Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

February 2016

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Provider types affected

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

Provider action needed

Change request (CR) 9434 announces that the Centers for Medicare & Medicaid Services (CMS) has determined that, effective for dates of service on or after July 9, 2015, evidence is sufficient to add human papillomavirus (HPV) testing under specified conditions. Make sure that your billing staffs are aware of this change.

Background

Medicare covers a screening pelvic examination and Pap test for all female beneficiaries at 12- or 24-month intervals, based on specific risk factors; however, current Medicare coverage does not include the HPV testing.

Section 1861(ddd) of the Social Security Act (the Act) (see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*) states that CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process. The preventive services must meet all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability;
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and,
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS has reviewed the USPSTF recommendations and supporting evidence for screening for cervical cancer with HPV co-testing, and has determined that the criteria were met. Therefore, effective for claims with dates of service

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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.

Guidance on the PQRS 2014 reporting year and 2016 payment adjustment for RHCs, FQHCs, and CAHs

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 and FQHCs

Question:

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

Answer:

If you bill professional services paid under or based on the Part B Medicare physician fees schedule (PFS) submitted via CMS-1500 or CMS-1450 claim form or the electronic equivalents 837P and 837I, you are considered a PQRS eligible professional (EP) and you are subject to PQRS analysis. Technical services, which are covered under Part B Medicare PFS, are not eligible for PQRS.

Additionally, services rendered under billing methodologies other than Part B Medicare PFS will not be included in PQRS analysis (that is, an EP who bills under an organization that is registered as a FQHC, yet he or she renders services that are not covered by the FQHC methodology).

The *2015 Physician Quality Reporting System List of Eligible Professionals* is available on the CMS website.

Question:

I'm an 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 2016 PQRS negative payment adjustment?

Answer:

If an eligible PQRS EP renders services under the Medicare PFS in addition to services under other billing schedules or methodologies, he or she must meet the PQRS reporting requirements for those services that fall under the Medicare PFS to avoid future payment adjustments regardless of the organization's participation in other fee schedules or methodologies.

Question:

Under what circumstances are professional Part B Medicare PFS services furnished by an EP at a setting outside an RHC/FQHC subject to the 2016 PQRS 2.0 percent negative payment adjustment?

Answer:

An EP is subject to the 2016 PQRS 2.0 percent negative payment adjustment if he or she has not satisfactorily reported 2014 PQRS quality measures as required by the EP's selected reporting mechanism (that is, as an individual EP or as an EP who is a part of a PQRS group practice).

For more information about the 2016 PQRS 2.0 percent negative payment adjustment, visit *Physician Quality Reporting System Payment Adjustment Information* on the CMS website.

To find timeline information, refer to the *2015 – 2017 Physician Quality Reporting System (PQRS) Timeline* on the CMS website.

To find general PQRS information, including information about payment adjustments, visit *Physician Quality Reporting System* on the CMS website.

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?

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PQRS

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Answer:

Yes, beginning in 2014, EPs at CAHs who bill Medicare Part B using Method II can participate in PQRS (and the Electronic Health Record [EHR] Incentive Program) if they add their Individual National Provider Identifier (NPI) on the CMS-1450 Institutional Claim form (not the CMS-1500 form). For the 5010 version of the 837 I, Fiscal Intermediary Shared System (FISS) shall accept rendering physician/practitioner information at the line level (loop 2420A) or at the claim level if the rendering physician/practitioner is different from the attending physician/practitioner (loop 2310D).

For the 2014 PQRS program year, EPs who bill using CAH Method II will not be able to report via the claims-based reporting mechanism as the claims system needed to be updated to pull PQRS quality-data codes (QDCs) off the 1450 claim form and only pulled off of the CMS 1500 claim form in 2014. However, EPs who bill using CAH Method II will be able to report PQRS via registry, EHR, qualified clinical data registry (QCDR), and group practice reporting option (GPRO).

If you need assistance determining whether or not your provided services are included in PQRS measures, please contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via *qnetsupport@hcqis.org*. The QualityNet help desk is available from 7:00 a.m. to 7:00 p.m., Monday through Friday.

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 from the rendering NPI at the claim level. For more information about this billing standard requirement, refer to *Fiscal Intermediary Shared System (FISS) and Common Working File (CWF) System Enhancement for Storing Line Level Rendering Physicians/Practitioners National Provider Identifier (NPI) Information*.

