4 – Electron Microscope, 220.7 – Xenon Scan, and 220.8 – Nuclear Radiology Procedure from the Medicare *National Coverage Determinations Manual* or the *NCD Manual*.

Providers and their staffs should be aware that removing an NCD results in coverage determinations being at the discretion of local MACs within their respective jurisdictions.

Background

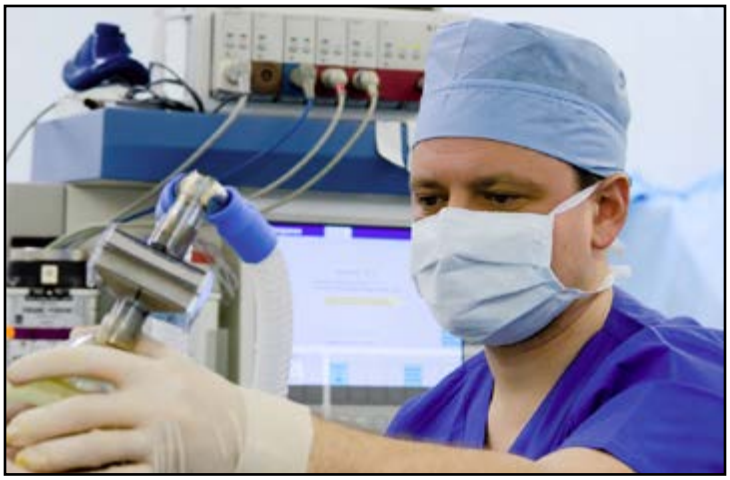
CR 9095 removes seven NCDs from Publication 100-03, *NCD Manual*, pursuant to the expedited process that was established in an August 7, 2013, *Federal Register* (FR) notice (78 FR 48164).

The FR notice is available at *http://www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/FR08072013.pdf*.

A Centers for Medicare and Medicaid Services (CMS) decision memorandum dated December 18, 2014, contains a summary of the expedited removal process and explicitly removes seven NCDs from the *NCD Manual* sections as follows:

- 50.6 – Tinnitus masking;
- 160.4 – Stereotactic cingulotomy as a means of psychosurgery;
- 160.6 – Carotid sinus nerve stimulator;
- 160.9 – Electroencephalographic (EEG) monitoring during open-heart surgery;
- 190.4 – Electron microscope;
- 220.7 – Xenon scan; and
- 220.8 – Nuclear radiology procedure.

You can review the CMS decision memorandum at



http://www.cms.gov/medicare-coverage-database/details/medicare-coverage-document-details.aspx?MCDId=29&mcdtypename=National+Coverage+Determinations+Proposed+for+Removal&MCDIndexType=7&bc=AgAEAAAAAAAA AA%3d%3d&.

In the absence of an NCD, MACs should revert to historical standing policy and consider whether any Medicare claims for these services are reasonable and necessary under the Social Security Act (Section 1862(a)(1)(A); see *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm*) consistent with the existing guidance for making such decisions when there is no NCD.

Additional information

The official instruction, CR 9095, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R180NCD.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: MM9095
Related Change Request (CR) #: CR 9095
Related CR Release Date: March 6, 2015
Effective Date: December 18, 2014
Related CR Transmittal #: R180NCD
Implementation Date: April 6, 2015

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

***Note**: This article was revised February 25, 2015, to delete information pertaining to diagnosis coding and reference to change request (CR) 8350. All other information remains the same. This article was previously published in the April 2014 edition of Medicare A Connection.*

Provider types affected

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

Provider action needed

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

Background

Denial notices for non-covered levels of RNHCI care

RNHCI facilities sometimes provide services to Medicare beneficiaries that do not qualify for Medicare coverage and for which the beneficiary may seek payment from another insurer. The other insurer may require a denial from Medicare before making payment for these services. Medicare systems require submission of a NOE before any RNHCI claims can be processed. In order for a claim requesting a denial notice to be processed, the RNHCI would need to inappropriately submit an NOE, since the beneficiary is not requesting Medicare coverage of RNHCI services.

In order to avoid having the RNHCI issue an inappropriate NOE, the RNHCI may request in writing a denial notice from the appropriate MAC. In response, the MAC will

provide the RNHCI with a manual denial letter. This letter may then be submitted to a secondary insurer as evidence of a prior Medicare denial.

Additional information

The official instruction, CR 8559 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2930CP.pdf*.

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

MLN Matters® Number: MM8559 *Revised*
Revised Related Change Request (CR) #: CR 8559
Related CR Release Date: April 11, 2014
Effective Date: July 14, 2014
Related CR Transmittal #: R2930CP
Implementation Date: July 14, 2014

Screening for hepatitis C virus in adults

***Note**: This article was revised March 13, 2015, to reflect the revised change request (CR) 8871 issued March 11. The article was revised to (1) replace "January 1, 2015, MPFSDB" with "January 1, 2016, CLFS" under "Background," (2) remove 50 (FQHC) and 72 (RHC) from the list of place of service codes under "Professional billing requirements," (3) clarify payment method for type of bill 13x, (4)add clarifying language for FQHC and RHC, and remove incorrect language regarding claim processing for federally qualified health centers (FQHCs)and rural health clinic (RHC), (5) clarify Medicare administrative contractor (MAC)claim processing prior to January 1, 2016, instead of January 1, 2015, also in the "Background" section. All other information remains the same. This information was previously published in the December 2014 Medicare A Connection, Pages 11-13.*

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for hepatitis C virus (HCV) screening services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 8871 states, effective June 2, 2014, the Centers for Medicare & Medicaid Services CMS) will cover screening for HCV consistent with the grade B recommendations by the United States Preventive Services Task Force (USPSTF) for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. Make sure your billing staffs are aware of these changes.

Background

Hepatitis C virus (HCV) is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the western world.

Prior to June 2, 2014, CMS did not cover screening for HCV in adults. Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process.

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices) when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. Adults at high risk for HCV infection. "High risk" is defined as persons with a current or past history of illicit injection drug use, and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.
2. Adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965. A single, once-in-a-lifetime screening test is covered for these individuals.

The determination of "high risk for HCV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

General claim processing requirements for claims with dates of service on and after June 2, 2014

1. New HCPCS G0472, short descriptor – Hep C screen high risk/other and long descriptor- Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used. HCPCS G0472 will appear in the January 2016 recurring updates of the clinical laboratory fee schedule (CLFS) and the integrated outpatient code editor (IOCE) with a June 2, 2014, effective date. MACs shall apply contractor pricing to claims with dates of service June 2, 2014, through December 31, 2015 that contain HCPCS G0472. MACs will not automatically adjust claims that may be processed in error, but will adjust such claims that you bring to their attention.
2. Beneficiary coinsurance and deductibles do not apply to HCPCS G0472.
3. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:
   - HCPCS G0472

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4. For those determined to be high-risk initially, claims must be submitted with:
   - HCPCS G0472; and
   - ICD-9 diagnosis code V69.8, other problems related to lifestyle/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented).
5. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
   - HCPCS G0472;
   - ICD diagnosis code V69.8/Z72.89; and
   - ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented).

Note: Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

Institutional billing requirements

Effective for claims with dates of service on and after June 2, 2014, institutional providers may use types of bill (TOB) 13x, 71x, 77x, and 85x when submitting claims for HCV screening, HCPCS G0472. Medicare will deny G0472 service line-items on other TOBs using the following messages:

- **Claim adjustment reason code (CARC) 170** – Payment denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks code (RARC) N95** – This provider type/provider specialty may not bill this service.
- **Group code CO** (contractual obligation) – If claim received without a GZ modifier.

The service is paid on the following basis:

- **Outpatient hospitals** – TOB 13x – based on the outpatient prospective payment system.
- **Rural health clinics (RHCs)** – TOB – and federally qualified health centers (FQHCs) - 77x - For RHCs and FQHCs that are authorized to bill under the all-inclusive rate (AIR) system, payment for the professional component is included in the AIR. For FQHCs authorized to bill under the FQHC prospective payment system (PPS), payment for the professional component is included in the FQHC PPS rate. HCV screening is not a stand-alone payable visit for RHCs and FQHCs.
- **Critical access hospitals (CAHs)** – TOB 85x – based on reasonable cost; and
- **CAH Method II** – TOB 85x – based on 115 percent of the lesser of the MPFS amount or actual charge as applicable with revenue codes 096x, 097x, or 098x.

Note: Separate guidance shall be issued for FQHCs that are authorized to bill under the prospective payment system.

Professional billing requirements

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCPCS G0472, only when services are submitted by the following provider specialties found on the provider's enrollment record:

01 – General practice

08 – Family practice

11 – Internal medicine

16 – Obstetrics/gynecology

37 – Pediatric medicine

38 – Geriatric medicine

42 – Certified nurse midwife

50 – Nurse practitioner

89 – Certified clinical nurse specialist

97 – Physician assistant

Medicare will deny claims submitted for these services by providers other than the specialty types noted above. When denying such claims, Medicare will use the following messages:

- **CARC 184** – The prescribing/ordering provider is not eligible to prescribe/order the service.
  Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N574** – Our records indicate the ordering/referring provider is of a type/specialty that cannot order/refer. Please verify that the claim ordering/referring information is accurate or contact the ordering/referring provider.
- **Group code** CO if claim received without GZ modifier.

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCV screening, HCPCS G0472, only when submitted with one of the following place of service (POS) codes:

11 – Physician's office

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22 – Outpatient hospital

49 – Independent clinic

71 – State or local public health clinic

81 – Independent laboratory

Medicare will deny claims submitted without one of the POS codes noted above with the following messages:

- **CARC 171** – Payment denied when performed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N428** – Not covered when performed in this place of service.
- **Group code** – CO if claim received without GZ modifier.

Other billing information for both professional and institutional claims

On both institutional and professional claims, Medicare will deny claims line-items for HCPCS G0472 with dates of service on or after June 2, 2014, where it is reported more than once-in-a-lifetime for beneficiaries born from 1945 through 1965 and who are not high risk. Medicare will also line-item deny when more than one HCV screening is billed for the same high-risk beneficiary prior to their annual eligibility criteria being met. In denying these claims, Medicare will use:

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached.
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code** – CO if claim received without GZ modifier.

When applying the annual frequency limitation, MACs will allow both a claim for a professional service and a claim for a facility fee. In addition, remember that the initial HCV screening for beneficiaries at high risk must also contain ICD-9 diagnosis code V69.8 (ICD-10 code Z72.89 once ICD-10 is implemented).

Then, for the subsequent annual screenings for high risk beneficiaries, you must include ICD-9 code V69.8 and 304.91 (ICD-10 of Z72.89 and F19.20 once ICD-10 is implemented). Failure to include the diagnosis code(s) for high risk beneficiaries will result in denial of the line item. In denying these payments, Medicare will use the following:

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached. (for initial high risk screening), or,
- **CARC 167** – This (these) diagnosis(es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (for subsequent annual high risk screening)
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp* on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code** CO if claim received without GZ modifier.

Additional information

The official instruction, CR 8871, was issued to your MAC regarding this change via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3215CP.pdf*. The second transmittal updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R177NCD.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: MM8871 *Revised*
Related Change Request (CR) #: CR 8871
Related CR Release Date: March 11, 2015
Effective Date: June 2, 2014
Implementation Date: January 5, 2015, for non-shared MAC and edits and CWF analysis; April 6, 2015, for remaining shared system edits
Related CR Transmittal #: R3215CP and R177NCD

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**

Noncovered services – revision to the draft Part A LCD

LCD ID number: L28991 (Florida)
LCD ID number: L29023 (Puerto Rico/U.S. Virgin Islands)

The Medical Policy & Procedures Department evaluated the following services and determined that they are not considered medically reasonable and necessary at this time based on current available published evidence (e.g., peer-reviewed medical literature, and published studies).

Therefore, the following procedure codes have been added to the draft noncovered services local coverage determination (LCD) and are open for comment. The comment period for this revision is from February 14, 2015, to March 30, 2015. After a draft LCD becomes effective/active, any stakeholder may request a revision to the LCD, by following the reconsideration process as outlined on our website.

- C9737 – Laparoscopy, surgical, esophageal sphincter augmentation with device (eg, magnetic band)
- *0378T – 0379T* - Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days
- *0380T - Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report*
- *0381T – 0382T* – External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- *0383T – 0384T* – External heart rate and 3-axis accelerometer data recording from 15 to 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- *0385T – 0386T* – External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- **0387T- Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular*
- **0388T - Transcatheter removal of permanent leadless pacemaker, ventricular*
- **0389T - Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system*
- **0390T - Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure or test with analysis, review and report, leadless pacemaker system*
- **0391T - Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system*
- *43289 - Unlisted laparoscopy procedure, esophagus (LINX)*
- **91200 - Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report*

*Covered if beneficiary is enrolled in a MAC approved Investigational Device Exemption (IDE) study.

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the quality of the evidence per the *Program Integrity Manual*.

When addressing the articles and related information in the public domain, the jurisdiction N (JN) Medicare administrative contractor (MAC) reached the determination that available evidence was of moderate to low quality, consisting of small case series, retrospective studies, and review articles reporting limited safety and efficacy data for these procedures.

Due to the unavailability of high quality evidence, the JN MAC reiterates that there is insufficient scientific evidence to support these and therefore they are not considered reasonable and necessary under Section 1862(a)(1)(a) of the Social Security Act.

Any denied claim would have Medicare's appeal rights. The second level of appeal (qualified independent contractor) requires review by a clinician to uphold any denial. Providers should submit for review all the relevant medical documentation and case specific information of merit and/or new information in the public domain.

An interested stakeholder can request a reconsideration of an LCD after the draft is finalized, the notice period has ended, and the draft becomes active.

In the case of the noncovered services LCD, the stakeholder may request the list of the articles and related information in the public domain that were considered by the Medical Policy department in making the noncoverage decision. If the stakeholder has new information based on the evaluation of the list of articles and related information, an LCD reconsideration can be initiated. It is

See **NONCOVERED**, next page

Mohs micrographic surgery – revisions to the Part A LCD

LCD ID number: L28932 (Florida)
LCD ID number: L28953 (Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 9007, the "Documentation Requirements" section of the Mohs micrographic surgery (MMS) local coverage determination (LCD) was revised to indicate that if a pathology code is billed on the same day as MMS, then the documentation must support a separate excision/biopsy/repair was performed.

The Coding Guidelines attachment was also revised.

Effective date

The LCD revision is effective for **services rendered on or after February 9, 2015**. 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 "Attachments" in the Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please *click here*.

Surgical management of morbid obesity – revision to the Part A LCD

LCD ID number: L33019
(Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for surgical management of morbid obesity was revised to update the "Comorbid Conditions" and "Contraindications to Bariatric Surgery" under the "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD.

In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

The LCD revision is effective for **services rendered on or after February 19, 2015**. 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 "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.
Note: To review active, future, and retired LCDs, please *click here*.

Future ICD-10 Local coverage determinations (LCDs)

It has come to our attention that ICD-10 LCDs currently published in the Medicare coverage database (MCD) for notice that include diagnosis code ranges may be missing diagnosis codes within the range.

First Coast Service Options, Inc. (First Coast) is working with the MCD national contractor to resolve the issue.

If you have an immediate need to clarify aspects of a future effective ICD-10 LCD, please contact *medical.policy@fcso.com*. When these issues are resolved, an update will be published.

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the responsibility of the interested stakeholder to request the evidentiary list from the contractor and to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the web site.

Also, any interested party could request Centers for Medicare & Medicaid Services (CMS) to consider developing a national coverage determination (NCD). Of note, if the evidence is not adequate for coverage under section 1862(a)(1)(A), an item or service may be considered for coverage under the CMS Coverage with Evidence Development (CED) policy in which "reasonable and necessary" is established under 1862(a)(1)(E) of the Act. Under the authority of Section 1862(a)(1)(E), the NCD process may result in coverage if the item or service is covered only when provided within a setting in which there is a pre-specified process for gathering additional data, and in which that process provides additional protections and safety measures for beneficiaries, such as those present in certain clinical trials.

Note: To review active, future, and retired LCDs, please *click here*.

Syphilis test – revisions to the Part A LCD

LCD ID number: L29044 (Florida)
LCD ID number: L29045 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for syphilis test was most recently revised January 1, 2014. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to reflect current Centers for Medicare & Medicaid Services (CMS) language based on change request (CR) 7610 [Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs] and Medicare National Coverage Determinations (NCD) Manual, Chapter 4, §210.10, Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs.

In addition, the "CMS National Coverage Policy" section of the LCD was updated to include CR 7610 and NCD 210.10.This LCD limits diagnostic syphilis testing for the treatment of syphilis. Screening for syphilis will be covered when provided in accordance to the coverage limitations of NCD 210.10.

Effective date

The LCD revision is effective for **claims processed on or after March 12, 2015, for services rendered on or after November 8, 2011**. 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 "Attachments" in the Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please *click here*.

Collagenase clostridium histolyticum (Xiaflex®) – revision to the Part A LCD

LCD ID number: L31223
(Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for collagenase clostridium histolyticum (Xiaflex®) was revised based on a reconsideration request to include the Food and drug administration (FDA) label expansion for the treatment of Dupuytren's contracture to allow for up to two injections affecting two joints or two cords of the same hand within the same treatment visit.

The "Utilization Guidelines" and "Sources of Information and Basis of Decision" sections of the LCD were updated.

Effective date

The LCD revision is effective for **claims processed on or after February 17, 2015**, for **dates of service on or after October 20, 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 "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please *click here*.

Local coverage determinations (LCDs) – missing information

It has come to our attention that some LCDs listed in the current Medicare coverage database (MCD) are incomplete in that the "CPT/HCPCS", and "ICD-9 codes that support medical necessity" sections may be missing. First Coast Service Options, Inc. (First Coast) wants to clarify that the missing information is due to a database issue and it does not represent a change in LCD coverage nor documentation or utilization requirements.

This information may be also missing from the First Coast LCD lookup tool. First Coast is working with the MCD national contractor to resolve the issue. If you have an immediate need to clarify aspects of a current LCD, please contact medical.policy@fcso.com with the LCD name and number. When these issues are resolved an update will be published.

Electronic Data Interchange

ICD-10 conversion and coding revisions with ICD-9 updates to NCDs – second maintenance update

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9087 which is the second maintenance update of ICD-10 conversions and coding updates specific to national coverage determinations (NCDs).