Additional information

For additional information about PQRS, visit *Physician Quality Reporting System*.

For more information about EPs under CAH II participating in PQRS, refer to the "CAH-II Reporting for PQRS" toolkit at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html*.

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

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Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

Implementation of fingerprint-based background checks

Provider types affected

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

Provider action needed

Stop – impact to you

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to announce the implementation of fingerprint-based background checks as part of enhanced enrollment screening provisions contained in Section 6401 of the Affordable Care Act.

Caution – what you need to know

Fingerprint-based background checks are generally completed on individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. **A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a high risk provider or supplier**. Note that the high level of risk category applies to providers and suppliers who are newly enrolling durable Medicare equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers or home health agencies (HHA). It also applies to providers and suppliers who have been elevated to the high risk category. CMS may adjust a particular provider or supplier's screening level from "limited" to "high" or "moderate" to "high" if any of the following occur:

- CMS has imposed a payment suspension within the last 10 years;
- Has been excluded from Medicare by the OIG;
- Has had billing privileges revoked by CMS within the previous 10 years;
- Has been excluded from any federal health care program;
- Has been subject to any final adverse action, in the previous 10 years;
- Has been terminated or is otherwise precluded from billing Medicaid; or
- CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within six months from the date the moratorium was lifted.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details.

Background

As part of the enhanced enrollment screening provisions contained in the Affordable Care Act (see *http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf*), the Centers for Medicare & Medicaid Services (CMS) implemented fingerprint-based background checks. The fingerprint-based background checks will be used to detect bad actors who are attempting to enroll in the Medicare program and to remove those currently enrolled. Once fully implemented, the fingerprint-based background check will be completed on all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a provider or supplier. Fingerprint-based background checks are also required for any provider or supplier who has been elevated to the high risk category for any of the following reasons:

- CMS has imposed a payment suspension within the last 10 years;
- Has had billing privileges revoked by CMS within the previous 10 years;
- Has been excluded from any Federal Health Care program;
- Has been subject to any final adverse action, in the previous 10 years;
- Has been terminated or is otherwise precluded from billing Medicaid; or
- CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within six months from the date the moratorium was lifted.

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Please refer to 42 CFR 424.518(c)(3) at *http://www.ecfr.gov/cgi-bin/text-idx?SID=a39ae0804106965d82b5ae6413ba550e&node=42:3.0.1.1.11.12.5.11&rgn=div8* and the *Medicare Program Integrity Manual* (Chapter 15 (Medicare Enrollment), Section 15.19.2.1C (Screening Categories-Background-High)) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf*.

Note: The fingerprint-based background checks will be applied to providers and suppliers in the high level of risk category, which includes newly enrolling DMEPOS suppliers, home health agencies (HHA), and providers and suppliers who have been elevated to the high risk category in accordance with enrollment screening regulations.

The fingerprint-based background check implementation has been phased in beginning in 2014.

Affected providers and suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a notification letter to the affected providers or suppliers listing all 5 percent or greater owners who are required to be fingerprinted. The notification letter will be mailed to the provider or supplier's correspondence address and the special payments address on file with Medicare. Generally, an individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed.

The relevant individuals will have 30 days from the date of the notification letter to be fingerprinted. If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.

The notification letter will identify contact information for the *fingerprint-based background check contractor (FBBC)*. The relevant individual(s) are required to contact the FBBC prior to being fingerprinted to ensure the fingerprints are accurately submitted to the Federal Bureau of Investigation (FBI) and results are properly returned to CMS. Providers/suppliers may contact the FBBC by telephone or by accessing the FBBC's website. Contact information for the FBBC will be provided in the notification letter received from the MAC. Once contacted, the FBBC will provide at least three fingerprint locations convenient to the relevant individual's location. One of these locations will be a local, state, or federal law enforcement facility.

The relevant individuals who are required to undergo the fingerprint-based background check will incur the cost of having their fingerprints taken, and the cost may vary depending on location. **Once an individual has submitted his/her fingerprints, if that individual is subsequently required to undergo a fingerprint-based background check in accordance with 42 CFR 424.518(c), CMS will, to the extent possible, rerun the fingerprint-based background check rather than requiring resubmission of fingerprints.** You can review 42 CFR 424.518(c) at *http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.1.11.12.5.11&rgn=div8*.