The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, and CR 8691. Links to related *MLN Matters*® articles MM7818, MM8109, MM8197, and MM8691 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these spreadsheets attached to CR 9087 for the following 13 NCDs:

NCD	NCD title
20.29	Hyperbaric oxygen therapy
20.9.1	Ventricular assist devices
50.3	Cochlear implantation
80.2	Photodynamic therapy
80.2.1	Ocular photodynamic therapy (OPT)
80.3	Photosensitive drugs
80.3.1	Verteporfin
110.10	Intravenous iron therapy
150.3	Bone (Mineral) density studies
160.18	Vagus nerve stimulation
180.1	Medical nutrition therapy
210.2	Screening pap smears and pelvic examinations for early detection of cervical or vaginal cancer
250.3	Intravenous immune globulin for the treatment of autoimmune mucocutaneous blistering diseases

Background

CR 9087's purpose is to create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, plus all associated coding infrastructure such as HCPCS/*CPT*® codes, reason/remark codes, frequency edits, POS/TOB/provider specialties, and so forth. The requirements described in CR 9087 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the attached Medicare NCD spreadsheets.

Please note that there are 10 spreadsheets attached to CR 9087. These spreadsheets relate to 13 NCDs, and provide pertinent policy/coding information necessary to implement ICD-10. Further, you should be aware that NCD policies may contain specific covered, non-covered and/or discretionary diagnosis coding. These spreadsheets are designated as such and are based on current NCD policies and their corresponding edits.

Nationally covered and non-covered diagnosis code editing is finite and cannot be revised without subsequent discussions with CMS. Discretionary code lists are to be regarded as CMS' compilation of discretionary codes based on current analysis/interpretation. Local MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions. Nothing contained in CR 9087 should be construed as new policy. Some coding details are as follows:

1. The ICD-10 diagnosis/procedure codes associated with the NCDs attached to CR 9087 are not to be implemented until October 1, 2015, or until ICD-10 is implemented.
2. Your MAC will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages, where appropriate:

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- **Remittance advice remark code (RARC) N386** (This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered), along with claim adjustment reason code (CARC) 50 (These are noncovered services because this is not deemed a "medical necessity" by the payer), CARC 96 (Non-covered charge(s). At least one remark code must be provided [may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT]), and/or CARC 119 (Benefit maximum for this time period or occurrence has been reached).

3. When denying claims associated with the attached NCDs, except where otherwise indicated, your MACs will use:

   - **Group code PR** (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 (advance beneficiary notice), or with occurrence code 32 and a GA modifier (The provider or supplier has provided an advance beneficiary notice (ABN) to the patient), indicating a signed ABN is on file).

   - **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier (The provider or supplier expects a medical necessity denial; however, did not provide an advance beneficiary notice (ABN) to the patient), indicating no signed ABN is on file).

Note: For modifier GZ, use CARC 50 and MSN 8.81 (If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid.

However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/supplier).

Additional information

The official instruction, CR 9087, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1478OTN.pdf*.

The spreadsheet attachments to CR 9087 are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1478OTN.zip*.

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

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

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

MM8691 is available for review at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.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: MM9087
Related Change Request (CR) #: CR 9087
Related CR Release Date: March 6, 2015
Effective Date: April 6, 2015; for designated ICD-9 updates and all local system edits (ICD-9 and ICD-10); July 1, 2015, for all ICD-9 shared system edits; October 1, 2015, for all ICD-10 shared system edits (or whenever ICD-10 is implemented)
Related CR Transmittal #: R1478OTN
Implementation Date: April 6, 2015, for designated ICD-9 updates and all local system edits; July 6, 2015, for ICD-9 and ICD-10 shared system edits

Automation of the request for reopening claims process

Note: *This article was revised March 17, 2015, and February 23, 2015 to reflect the revisions to change request (CR) 8581 issued December 19, 2014, and February 20, 2015. Clarifications were made regarding the relationship of reopenings to timely filing and also to certain denied claims lines and to clarify the need for a "Remarks" field code for certain reopenings. In addition, the effective and implementation dates are revised. All other information remains the same. This article was previously printed in the September 2014 Medicare A Connection, Pages 34-36.*

Note: To assist providers with coding a request to reopen claims that are beyond the filing timeframes a special edition article, SE1426, has been developed. That article contains some additional information on this process as well as condition codes and billing scenarios. The article may be reviewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf*

Provider types affected

This *MLN Matters*® article is intended for providers, including home health and hospice providers, and suppliers submitting institutional claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on CR 8581 which informs A/MACs about changes that will allow providers and their vendors to electronically request reopenings of claims. Make sure your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

When a provider needs to correct or supplement a claim, and the claim remains within timely filing limits, providers may submit an adjustment claim to remedy the error. When the need for a correction is discovered beyond the claims timely filing limit, an adjustment bill is not allowed and a provider must utilize the reopening process to remedy the error.

Generally, reopenings are written requests for corrections that include supporting documentation. However, a standard process across all A/MACs has not been available. In an effort to streamline and standardize the process for providers to request reopenings, CMS petitioned the National Uniform Billing Committee (NUBC) for a "new" bill type frequency code to be used by providers indicating a request for reopening and a series of condition codes that can be utilized to identify the type of Reopening being requested.

These institutional reopenings must be submitted with a "Q" frequency code to identify them as a reopening.

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (i.e., filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (e.g., claim determinations may be reopened within one year of the date of receipt of the initial determination for any reason, or within one to four years of the date of receipt of the initial determination upon a showing of good cause). Reopenings are only allowed after normal timely filing period has expired.

If the normal timely filing period has not expired, the MAC will return the reopening to the provider and request the provider submit an adjustment claim not a reopening.

Also, MACs interrogate the remarks field for good cause on reopenings that have an adjustment reason code of R2 or R3 and they will return the reopening to the provider when the remarks field is not annotated with one of the following 15 character remarks:

- GOOD_CAUSE-_C-A (underline indicates a space)
- GOOD_CAUSE-_NME (underline indicates a space)
- GOOD_CAUSE-_F/E (underline indicates a space)

Reopenings are also separate and distinct from the appeals process. A reopening will not be granted if an appeal decision is pending or in process.

MACs will not allow claim lines that have been denied through a Medicare review process (for example, MR,

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RAC, CERT, OIG, QIO, etc.) to be reopened, however, other claim lines that were not denied through a Medicare Review process shall be allowed to be reopened.

Also, MACs will not allow direct data entry (DDE) claims that have been fully denied to be reopened. Providers must appeal these claims.

Decisions to allow reopenings are discretionary actions on the part of your A/MAC. An A/MAC's decision to reopen a claim determination, or refusal to reopen a claim determination, is not an initial determination and is therefore not appealable. Requesting a reopening does not guarantee that request will be accepted and the claim determination will be revised, and does not extend the timeframe to request an appeal. If an A/MAC decides not to reopen an initial determination, the A/MAC will return to provider (RTP) the reopening request indicating that the A/MAC is not allowing this discretionary action.

In this situation, the original initial determination stands as a binding decision, and appeal rights are retained on the original initial determination. New appeal rights are not triggered by the refusal to reopen, and appeal filing timeframes on the original initial determination are not extended following a contractor's refusal to reopen. However, when an A/MAC reopens and revises an initial determination, that revised determination is a new determination with new appeal rights.

Providers are reminded that submission of adjustment bills or reopening requests in response to claim denials resulting from review of medical records (including failure to submit medical records in response to a request for records) is not appropriate. Providers must submit appeal requests for such denials.

Additionally, many A/MACs allow reopenings to be submitted hardcopy (by mail or fax) or through a provider online portal. The creation of this new process does not eliminate or negate those processes. Contact your MAC about other ways reopenings may be submitted.

Additional information

The official instruction, CR 8581, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3219CP.pdf*.

For additional information regarding the distinction between adjustment bills, which are subject to normal claims processing timely filing limits, and reopenings, which may be requested beyond timely filing limitations, review Chapter 1, Section 70.5 of the *Medicare Claims Processing Manual* (IOM 100-4). That manual chapter is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf*.

For additional information regarding the processing of appeals, review Chapter 29 in the *Medicare Claims Processing Manual* at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf*.

For additional information regarding the processing of requests for reopening, review Chapter 34 in the *Medicare Claims Processing Manual* at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf*.

Attachment 1 will assist providers with coding claim's request for reopening.

Attachment 1 - Coding requirements:

These claims must be submitted with a "Q" in the 4th position of the type of bill (TOB xxxQ) to identify them as a Reopening.

Condition code definitions for reopening

Condition code	Title	Definition
R1	Request for reopening reason code – mathematical or computational mistakes	Mathematical or computational mistakes
R2	Request for reopening reason code – inaccurate data entry	Inaccurate data entry, e.g., mis-keyed or transposed provider number, referring NPI, date of service, procedure code, etc.
R3	Request for reopening reason code – misapplication of a fee schedule.	Misapplication of a fee schedule
R4	Request for reopening reason code – computer errors	Computer errors.
R5	Request for Reopening Reason Code – Incorrectly Identified Duplicate	Claim Claims denied as duplicates which the party believes were incorrectly identified as a duplicate.

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Condition code	Title	Definition
R6	Request for Reopening Reason Code – Other Clerical Errors or Minor Errors and Omissions not Specified in R1-R5 above	Other clerical errors or minor errors and omissions not specified in R1-R5 above.
R7	Request for reopening reason code – corrections other than clerical errors	Claim corrections other than clerical errors within one year of the date of initial determination.
R8	Request for reopening reason code – new and material evidence	A reopening for good cause (one to four years from the date of the initial determination) due to new and material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion.
R9	Request for reopening reason code – faulty evidence	A reopening for good cause (one to four years from the date of the initial determination) because the evidence that was considered in making the determination or decision clearly shows that an obvious error was made at the time of the determination or decision.

MLN Matters® Number: MM8581 *Revised*
Revised Related Change Request (CR) #: CR 8581
Related CR Release Date: March 16, 2015
Effective Date: Claims received on or after October 1, 2015
Related CR Transmittal #: R3219CP
Implementation Date: October 5, 2015

Validation of payment group codes for prospective payment systems based on patient assessments

Note: This article has been rescinded as the related change request (CR) 9016 was rescinded.

It was previously published in the *February 2015 edition of Medicare A Connection*, Page 20.

MLN Matters® Number: MM9016 *Revised*
Rescinded Related Change Request (CR) #: CR 9016
Related CR Release Date: January 30, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R1459OTN
Implementation Date: July 6, 2015

CMS releases two new ICD-10 videos

The Centers for Medicare & Medicaid Services has released two animated short videos that explain key ICD-10 concepts. The videos are less than four minutes each and available on the *Provider Resources* Web page:

- *Introduction to ICD-10 Coding* – gives an overview of ICD-10's features and explains the benefits of the new code set to patients and to the health care community
- *ICD-10 coding and diabetes* – uses diabetes as an example to show how the code set captures important clinical details

Keep up to date on ICD-10

Visit the *ICD-10* website for the latest news and resources to help you prepare.

ICD-10 testing – acknowledgement testing with providers

***Note**: This article was revised February 27, 2015, to reflect the revised change request (CR) 8858, issued February 24. In the article, the CR release date, transmittal number, and the Web address for accessing CR 8858 are revised. All other information remains the same. This article was previously published in the September 2014 edition of Medicare A Connection, Page 26.*

Provider types affected

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

Provider action needed

CR 8858 instructs MACs to promote three specific acknowledgement testing weeks with providers, and provide data and statistics to the Centers for Medicare & Medicaid Services (CMS) to demonstrate readiness for the International Classification for Disease 10th Edition Clinical Modification (ICD-10) transition. Make sure that your billing staffs are aware of these ICD-10 testing opportunities.

Background

CMS is in the process of implementing ICD-10. All covered entities must be fully compliant on October 1, 2015.

CR 8858 instructs all MACs and the DME MAC common electronic data interchange (CEDI) contractor to promote ICD-10 acknowledgement testing with trading partners during three separate testing weeks, and to collect data about the testing. These testing weeks will be:

- November 17-21, 2014
- March 2-6, 2015
- June 1-5, 2015

The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 implementation. While submitters may acknowledgement test ICD-10 claims at any time through implementation, the ICD-10 testing weeks have been created to generate awareness and interest, and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

These testing weeks will allow trading partner's access to MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on the CMS website, the CEDI website and each MAC's website.

Key points of the testing process for CR 8858

- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing NPI validation edits.
- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Test claims will be subject to all existing EDI front-end edits, including submitter authentication and NPI validation.
- Testing will not confirm claim payment or produce a remittance advice.
- MACs and CEDI will be appropriately staffed to handle increased call volume on their electronic data interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during this week.
- Your MAC will announce and promote these testing weeks via their listserv messages and their website.

Additional information

The official instruction, CR 8858, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1472OTN.pdf*.

The EDI help desk numbers for institutional claim submitters are available at *http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartA.pdf* and the numbers for professional claims submitters are available at *http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartB.pdf*.

MLN Matters® Number: MM8858
Related Change Request (CR) #: CR 8858
Related CR Release Date: February 24, 2015
Effective Date: 30 Days From Issuance (See test dates)
Related CR Transmittal #: R1472OTN
Implementation Date: November 17 through 21, 2014, for the November testing week; March 2 through 6, 2015, for the March testing week; June 1 through 5, 2015, for the June testing week.

Reporting force balance payment on electronic remittance advice 835 and cross-over beneficiary 837 claims

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request 9050 to alert providers that claim adjustment reason code (CARC) A7 will be replaced on July 1, 2015, by CARC 121 to report force-balancing of out of balance (OOB) claims payment/adjudication.

Background

CR 9050 modifies the way MACs report force balancing of OOB claim payment/adjudication. Currently, MACs are using CARC A7 − presumptive payment adjustment to report the balancing of OOB payments.

CR 9050 instructs MACs to use CARC 121 − Indemnification adjustment − compensation for outstanding member responsibility in place of A7. This will be effective July 1, 2015. In addition, MACs will use group code OA (Other Adjustment) as the required group code.

Finally, MACs will report offsetting of Veterans Affairs claims at the provider level using PLB code J1 "Non-Reimburseable" and an offsetting dollar amount.

Additional information

The official instruction for CR 9050 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1467OTN.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: MM9050
Related Change Request (CR) #: CR 9050
Related CR Release Date: February 13, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R1467OTN
Implementation Date: July 6, 2015

Disclaimer

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

Medicare claims processing guidance for implementing ICD-10 – a re-issue of MM7492

***Note**: This article was revised February 20, 2015, to add a question and answer regarding dual processing of ICD-9 and ICD-10 codes. All other information remains the same. This article was previously published in the August 2014 edition of Medicare A Connection, Pages 45-50.*

Provider types affected

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

Provider action needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of CR7492 (and related *MLN Matters*® article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. **This article updates MM7492 to reflect the October 1, 2015, implementation date.** Make sure your billing and coding staffs are aware of these changes.

Key points of SE1408

General reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to *http://www.cms.gov/Medicare/Coding/ICD10/index.html* for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General claims submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be returned to provider (RTP) as unprocessable.

Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain **both** ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code.

Likewise, Medicare will also RTP all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Will the Centers for Medicare & Medicaid Services (CMS) allow for dual processing of ICD-9 and ICD-10 codes (accept and process both ICD-9 and ICD-10 codes for dates of service on and after October 1, 2015)?

No, CMS will not allow for dual processing of ICD-9 and ICD-10 codes after ICD-10 implementation on October 1, 2015. Many providers and payers, including Medicare have already coded their systems to only allow ICD-10 codes beginning October 1, 2015. The scope of systems changes and testing needed to allow for dual processing would require significant resources and could not be accomplished by the October 1, 2015, implementation date. Should CMS allow for dual processing, it would force all entities with which we share data, including our trading partners, to also allow for dual processing. In addition, having a mix of ICD-9 and ICD-10 codes in the same year would have major ramifications for CMS quality, demonstration, and risk adjustment programs.

Claims that span the ICD-10 implementation date

CMS has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2015, and earlier and where

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ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2015.

The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional providers

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
11x	Inpatient hospitals (incl. TERFHA hospitals, prospective payment system (PPS) hospitals, long term care hospitals (LTCHs), critical access hospitals (CAHs)	If the hospital claim has a discharge and/ or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
12x	Inpatient Part B hospital services	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
13x	Outpatient hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
14x	Non-patient laboratory services	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
18x	Swing beds	If the [swing bed or SNF] claim has a discharge and/ or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH

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Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
21x	Skilled nursing (inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/ or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
22x	Skilled nursing facilities (inpatient Part B)	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
23x	Skilled nursing facilities (outpatient)	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
32x	Home health (inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home health – request for anticipated payment (RAPs)*	* Note – RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See note

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Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
34x	Home health – (outpatient)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
71x	Rural health clinics	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
72x	End-stage renal disease (ESRD)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
73x	Federally qualified health clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74x	Outpatient therapy	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

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Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
75x	Comprehensive outpatient rehab facilities	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
76x	Community mental health clinics	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
77x	Federally qualified health clinics (effective 4/4/10)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
81x	Hospice-hospital	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

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Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
82x	Hospice – non hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
83x	Hospice – hospital based	N/A	N/A
85x	Critical access hospital	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

Table B - Special outpatient claims processing circumstances

Scenario	Claims processing requirement	Use FROM or THROUGH date
3-day / 1-day payment window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – professional claims

Type of claim	Claims processing requirement	Use FROM or THROUGH date
All anesthesia claims	Anesthesia procedures that begin on 9/30/2015, but end on 10/1/2015, are to be billed with ICD-9 diagnosis codes and use 9/30/2015, as both the FROM and THROUGH date.	FROM

Table D – supplier claims

Supplier type	Claims processing requirement	Use FROM or THROUGH/TO date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015, (i.e., the FROM date of service occurs prior to 10/1/2015, and the TO date of service occurs after 10/1/2015).	FROM

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Reimbursement

2015 update for DMEPOS fee schedule

***Note**: This article was revised February 24, 2015, to reflect the revised change request (CR) 8999. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were updated. All other information remains the same. This information was previously published in the December 2014 edition, Pages 38-40.*

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 8999 to advise providers of the 2015 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staffs are aware of these updates.

Background

CMS updates the DMEPOS fee schedules on an annual basis in accordance with statute and regulations. The 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-andGuidance/Guidance/Manuals/Downloads/clm104c23.pdf*.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints, casts and intraocular lenses (IOLs) inserted in a physician's office.

Key points

Fee schedule files

The DMEPOS fee schedule file will be available for providers and suppliers, as well as State Medicaid Agencies, managed care organizations, and other interested parties at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/*.

HCPCS codes added/deleted

The following new codes are effective January 1, 2015:

- A4602 in the inexpensive/routinely purchased (IN) payment category.
- The following new codes are in the prosthetics and orthotics (PO) payment category: A7048, L3981, L6026, L7259, and L8696. (Fee schedule amounts for these codes will be added to the DMEPOS fee schedule, effective January 1, 2015.)
- Also, code A4459 is added.

The base fee for code A4602 will be submitted to CMS by CMS contractors by April 3, 2015, for inclusion in the July

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Additional information

You may also want to review SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2015.