Fingerprinting can be completed on the FD-258 form or electronically at certain locations. CMS strongly encourages all required applicants to provide electronic fingerprints, but CMS will accept the FD-258 card instead. If the FD-258 form is submitted, the FBBC will convert the paper form to electronic submission to the FBI. You can review the FD-258 form at *https://www.fbi.gov/about-us/cjis/identity-history-summary-checks/fd-258-1*.

Once the fingerprint process is complete, the fingerprints will be forwarded to the FBI for processing. Within 24 hours of receipt, the FBI will compile the background history based on the fingerprints and will share the results with the FBBC. CMS, through the FBBC, will assess the law enforcement data provided for the fingerprinted individuals. The FBBC will review each record and provide a fitness recommendation to CMS. CMS will assess the recommendation and make a final determination.

- All fingerprint data will be stored according to:
- Federal requirements;
- FBI Security and Management Control Outsourcing Standards for Channelers and Non-Channelers; and
- The FBI Criminal Justice Information Services (CJIS) security policy.

The FBBC will maintain Federal Information Systems Management Act (FISMA) certification and comply with the FBI (CJIS) Security Policy. All data will be secured in accordance with the Privacy Act of 1974 and the FBI CJIS security policy.

CMS will rely on existing authority to deny enrollment applications and revoke existing Medicare billing privileges per 42 CFR §424.530(a) and §424.535(a) (*http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.1.11.12.5.15&rgn=div8*) if an individual who maintains a 5 percent or greater direct or indirect ownership interest in a provider or supplier has submitted an enrollment application that contains false or misleading information. Providers or suppliers will be notified by CMS if the assessment of the fingerprint based background check results in the denial of its enrollment application or revocation of its existing Medicare billing privileges.

Additional information

If you have any questions, please contact your MAC at their toll-free number, which may be found at

See **FINGER**, next page

Extension of provider enrollment moratoria for home health agencies and Part B ambulance suppliers

***Note**: This article was revised February 2, 2016, to reflect an extension of the temporary moratoria for an additional six months, as noted in the article. All other information remains the same. This information was previously published in the August 2015 Medicare B Connection, page 4.*

Provider types affected

This *MLN Matters*® article is intended for home health agencies, home health agency sub-units, and part B ground ambulance suppliers in certain geographic areas of Florida, Illinois, Michigan, Texas, Pennsylvania, and New Jersey that provide services to Medicare, Medicaid, and CHIP beneficiaries.

Provider action needed

Stop – impact to you

Effective January 29, 2016, the temporary moratoria on new home health agencies, home health agency sub-units, and part B ground ambulance suppliers are being extended for an additional six months in certain geographic locations.

Caution – what you need to know

During the six-month temporary moratoria, initial provider enrollment applications and change of information applications to add additional practice locations, received from home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in the moratoria counties will be denied. Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

Go – what you need to do

Effective January 29, 2016, home health agencies, home health agency sub-units, and Part B ground ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the six-month moratoria has expired. CMS will announce in the *Federal Register* when the moratorium has been lifted, extended, or changed.

Background

In accordance with *42 CFR §424.570(c)*, the Centers for Medicare & Medicaid Services (CMS) may impose a moratorium on the enrollment of new Medicare providers and suppliers of a specific type or the establishment of new practice locations in a particular geographic area.

On January 29, 2016, CMS announced, in a *Federal Register* notice (*http://federalregister.gov/a/2016-01835*), the extension of temporary moratoria on the enrollment of new home health agencies, home health agency sub-units and part B ambulance suppliers in designated geographic locations.

The moratoria initially became effective on July 30, 2013, and the implementation was announced in the *Federal Register* which may be accessed at: *https://federalregister.gov/a/2013-18394*. The moratoria were expanded January 30, 2014, and the expansion was announced in the *Federal Register* which may be accessed at: *https://federalregister.gov/a/2014-02166*.

Moratoria extension

Effective January 29, 2016, the temporary moratorium on new home health agencies and home health agency sub-units is being extended for an additional six months in the areas stated in Table 1.

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http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html.

Document history

Date of change	Description
January 27, 2016	The article was revised to update language in the article and to emphasize affected providers and suppliers in the *Caution* section.