You may also want to review SE1410 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.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: SE1408
Revised Related Change Request (CR) #: 7492
Related CR Release Date: N/A
Effective Date: October 1, 2014
Related CR Transmittal #: N/A
Implementation Date: N/A

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2015 DMEPOS fee schedule update.

The following codes are deleted from the DMEPOS fee schedule files effective January 1, 2015: A7042, A7043, L6025, L7260, and L7261.

For gap-filling purposes, the 2014 deflation factors by payment category are as follows:

Factor	Category
0.459	Oxygen
0.462	Capped rental
0.464	Prosthetics and orthotics
0.588	Surgical dressings
0.640	Parenteral and enteral nutrition
0.963	Intraocular lenses
0.980	Splints and casts

Specific coding and pricing issues

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2015, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during 2013.

The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2015.

Diabetic testing supplies (DTS)

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order competitive bidding program (CBP) under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are re-competed. The national competitive bidding program for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016.

The program instructions reviewing the changes are in Transmittal 2661, CR 8204, dated February 22, 2013. The *MLN Matters*® article related to CR 8204 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM8204.pdf*.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for multi-factor productivity (MFP), which results in update of 1.5 percent for 2015. The single payment amount public use file for the national mail order competitive bidding program is available at *http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts*.

2015 fee schedule update factor of 1.5 percent

For 2015, the update factor of 1.5 percent is applied to the applicable 2014 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2015 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2014, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.6 percent and the CPI-U percentage increase is 2.1 percent. Thus, the 2.1 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 1.5 percent for the update factor.

2015 update to the labor payment rates

The table below contains the 2015 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the 12-month period ending with June 30, 2014, is 2.1

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percent this change is applied to the 2014 labor payment amounts to update the rates for 2015.

The 2015 labor payment amounts in the following table are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2015, through December 31, 2015.

State	K0739	L4205	L7520
AK	$27.98	$31.88	$37.50
AL	$14.86	$22.14	$30.05
AR	$14.86	$22.14	$30.05
AZ	$18.37	$22.11	$36.97
CA	$22.79	36.34	$42.35
CO	$14.86	$22.14	$30.05
CT	$24.81	$22.63	$30.05
DC	$14.86	$22.11	$30.05
NC	$14.86	$22.14	$30.05
ND	$18.51	$31.81	$37.50
NE	$14.86	$22.11	$41.90
NH	$15.95	$22.11	$30.05
NJ	$20.04	$22.11	$30.05
NM	$14.86	$22.14	$30.05
NV	$23.67	$22.11	$40.96
NY	$27.35	$22.14	$30.05
DE	$27.35	$22.11	$30.05
FL	$14.86	$22.14	$30.05
GA	$14.86	$22.14	$30.05
HI	$18.37	$31.88	$37.50
IA	$14.86	$22.11	$35.97
ID	$14.86	$22.11	$30.05
IL	$14.86	$22.11	$30.05
IN	$14.86	$22.11	$30.05
KS	$14.86	$22.11	$37.50
KY	$14.86	$28.34	$38.43
LA	$14.86	$22.14	$30.05
MA	$24.81	$22.11	$30.05
MD	$14.86	$22.11	$30.05
ME	$24.81	$22.11	$30.05
MI	$14.86	$22.11	$30.05
MN	$14.86	$22.11	$30.05
MO	$14.86	$22.11	$30.05
MS	$14.86	$22.14	$30.05
MT	$14.86	$22.11	$37.50
OH	$14.86	$22.11	$30.05
OK	$14.86	$22.14	$30.05
OR	$14.86	$22.11	$43.21
PA	$15.95	$22.77	$30.05
PR	$14.86	$22.14	$30.05
RI	$17.70	$22.79	$30.05
SC	$14.86	$22.14	$30.05
SD	$16.60	$22.11	$40.18
TN	$14.86	$22.14	$30.05
TX	$14.86	$22.14	$30.05
UT	$14.90	$22.11	$46.79
VA	$14.86	$22.11	$30.05
VI	$14.86	$22.14	$30.05
VT	$15.95	$22.11	$30.05
WA	$23.67	$32.44	$38.53
WI	$14.86	$22.11	$30.05
WV	$14.86	$22.11	$30.05
WY	$20.71	$29.50	$41.90
WY	$20.71	$29.50	$41.90

2015 national monthly payment amounts for stationary oxygen equipment

As part of CR 8999, CMS is implementing the 2015 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2015. Included is the updated national 2015 monthly payment amount of $180.92 for stationary oxygen equipment codes in the DMEPOS fee schedule. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE). Also, the updated 2015 monthly payment amount of $180.92 includes the 1.5 percent update factor for the 2015 DMEPOS fee schedule. Thus, the 2014 rate changed from $178.24 to the 2015 rate of $180.92.

When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2015 maintenance and servicing payment amount for certain oxygen equipment

Also updated for 2015 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment instructions for claims for maintenance and servicing of oxygen equipment are in Transmittal 635, CR 6792, dated February 5, 2010, (see the article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM6792.pdf*) and Transmittal 717, CR 6990, dated June

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8, 2010, (see the related article at *http://www.cms.gov/Outreach-andEducation/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM6990.pdf*).

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a 2015 maintenance and servicing fee of $69.76 for oxygen concentrators and transfilling equipment.

Update to change request (CR) 8566

Effective April 1, 2014, payment on a purchase basis was established for capped rental wheelchair accessory codes furnished for use with complex rehabilitative power wheelchairs. Such accessories are considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at 42 CFR Section 414.229(a)(5). These changes were implemented in Transmittal 1332, CR 8566, dated January 2, 2014. Code E2378 is added to the list of codes eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair.

Additional information

The official instruction for CR 8999 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R3190CP.pdf*.

If you have questions please contact your MAC at their toll-free number; the number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork-MLN/MLNMattersArticles/index.html* under - *How Does It Work*?

MLN Matters® Number: MM8999 *Revised*
Related Change Request (CR) #: CR 8999
Related CR Release Date: February 6, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3190CP
Implementation Date: January 5, 2015

Mass adjustment of claims containing codes G0473 and '77063'

Due to a systems error, coinsurance and deductible are not being waived on claims containing codes G0473 (intensive behavioral therapy for obesity) and *77063* (screening digital breast tomosynthesis, bilateral).

The problem will be corrected April 6, 2015. For claims with dates of service of January 1, 2015, through March 31, 2015, Medicare administrative contractors will be mass adjusting these claims and issuing corrected payments for all impacted claims.

The problem will be corrected April 6, 2015. Providers must reimburse beneficiaries for any overpayment caused by this error.

Renaming PPS-FLX6- payment field in the inpatient prospective payment system pricer output

***Note**: This article was revised February 23, 2015, to reflect the revised change request (CR) 9031 issued on February 18. 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 February 2015 edition of Medicare A Connection, Page 26.*

Provider types affected

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

Provider action needed

Change request (CR) 9031 informs MACs about the changes to the PPS-FLX6- PAYMENT field in the IPPS PRICER output record, created in CR 8546. The field will be renamed to identify the field as the hospital acquired condition (HAC) reduction amount. Make sure that your billing staffs are aware of these changes.

Background

Section 3008 of the Affordable Care Act established a program, beginning in fiscal year (FY) 2015, for IPPS hospitals to improve patient safety by imposing financial penalties on hospitals that perform poorly with regard to certain hospital acquired conditions (HACs). HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay.

Under the HAC reduction program, hospitals that rank in the lowest-performing quartile of selected HAC measures will be subject to a reduction of what they would otherwise be paid under the IPPS. The HAC payment reduction amount is currently displayed in the PPS-FLX6- PAYMENT field. The new name for this field will be HAC PAYMENT AMT.

Additional information

The official instruction, CR 9031 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1471OTN.pdf.*

If you have questions please contact your MAC at their toll-free number. The 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: MM9031 *Revised*
Revised Related Change Request (CR) #: CR 9031
Related CR Release Date: February 18, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R1471OTN
Implementation Date: July 6, 2015

Correcting the display issue for OPPS claims where value code "FD" is present

CMS is correcting a display issue for outpatient prospective payment system (OPPS) claims with value code "FD," which was caused by the implementation of payer-only value code "QD." The following claims are affected:

- Type of bill 13x (outpatient diagnostic testing services)
- Processed on or after January 1, 2014 and prior to the July 2015 OPPS pricer quarterly release
- Value code "FD" is present but does not represent the device credit capped amount used for pricing the claim.

Medicare administrative contractors will be mass adjusting any processed claims not reflecting a difference that met the above criteria within 60 days after successful implementation of the payer-only value code "QD" into production on or about July 6, 2015. No action is required by providers.

Outpatient prospective payment system April 2015 update

Provider types affected

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

Provider action needed

Change request (CR) 9097 describes changes to and billing instructions for various payment policies implemented in the April 2015 outpatient prospective payment system (OPPS) update. Make sure your billing staffs are aware of these changes.

Background

The April 2015 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 9097.

The April 2015 revisions to I/OCE data files, instructions, and specifications are provided in CR 9107. Upon release of CR 9107, a *MLN Matters*® article related to CR 9107 will be available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9107.pdf* on the Centers for Medicare & Medicaid Services (CMS) website. The key changes to and billing instructions for various payment policies implemented in the April 2015, OPPS update are as follows:

Changes to device edits for April 2015

The most current list of device edits can be found under "Device and Procedure Edits" at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS*. Failure to pass these edits will result in the claim being returned to the provider.

New device pass-through categories

The Social Security Act (Section 1833(t)(6)(B); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Social Security Act requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device pass-through category as of April 1, 2015. Table 1 provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

Table 1 – New device pass-through categories

HCPCS	Effective date	SI	Short descriptor	Long descriptor
C2623	04/01/15	H	Cath, translumin, drugcoat	Catheter, transluminal angioplasty, drug-coated, non-laser

a. Device offset from payment

Section 1833(t)(6)(D)(ii) of the Social Security Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8). CMS has determined that a portion of the APC payment amount associated with the cost of C2623 is reflected in procedures assigned to various peripheral transluminal angioplasty codes in APC 0083, APC 0229, and APC 0319. The C2623 device may be billed with various peripheral transluminal balloon angioplasty codes that are assigned to these three APCs for 2015. The device offset from payment represents a deduction from pass-through payments for the device in category C2623.

New services

No new services have been assigned for payment under the OPPS effective April 1, 2015.

Drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) effective April 1, 2015

For 2015, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP plus 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical.

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In 2015, a single payment of ASP plus 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2015 and drug price restatements can be found in the April 2015 update of the OPPS Addendum A and Addendum B at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*.

b. Drugs and biologicals with OPPS pass-through status effective April 1, 2015

Six drugs and biologicals have been granted OPPS pass-through status effective April 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and biologicals with OPPS pass-through status effective April 1, 2015

HCPCS code	Short descriptor	Long descriptor	APC	Status indicator
C9445	C-1 esterase, Ruconest	Injection, c-1 esterase inhibitor (human), Ruconest, 10 units	9445	G
C9448	Oral netupitant palonosetron	Netupitant (300mg) and palonosetron (0.5 mg), oral	9448	G
C9449	Inj, blinatumomab	Injection, blinatumomab, 1 mcg	9449	G
C94501	Fluocinolone acetonide implt	Injection, fluocinolone acetonide intravitreal implant, 0.19 mg	9450	G
C9451	Injection, peramivir	Injection, peramivir, 1 mg	9451	G
C9452	Inj, ceftolozane/ tazobactam	Injection, ceftolozane/ tazobactam, 5 mg	9452	G

1. HCPCS code C9450 is associated with Iluvien® and should not be used to report any other fluocinolone acetonide intravitreal implant (for example, Retisert®). Hospitals should note that the dosage descriptor for Iluvien is 0.01 mg.

Because each implant is a fixed dose containing 0.19 mg of fluocinlone acetonide, hospitals should report 19 units of C9450 for each implant.

c. Drugs and biologicals based on ASP methodology with restated payment rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis.

The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

d. Revised status indicator (SI) for HCPCS codes J0365 and J7189

Effective April 1, 2015, the status indicator for HCPCS code J0365 (Injection, aprotonin, 10,000 kiu) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Also, effective April 1, 2015, the status indicator for HCPCS code J7189 (Injection, factor xiii (antihemophilic factor, human), 1 i.u.) will change from SI=N (Paid under OPPS; payment is packaged into payment for other services) to SI=K (Paid under OPPS; separate APC payment).

These codes are listed in Table 3 below along with the effective date for the revised status indicator.

Table 3 – Drugs and biologicals with revised status indicators

HCPCS code	Long descriptor	APC	Status indicator	Effective date
J0365	Injection, aprotonin, 10,000 kiu		E	4/1/2015
J7189	Injection, factor xiii (antihemophilic factor, human), 1 i.u.	1416	K	4/1/2015

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e. Reassignment of skin substitute products from the low cost group to the high cost group

Two existing skin substitute products have been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. These products are listed in Table 4 below.

Table 4 – Updated skin substitute product assignment to high cost status effective April 1, 2015

HCPCS code	Short descriptor	Status indicator	Low/high cost status
Q4150	Allowrap DS or Dry 1 sq cm	N	High
Q4153	Dermavest 1 square cm	N	High

f. Other changes to 2015 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

Effective April 1, 2015, HCPCS code Q9975 Factor VIII FC Fusion Recomb, will replace HCPCS code C9136 Factor viii (Eloctate). The SI will remain G, "Pass-Through Drugs and Biologicals." Table 5 describes the HCPCS code change and effective date.

Table 5 – New HCPCS codes for certain drugs and biologicals effective April 1, 2015

HCPCS code	Short desc.	Long desc.	Stat. ind.	APC	Add. date	Term. date
C9136	Factor viii (Eloctate)	Injection, factor viii, fc fusion protein, (recomt.), per i.u.	G	1656	Jan. 01, 2015	Mar. 31, 2015
Q9975	Factor VIII FC Fusion Recomb	Injection, factor viii, fc fusion protein, (recomt.), per i.u.	G	1656	Apr. 1, 2015	

g. Corrected copayment rate for HCPCS code J7315 effective January 1, 2014 – March 31, 2015

The beneficiary copayment for HCPCS code J7315 was erroneously set to 20 percent of the APC payment rate in the OPPS Pricer from January 1, 2014, through March 31, 2015.The corrected copayment is listed in Tables 6 through 10 below. For claims impacted with HCPCS J7315, APC 1448, instructions for mass adjusting claims will be provided in future notification.

Table 6 – Corrected copayment rate for HCPCS code J7315 effective January 1, 2014 – March 31, 2014

HCPCS code	Stat. ind.	APC	Short desc.	Pmt. rate	Corrected minimum unadjusted copayment
J7315	G	1448	Opthalmic mitomycin	$379.47	$0

Table 7 – Corrected copayment rate for HCPCS code J7315 effective April 1, 2014 – June 30, 2014

HCPCS code	Stat. ind.	APC	Short desc.	Pmt. rate	Corrected minimum unadjusted copayment
J7315	G	1448	Opthalmic mitomycin	$379.66	$0

Table 8 – Corrected copayment rate for HCPCS vode J7315 effective July 1, 2014 – September 30, 2014

HCPCS code	Stat. ind.	APC	Short descriptor	Pmt. rate	Corrected minimum unadjusted copayment
J7315	G	1448	Opthalmic mitomycin	$379.59	$0

Table 9 – Corrected copayment rate for HCPCS code J7315 effective October 1, 2014 – December 31, 2014

HCPCS code	Stat ind.	APC	Short desc.	Pmt. rate	Corrected minimum unadjusted copayment
J7315	G	1448	Opthalmic mitomycin	$366.88	$0

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Table 10 – Corrected copayment rate for HCPCS code J7315 effective January 1, 2015 – March 31, 2015

HCPCS code	Stat ind.	APC	Short descriptor	Pmt rate	Corrected minimum unadjusted copayment
J7315	G	1448	Opthalmic mitomycin	$372.80	$0

h. Corrected copayment rate for HCPCS code C9447 effective January 1, 2015 – March 31 2015

The beneficiary copayment for HCPCS code C9447 was erroneously set to 20 percent of the APC payment rate in the OPPS pricer from January 1, 2015 through March 31, 2015. The corrected copayment is listed in table 11 below, and has been installed in the April 2015 OPPS pricer, effective for services furnished on January 1, 2015 through March 31, 2015.

The MACs will adjust claims with code C9447 that were originally processed prior to installation of the April 2015 OPPS pricer.

Table 11 – Corrected copayment rate for HCPCS code C9447 effective January 1, 2015 – March 31, 2015

HCPCS code	Stat. ind.	APC	Short desc.	Pmt. rate	Corrected minimum unadjusted copayment
C9447	G	1663	Inj, phenyl-ephrine ketorolac	$418.70	$0

i. New vaccine *CPT*® codes

Three new vaccine *CPT*® codes have been established. The following table lists these new vaccine codes, their OPPS status indicator, and effective date.

Table 12 – New vaccine *CPT*® codes

CPT® code	Short desc.	Long desc.	2015 SI	Effective date
90620	Menb rp w/omv vaccine im	*Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use*	E	2/1/2015

CPT® code	Short desc.	Long desc.	2015 SI	Effective date
90621	Menb rlp vaccine im	*Meningococcal recombinant lipoprotein vaccine, serogroup B, three dose schedule, for intramuscular use*	E	2/1/2015
90697	Dtap-ipv-hib-hepb vaccine im	*Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use*	E	1/1/2015

Inpatient only list

CMS is revising billing instructions to allow payment for inpatient only procedures that are provided to a patient in the outpatient setting on the date of the inpatient admission or during the three calendar days (or one calendar day for a non-subsection (d) hospital) preceding the date of the

inpatient admission that would otherwise be deemed related to the admission to be bundled into billing of the inpatient admission, according to Medicare policy for the payment window for outpatient services treated as inpatient services. Effective April 1, 2015, inpatient only

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procedures that are provided to a patient in the outpatient setting on the date of the inpatient admission or during the three calendar days (or one calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission, according to the policy for the payment window for outpatient services treated as inpatient services will be covered by CMS and are eligible to be bundled into the billing of the inpatient admission.
CMS is updating the *Medicare Claims Processing Manual*, (Chapter 4, Sections 10.12 and 180.7) to reflect the revised impatient only payment policy. This revised section is included as an attachment to CR 9097.

Reporting of the "PO" HCPCS modifier for outpatient service furnished at an off-campus provider-based department

As stated in the 2015 OPPS final rule, CMS finalized the instructions related to the reporting of the "PO" modifier (the short descriptor "Serv/proc off-campus pbd," and the long descriptor "Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments.").

The "PO" HCPCS modifier is to be reported with every code for outpatient hospital services furnished in an off-campus PBD of a hospital. Reporting of this new modifier will be voluntary for one year (2015), with reporting required beginning on January 1, 2016. The modifier should not be reported for remote locations of a hospital, satellite facilities of a hospital, or for services furnished in an emergency department.