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MORATORIA

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Table 1: Home health agencies and home health agency sub-units under temporary moratorium

City and state	Counties
Fort Laud, FL	Broward
Miami, FL	Miami-Dade Monroe
Detroit, MI	Macomb Monroe Oakland Washtenaw Wayne
Dallas, TX	Collin Dallas Denton Ellis Kaufman Rockwall Tarrant
Houston, TX	Brazoria Chambers Fort Bend Galveston Harris Liberty Montgomery Waller
Chicago, IL	Cook DuPage Kane Lake McHenry Will

In addition, the temporary moratorium on new part B ground ambulance suppliers is being extended for an additional six months in the areas stated in Table 2.

Table 2: Part B ambulance suppliers under six-month temporary moratorium

City and state	Counties
Houston, TX	Harris Brazoria Chambers Fort Bend Galveston Liberty Montgomery Waller
Philadelphia, PA	Bucks (PA) Delaware (PA) Montgomery (PA) Philadelphia (PA) Burlington (NJ) Camden (NJ) Gloucester (NJ)

Initial provider enrollment applications and change of information applications to add additional practice locations received from home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in the above listed counties will be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

Note: Home health agencies, home health agency sub-units, and Part B ground ambulance suppliers are afforded appeal rights. However, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. CMS' basis for imposing a temporary moratorium is not subject to review.

Additional information

For more information regarding CMS' use of temporary moratoria, please review *MLN Matters*® article MM7350 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf*.

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

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Prohibition on balance billing dually eligible individuals enrolled in the QMB program

***Note**: This article was revised February 1 and February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under "Important Clarifications Concerning Qualified Medicare Beneficiary (QMB) Balance Billing Law." All other information is the same. This information was previously published in the September 2012 Medicare A Connection, page 13.*

Provider types affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in original Medicare or a Medicare Advantage plan.

What you need to know

Stop – impact to you

This special edition *MLN Matters*® article from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing** (such charges are known as "balance billing"). QMB is a Medicare Savings Program that exempts Medicare beneficiaries from Medicare cost-sharing liability.

Caution – what you need to know

The QMB program is a state Medicaid benefit that covers Medicare deductibles, coinsurance, and copayments, subject to state payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance and copayments under certain circumstances.) Medicare providers may not balance bill QMB individuals for Medicare cost-sharing, regardless of whether the state reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers – not only those that accept Medicaid – must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately balance bill QMB individuals are subject to sanctions.

Go – what you need to do

Refer to the *Background* and *Additional information* sections of this article for further details and resources about this guidance. Please ensure that you and your staffs are aware of the federal balance billing law and policies regarding QMB individuals. Contact the Medicaid agency in the states in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a Medicare Advantage provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments. This practice is known as "balance billing."

Balance billing of QMBs is prohibited by federal law

Federal law bars Medicare providers from balance billing a QMB beneficiary under any circumstances. See **Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997**. (Please note, this section of the Act is available at *http://www.ssa.gov/OP_Home/ssact/title19/1902.htm*.)

QMB is a Medicaid program for Medicare beneficiaries that exempt them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. However, as permitted by federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who violate these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.)

Inappropriate balance billing persists

Despite federal law, erroneous balance billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. See *Access to Care Issues Among qualified Medicare beneficiaries (QMB)*, Centers for Medicare & Medicaid Services July 2015 at

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

Important clarifications concerning QMB balance billing law

Be aware of the following policy clarifications to ensure compliance with QMB balance billing requirements. First,

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know that all original Medicare and MA providers – not only those that accept Medicaid – must abide by the balance billing prohibitions.

In addition, QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different state than the state in which care is rendered.

Finally, note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the *State Medicaid Manual*, which is no longer in effect.

Ways to improve processes related to QMBs

Proactive steps to identify QMB individuals you serve and to communicate with state Medicaid agencies (and Medicare advantage plans if applicable), can promote compliance with QMB balance billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients. Find out what cards are issued to QMB individuals so you can in turn ask all your patients if they have them. Learn if you can query state systems to verify QMB enrollment among your patients. If you are a Medicare advantage provider contact the plan to determine how to identify the plan's QMB enrollees.
2. Discern what billing processes apply to seek reimbursement for Medicare cost-sharing from the states in which you operate. Different processes may apply to original Medicare and MA services provided to QMB beneficiaries. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

- If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare remittance advice.
- Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your state. You may need to complete a state provider registration process and be entered into the state payment system to bill the state.