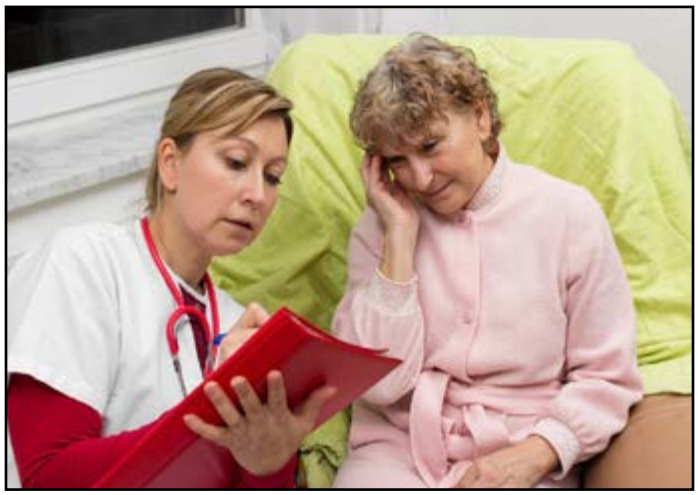
CMS is updating the *Medicare Claims Processing Manual*, (Chapter 4, Section 20.6.11) to include the use of the "PO" HCPCS modifier. The revised manual section is included as an attachment to CR 9097.

Clarification regarding propel and propel mini coding

Hospitals may report C2625 (Stent, non-coronary, temporary, with delivery system) when utilizing the Propel™ and Propel Mini™ drug eluting sinus implants by Intersect ENT. These implants are appropriately described by C2625.

Clarification regarding Cysview® coding

When billing for cystoscopy procedures using Cysview® (hexaminolevulinate hydrochloride), hospitals are reminded to report HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose) on a separate claim line from the cystoscopy procedure code. Consistently reporting charges for C9275 in addition to the appropriate cystoscopy procedure code will ensure that CMS has accurate claims data for future rate-setting.



Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare administrative contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 9097, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3217CP.pdf*.

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

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Related Change Request (CR) #: CR 9097
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Related CR Transmittal #: R3217CP
Implementation Date: April 6, 2015

Medicare physician fee schedule database April update

Provider types affected

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

Provider action needed

Change request (CR) 9104 informs MACs about the release of payment files based upon the 2015 Medicare physician fee schedule (MPFS) final rule. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to MACs based upon the 2015 MPFS final rule, published in the *Federal Register* on December 19, 2014, to be effective for services furnished between January 1, 2015, and December 31, 2015.

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. Under current law, the conversion factor will be adjusted for services furnished on or after April 1, 2015. The files with the new conversion factor will be provided with the April quarterly update.

In the final rule, Centers for Medicare & Medicaid Services (CMS) announced a conversion factor of $28.2239 for this period, resulting in an average reduction of 21.2 percent from the 2014 rates. In most prior years, Congress has taken action to avert large across-the-board reductions in provider fee schedule rates before they went into effect.

CMS supports legislation to permanently change the sustainable growth rate to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care. Changes for certain *Current Procedural Terminology*® (*CPT*®)/HCPCS codes included in the April update to the 2015 MPFSDB are as follows:

- J1826 Procedure status = E
- J9010 Procedure status = N
- *77063* Type of service = 1
- *93355* Multiple surgery ondicator = 2 and type of service = 4
- *93644* type of service = 2

Code G0279 has a new short descriptor of "Tomosynthesis, mammo". In addition, the following codes have a procedure status of "I": *80300, 80301, 80302, 80303, 80304, 80320, 80321, 80322, 80323, 80324, 80325, 80326, 80327, 80328, 80329, 80330, 80331, 80332, 80333, 80334, 80335, 80336, 80337, 80338, 80339, 80340, 80341, 80342, 80343, 80344, 80345,*

80346, 80347, 80348, 80349, 80350, 80351, 80352, 80353, 80354, 80355, 80356, 80357, 80358, 80359, 80360, 80361, 80362, 80363, 80364, 80365, 80366, 80367, 80368, 80369, 80370, 80371, 80372, 80373, 80374, 80375, 80376, and *80377*.

Effective for services on or after April 1, 2015, the following codes will have a procedure status of "X": *81500, 81503, 81506, 81508, 81509, 81510, 81511, 81512, and 81599*.

Also, effective for services on or after April 1, 2015, new code Q9975 is added with a short descriptor of "Factor VIII FC Fusion Recomb" and a long descriptor of "Injection, Factor VIII, FC Fusion Protein (Recombinant), per iu". The procedure status code for Q9975 is "E" and it has a global surgery modifier of "XXX". Finally, S8032 was transposed as S0832 in the January 2015 MPFS; S0832 has been replaced with S8032 in the April 2015 MPFS.

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

Additional information

The official instruction, CR 9104, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3205CP.pdf*.

MLN Matters® Number: MM9104
Related Change Request (CR) #: CR 9104
Related CR Release Date: February 27, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R3205CP
Implementation Date: April 6, 2015

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April 2015 integrated outpatient code editor update

Provider types affected

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

Provider action needed

Change request (CR) 9107 informs the MACs that the I/OCE was updated for April 1, 2015. Make sure that your billing staffs are aware of these changes.

Background

CR 9107 informs the MACs, including the home health & hospice (HH&H) MACs, and the maintainer of the fiscal intermediary shared system (FISS) of the updates to the I/OCE for April 1, 2015.

The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis. The full list of I/OCE specifications can now be found at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html*.

The modifications of the IOCE for the April 2015 release (V16.1) are summarized in the table below. Readers should also read through the entire CR 9107 document and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective date' column.

Effective date	Edits affected	Modification
10/1/2015	1-5, 29, 86	Update the I/OCE program to include preliminary ICD-10-CM diagnosis code content for testing purposes only, for test claims with From Dates on or after 10/1/2015.
10/1/2015		Use the claim 'From Date' is used to determine which diagnosis code set is applied - Claims with 'From Dates' prior to 10/1/2015, use ICD-9-CM diagnosis codes and claims with from dates on or after 10/1/2015 use ICD-10-CM diagnosis codes
10/1/2015	5	Modify the edit criteria to trigger on a specified range of ICD10-CM diagnosis codes for claims with From Dates on or after 10/1/2015 - ICD-10-CM: Any code in the range V00 thru Y99 is principal diagnosis.
4/1/2015	5	Modify the description for edit five when returned for claims containing either ICD-9-CM or ICD-10-CM diagnosis codes (claims with From Dates on or after 10/1/2015, for ICD-10-CM diagnosis codes) - External cause of morbidity code cannot be used as principal diagnosis.
1/1/2015		Update comprehensive ambulatory payment classification (APC) program logic as follows: – Modify program logic to reduce the service units to 1 for primary comprehensive APC procedure line with status indicator (SI) = J1 when service units are >1; assign payment adjustment flag 11 with updated description reflecting action; – Update Appendix L (CR 9107) to provide clarification supporting complexity adjustments; – Update flowchart in Appendix L; and – Add documentation for processing of comprehensive APC procedures when present with payable inpatient procedures with modifier CA and patient status 20 (see item #24 page 10, and Appendix L, step #1).

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Effective date	Edits affected	Modification
1/1/2015		Modify the description for Payment Adjustment flag 11 (See Table 7 and Appendix G of CR 9107).
4/1/2015		Assign payment adjustment flag 11 to composite APC lines where multiple service units passed in have been reduced to one by IOCE program logic (for APCs 34, 172, 173, 175, 176 and 8001, 8004-8009); update flowcharts in Appendix C and Appendix K.
1/1/2014	57	Correct the logic for edit 57 to return on claims for extended assessment and management (EAM) composite APC when G0378 is present with a 1/1 service date. Update the flowcharts in Appendix K for EAM composite and direct referral composite to include reference to edit 57.
8/13/2013	71, 77	Update the code pair content for device/procedure and procedure/device editing associated with edits 71 and 77 retroactively to the earliest version of the IOCE to remove specific code pairs prior to an national coverage determination (NCD) approval date of 8/13/2013, for single chamber and dual chamber permanent cardiac pacemakers; add program logic to the IOCE to capture mid-quarter period of 7/1/2013, to 8/12/2013, to remove specified code pairs from editing for 71 and 77.
2/1/2015	67	Implement mid-quarter approval for codes *90620* and *90621*.
4/1/2015	87	Updates to the skin substitute product list (Appendix P, List E).
4/1/2015	84	Update federally qualified health center (FQHC) PPS logic to deactivate edit 84 for claims with bill type 77x; update Appendix F(a) to note deactivation of edit 84 for FQHC PPS bill type 77x (row 18).
4/1/2015		Update the FQHC PPS flowchart in Appendix M to reflect the deactivation of edit 84.
4/1/2015		Update qualifying code pair list for FQHC PPS in Appendix M.
1/1/2015		Update preventive services list (Appendix P, List C) to add G0473 to the Deductible/ Coinsurance N/A list.
4/1/2015	22	Add modifiers EX and JF to the valid modifier list.
4/1/2015		Make HCPCS/APC/SI changes as specified by CMS (data change files).
4/1/2015	20, 40	Implement version 21.1 of the NCCI (as modified for applicable institutional providers).

Additional information

The official instruction, CR 9107 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3218CP.pdf* on the CMS website.

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: MM9107
Related Change Request (CR) #: CR 9107
Related CR Release Date: March 13, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R3218CP
Implementation Date: April 6, 2015

Educational Events

Provider outreach and educational events – Spring 2015

Medicare "Ask-the-Contractor" teleconference (ACT): Chronic Care Management

When: Wednesday, April 29
Time: 11:30 a.m. - 1:00 p.m. ET – Delivery language: English
Type of Event: Webcast
Location: Jacksonville, Fl
http://medicare.fcso.com/Events/279017.asp

Medicare Speaks: Fort Lauderdale

When: May 19-20
Time: 7:30 a.m. -4:30 p.m. ET – Delivery language: English
Type of Event: Conference/Seminar
http://medicare.fcso.com/Medicare_Speaks/278353.pdf

Two easy ways to register

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

Please note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects™ Provider eNews

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

MLN Connects™ Provider eNews for February 19, 2015

MLN Connects™ Provider eNews for February 19, 2015

View this edition as a PDF

MLN Connects™ National Provider Calls

- ICD-10 Implementation and Medicare Testing – Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Register Now
- Video Slideshow and Follow-up Information Available for IRF-PAI MLN Connects™ National Provider Call

CMS Events

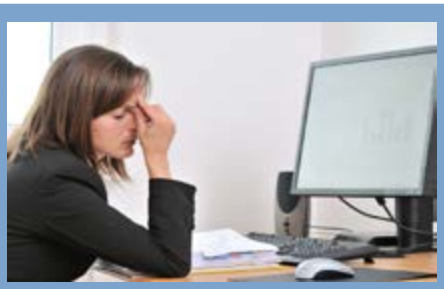
- Participate in ICD-10 Acknowledgement Testing Week: March 2 through 6, 2015
- Webinar for Comparative Billing Report on Modifiers 24 & 25: Specialty Surgeons
- Healthy Aging Summit

Announcements

- New Affordable Care Act Initiative to Encourage Better Oncology Care
- Update for Pharmacists Prescribing Part D Drugs
- Measles: Information for Healthcare Professionals
- Hospitals Must Start Medicare EHR Participation in 2015 to Earn Incentives
- PQRS: Program Year 2014 QRDA III Submission Errors with Incorrect Program Name

Medicare Learning Network® Educational Products

- "Independent Diagnostic Testing Facility (IDTF)" Fact Sheet – Released
- "Chronic Care Management Services" Fact Sheet – Released
- "Provider Compliance Tips for Spinal Orthoses" Fact Sheet – Released
- "Provider Compliance Tips for Enteral Nutrition Pumps" Fact Sheet – Released
- "Provider Compliance Tips for Diabetic Test Strips" Fact Sheet – Released
- "*Medicare Learning Network®* Suite of Products & Resources for Educators and Students" Educational Tool – Reminder
- "*Medicare Learning Network®* Suite of Products & Resources for Billers and Coders" Educational Tool – Reminder
- "*Medicare Learning Network®* Suite of Products & Resources for Inpatient Hospitals" Educational Tool – Reminder
- "*Medicare Learning Network®* Suite of Products & Resources for Compliance Officers" Educational Tool – Reminder
- *Medicare Learning Network®* Products Available In Electronic Publication Format



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*

MLN Connects™ Provider eNews for February 26, 2015

MLN Connects™ Provider eNews for February 26, 2015

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MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Register Now
- Physician Quality Reporting Programs: Reporting Once in 2015 – Registration Now Open

CMS Events

- Participate in ICD-10 Acknowledgement Testing Week: March 2 through 6, 2015

Announcements

- It's Still Flu Season
- CMS Strengthens Five Star Quality Rating System for Nursing Homes
- EHR Incentive Program: Deadline to Register Intent for a Public Health Measure is March 1
- Hospital Engagement Network Solicitation: Responses due March 30
- Medicare Geographic Reclassification under the IPPS Wage Index for FY 2016
- New FAQs on 2015 DMEPOS Medicare Payment Final Rule
- CMS to Release Comparative Billing Report in March on Modifier 25: Nurse Practitioners
- Sterilization of Ophthalmologic Surgical Instruments
- Two New ICD-10 Videos

Medicare Learning Network® Educational Products

- "Medicare Basics Commonly Used Acronyms" Educational Tool – Released
- "Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492" MLN Matters® Article – Revised
- "The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - A Better Way for Medicare to Pay for Medical Equipment" Fact Sheet – Revised
- New Medicare Learning Network® Educational Web Guides Fast Fact
- Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects™ Provider eNews for March 5, 2015

MLN Connects™ Provider eNews for March 5, 2015

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MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Last Chance to Register
- Physician Quality Reporting Programs: Reporting Once in 2015 – Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript
- Providers and Suppliers – Browse the MLN Connects® Call Program Collection of Resources

CMS Events

- Special Open Door Forum: Home Health Electronic Clinical Template and Home Health Paper Clinical Template

Announcements

- Help Your Medicare Patients "Bite into a Healthy Lifestyle" During National Nutrition Month® and Beyond
- Physician Groups that Demonstrate High Quality Care Receive Increases to Their Medicare Payments
- CMS Announces Release of 2015 Impact Assessment of Quality Measures Report
- Register for the Health Care Payment Learning and Action Network
- New EHR Attestation Deadline for Medicare Eligible Professionals: March 20
- Submission Extension for EPs Participating in PQRS via EHR and QCDR: March 20
- Hospital VBP FY 2017 Baseline Measures Report Now Available
- HHAs: Get Started with HHCAHPS Participation
- Request for Comments on ESRD Conditions for Coverage
- Physicians and Teaching Hospitals: Register in Open Payments System
- PQRS Payment Adjustments and Providers Who Rendered Services at IDTFs
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- Special CBSA Codes for Home Health Claims

See **MARCH 5**, next page

MLN Connects™ Provider eNews for March 12, 2015

MLN Connects™ Provider eNews for March 12, 2015

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In this edition:

MLN Connects™ National Provider Calls

- Physician Quality Reporting Programs: Reporting Once in 2015 – Last Chance to Register
- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 – Registration Now Open
- Medicare Shared Savings Program ACO: Application Process – Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- ICD-10 Coordination and Maintenance Committee Meeting
- Webinar for Comparative Billing Report on Modifier 25: Nurse Practitioners

Announcements

- Affordable Care Act Initiative Builds on Success of ACOs
- Physician-owned Hospital Initial Annual Ownership/ Investment Report: Extension of Filing Deadline
- New ST PEPPER Available
- Medicare EHR Incentive Program: Hardship Exceptions for Hospitals due April 1
- EHR Incentive Program: Part B Drugs and Payment Adjustments

Claims, Pricers, and Codes

- April 2015 Average Sales Price Files Now Available
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2014 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- "Guidance on the Physician Quality Reporting System (PQRS) 2013 Reporting Year and 2015 Payment Adjustment for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs)" MLN Matters® Article – Released
- "Global Surgery" Fact Sheet – Revised
- "Guidelines for Teaching Physicians, Interns, and Residents" Fact Sheet – Revised
- "Mental Health Services" Booklet – Revised
- "Medicare Vision Services" Fact Sheet – Reminder
- "HIPAA Privacy and Security Basics for Providers" Fact Sheet – Reminder
- Medicare Learning Network® Products Available In Electronic Publication Format

MARCH 5

From previous page

- FQHC Prospective Payment System File Update

Medicare Learning Network® Educational Products

- "Physician Feedback, Quality and Resource Use Reports (QRURs) and Value-Based Modifier Program – Overview & Implementation" MLN Matters® Article – Released
- "Diagnosis Coding: Using the ICD-10-CM" Web-Based Training Course – Released
- "Medicare Physician Fee Schedule" Fact Sheet – Revised
- "Medicare Enrollment Guidelines for Ordering/ Referring Providers" Fact Sheet – Reminder
- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet – Reminder
- New Medicare Learning Network® Provider Compliance Fast Fact
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects™ Provider eNews for March 19, 2015

MLN Connects™ Provider eNews for March 19, 2015

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In this edition:

MLN Connects™ National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 – Register Now
- Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data – Registration Opening Soon
- Medicare Shared Savings Program ACO: Application Process – Register Now

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July – Forms Due April 17
- eHealth Webinar: eCQM 101 on Quality Reporting Programs
- Medicare Basics for New Providers Webinar – Registration Now Open

Announcements

- Prepare for a Successful Transition to ICD-10 with Medicare Testing Resources
- RAs from January 2015 ICD-10 End-to-End Testing
- Bidding for Round 2 Recompete/National Mail-Order Recompete of the DMEPOS Competitive Bidding Program Closes March 25
- March is National Colorectal Cancer Awareness Month–Encourage Your Patients to Get Screened
- March is Save Your Vision Month
- Flu on the Decline but Still Active
- EHR Incentive Program: Eligible Professionals Attest for 2014 Participation by March 20
- CMS Extends Letter of Intent Deadlines for the Oncology Care Model
- Obtaining Your Quality and Resource Use Report: Updated Information Available
- CMS to Release Ophthalmology Comparative Billing Report in April
- Physician-owned Hospital Initial Annual Ownership/ Investment Report: Extension of Filing Deadline

Claims, Pricers, and Codes

- Mandatory Payment Adjustment Percentage of 2 percent Extended for Medicare FFS Claims (Sequestration)
- Correcting the Display Issue for OPPS Claims Where Value Code “FD” Is Present
- Mass Adjustment of Claims Containing Codes G0473 and 77063

Medicare Learning Network® Educational Products

- March 2015 Version of The *Medicare Learning Network*® Catalog – Released

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
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)*

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

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