3. Make sure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

QMB eligibility and benefits

Dual eligibility	Eligibility criteria	Benefits
Qualified Medicare Beneficiary (QMB only)	▪ Resources cannot exceed $7,280 for a single individual or $10,930 in 2015 for an individual living with a spouse and no other dependents. ▪ Income cannot exceed 100% of the federal poverty level (FPL) +$20 ($1,001/month – Individual $1,348/month – couple in 2015). **Note**: **These guidelines are a federal floor. Under Section 1902 (r)(2) of the Social Security Act, states can effectively raise these limits above these baseline federal standards**.	Medicaid pays Medicare Part A and B premiums, deductibles, co-insurance and co-pays to the extent required by the state Medicaid plan. ▪ Exempts beneficiaries from Medicare cost-sharing charges ▪ The state may choose to pay the Medicare advantage (Part C) premium.
QMB Plus	▪ Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage	Provides all benefits available to QMBs, as well as all benefits available under the state Plan to a fully eligible Medicaid recipient

Additional information

For more information about dual eligible categories and benefits, please visit *http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf*. Also, for more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the *Medicare Learning Network®* publication titled *Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles)*.

See **QMB**, next page

'Medicare Benefit Policy Manual' – RHC and FQHC update - Chapter 13

***Note**: This article was revised January 18, 2016, due to an updated change request (CR). The CR deleted Sections 180.5 and 210.2.1 from the chapter as the information has been reorganized to Sections 190.5 and 220.3 respectively. The CR release date, transmittal number and link to the transmittal were also changed. All other information remains the same. This information was previously published in the January 2016 Medicare B Connection, page 4.*

Provider types affected

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

What you need to know

CR 9442 informs MACs that Chapter 13 of the *Medicare Benefit Policy Manual* is updated to include new information, clarification of existing policies, and editorial changes.

Background

New information includes:

- Section 30.1 states that a RHC can count the time of a nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) when furnishing direct patient care in a patient's home or another location towards the requirement that an NP, PA, or CNM be available to furnish care at least 50 percent of the time the RHC is open to provide patient care.
- Section 110.5 states that payment for chronic care management (CCM) services is authorized for RHCs and FQHCs beginning on January 1, 2016, and provides an overview of the requirements.
- Sections 220.1 and 220.3 state that lung cancer screening using low-dose computed tomography is a covered preventive service and can be billed as a stand-alone visit if it is the only service furnished on that day with a RHC or FQHC practitioner, and applicable coinsurance and deductibles are waived.

Clarifying information includes:

- Use of modifier 59 (Section 40.3)
- Payment for procedures (Section 40.4)
- Description of ambulance services that are non-covered (Section 60.1)
- Description of group services that are non-covered (Section 60.1)
- Information on payment codes for FQHCs (Section 70.4)
- Cost reporting requirements (Section 80.1 and 80.2)
- Billable visits by dentists, podiatrist, optometrists, and chiropractors (Section 110.1)
- Description of mental health visits, billing for mental health visits, and payment for medication management (Section 170)
- Hepatitis C screening in RHCs and FQHCs (Sections 220.1 and 220.2).

Additional information

The official instruction, CR 9442, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R220BP.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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QMB

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For general Medicaid information, please visit the Medicaid Web page at *http://www.medicaid.gov/index.html*.

MLN Matters® Number: SE1128 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A

Implementation Date: N/A

Update to 'Medicare Program Integrity Manual,' Chapter 15

Provider types affected

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

Provider action needed

Change request (CR) 9390, from which this article was developed, makes several minor revisions to Chapter 15 of the *Medicare Program Integrity Manual*. These changes include, but are not limited to:

1. Clarifying the process for verifying correspondence telephone numbers
2. Clarifying the process for validating the credentials of technicians of independent diagnostic testing facilities (IDTF); and
3. Identifying the timeframe by which approval letters must be sent and to whom they must be sent.

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

Background

Chapter 15 of the *Medicare Program Integrity Manual* contains instructions regarding the processing of Form CMS-855 applications. CR 9390 makes the following key changes:

1. If online verification of an IDTF technician's credentials is not available or cannot be made, the MAC will request a copy of the technician's certification card.
2. The MAC will not request a social security card to verify an individual's identity or social security number.
3. Absent a CMS instruction or directive to the contrary, the MAC will send enrollment approval letters within 5 business days of approving the enrollment application.
4. For all applications other than the Form CMS-855S, the MAC will send development/approval letters/ revocation letters, etc., to the contact person if one is listed; otherwise, the contractor may send the letter to the provider or supplier at the provider's/supplier's correspondence address or special payments address.

Note: CR 9390 does not involve any legislative or regulatory policies and is restricted to changes in operational procedures.

Many of the other Chapter 15 revisions are small, such as inserting single words or short sentences, etc. Others are more significant and those revisions are in the revised Chapter 15, which is attached to CR 9390.

Additional information

The official instruction, CR 9390, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R636PI.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: MM9390
Related Change Request (CR) #: CR 9390
Related CR Release Date: February 4, 2016
Effective Date: March 4, 2016
Related CR Transmittal #: R636PI
Implementation Date: March 4, 2016

MANUAL

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Document history

Date of change	Description
January 18, 2016	The article was revised January 18, 2016, due to an updated CR. The CR deleted sections 180.5 and 210.2.1 from the chapter as the information has been reorganized to sections 190.5 and 220.3 respectively. The CR release date, transmittal number and link to the transmittal were also changed.

MLN Matters® Number: MM9442 *Revised*
Related Change Request (CR) #: CR 9442
Related CR Release Date: January 15, 2016
Effective Date: February 1, 2016
Related CR Transmittal #: R220BP
Implementation Date: February 1, 2016

Processing Issues

Transcatheter mitral valve repair claims editing incorrectly

Issue

A system error caused claims related to transcatheter mitral valve repair (TMVR), with dates of service on or after October 1, 2015, to edit incorrectly.

Resolution

A fix was implemented January 25, 2016.

Status/date

Closed February 4, 2016; all claims that were being temporarily held have been released.

Provider action

None

Current processing issues

Here is a link to a *table of current processing issues* for both Part A and Part B.

***Source**: Issue was originally posted under TDL 160124, which has no bearing on the agreement with customer service to publish all closed issues.*

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at *http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html*. Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU.

Online Medicare refreshers

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

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

Click here to explore the wide away of training opportunities.

Screening for the human immunodeficiency virus infection

Provider types affected

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

What you need to know

Change request (CR) 9403 informs MACs that the Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is adequate to conclude that screening of HIV infection for all individuals between the ages of 15-65 years is reasonable and necessary for early detection of HIV, and it is appropriate for individuals entitled to benefits under Part A or enrolled in Part B.

Background

On January 1, 2009, CMS was authorized to add coverage of "additional preventive services" through the national coverage determination (NCD) process if certain statutory requirements are met. One of those requirements is that the service(s) be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. Previously, the USPSTF strongly recommended screening for all adolescents and adults at increased risk for HIV infection, as well as all pregnant women. The USPSTF made no recommendation for or against routine HIV screening in adolescents and adults not at increased risk for HIV infection. Effective December 8, 2009, CMS issued a final decision supporting the USPSTF recommendations.

Change request (CR) 6786, Transmittal 1935, Screening for Human Immunodeficiency Virus (HIV) Infection, dated March 23, 2010, provides earlier implementation instructions related to NCD210.7. You may review the *MLN Matters*® article related to Transmittal 1935 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6786.pdf*.

In April 2013, the USPSTF updated these recommendations and recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened (Grade A recommendation). The USPSTF also recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown (Grade A recommendation).

CR 9403 instructs that effective for claims with dates of service on and after April 13, 2015, CMS will cover screening for HIV with the appropriate U.S. Food and Drug Administration (FDA)-approved laboratory tests and point-of-care tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the beneficiary's physician or practitioner within the context of a healthcare setting and performed by an eligible Medicare provider for these services, for beneficiaries who meet one of the following conditions below:

1. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for all adolescents and adults between the ages of 15 and 65, without regard to perceived risk.
2. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for adolescents younger than 15 and adults older than 65 who are at increased risk for HIV infection. Increased risk for HIV infection is defined as follows:
   - Men who have sex with men;
   - Men and women having unprotected vaginal or anal intercourse;
   - Past or present injection drug users;
   - Men and women who exchange sex for money or drugs, or have sex partners who do;
   - Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users;
   - Persons who have acquired or request testing for other sexually transmitted infectious diseases;
   - Persons with a history of blood transfusions between 1978 and 1985;
   - Persons who request an HIV test despite reporting no individual risk factors;
   - Persons with new sexual partners; or
   - Persons who, based on individualized physician interview and examination, are deemed to be at increased risk for HIV infection. The determination of "increased risk" for HIV infection is identified by the health care 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 recommendation should be a reflection of the service provided.
3. A maximum of three voluntary HIV screenings of pregnant Medicare beneficiaries:

See **HIV**, next page

HIV

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- When the diagnosis of pregnancy is known;
- During the third trimester; and
- At labor, if ordered by the woman's clinician.

Note: There is no co-insurance or deductible for tests paid under the clinical laboratory fee schedule (CLFS).

Billing requirements

Effective for claims with dates of service on or after April 13, 2015, MACs will recognize new HCPCS code G0475 (HIV antigen/antibody, combination assay, screening) as a new covered service for HIV screening.

Note: HCPCS G0475 will appear in the January 1, 2017, CLFS; in the January 1, 2016, integrated outpatient code editor (IOCE); in the January 2016 outpatient prospective payment system (OPPS); and in the January 1, 2016, Medicare physician fee xchedule (MPFS). HCPCS code G0475 will be effective retroactive to April 13, 2015, in the IOCE and OPPS.

For services from April 13 - September 30, 2015, inclusive, the diagnosis codes are:

ICD-9 code	Descriptor
V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V23.9	Supervision of unspecified high-risk pregnancy
V69.8	Other problems related to lifestyle
V73.89	Special screening examination for other specified viral diseases
V69.2	High risk sexual behavior

For dates of service on or after October 1, 2015, the diagnosis codes are:

ICD-10-code	Long description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester

ICD-10-code	Long description
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, second trimester
Z34.93	Encounter for supervision of normal pregnancy, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester
Z72.89	Other problems related to lifestyle
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior

On professional claims, the place of service must be either 81 (independent laboratory) or 11 (office).

If claims are received for screenings that exceed the maximum number allowed per year, the claim line item will be denied with the following remittance codes:

- **Claim adjustment reason code (CARC) 119**: "Benefit maximum for this time period or occurrence has been reached."

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HIV

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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. 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." and
- **Group code**: CO (contractual obligation).

Note that the next eligible date for the service will be provided on all common working file (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN).

Claims with HCPCS code G0475 for beneficiaries between the ages of 15 and 65 without regard to risk must also be submitted with a primary diagnosis code of either V73.89 (ICD-9) or Z11.4 (ICD-10). If that primary code is not present, the line item will be denied using the following messages:

- **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."
- **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 (contractual obligation).

Claims with HCPCS code G0475 for beneficiaries less than age 15 or greater than age 65 with increased risk must also be submitted with a primary diagnosis code of either V73.89 (ICD-9) or Z11.4 (ICD-10) and a secondary diagnosis code that denotes the high risk. The ICD-9 secondary codes are V69.2 or V69.8. The ICD-10 secondary diagnosis codes are Z72.51, Z72.89, Z72.52, or Z72.53. If that secondary code is not present, the line item will be denied using the following messages:

- **CARC 6**: "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N129**: "Not eligible due to the patient's age."
- **Group code**: CO (contractual obligation).

Effective for claims with dates of service on or after April 13, 2015, MACs will deny line-items on claims for pregnant beneficiaries denoted by a secondary diagnosis code above denoting pregnancy, if HCPCS code G0475, HIV screening, or *CPT*® code *80081*, obstetric panel, and primary diagnosis code V73.89/ Z11.4, as appropriate, are not present on the claim. Such line item denials will result in the following remittance messages:

- **CARC 11**: "The diagnosis is inconsistent with the procedure. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **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 (contractual obligation).

Institutional claims for G0475 submitted on types of bill (TOB) 12x, 13x, 14x, 22x, and 23x will be paid based on the CLFS with dates of service on or after January 1, 2017. MACs will apply their pricing to claims with dates of service of April 13, 2015, through December 31, 2016. Such claims submitted on TOB 85x will be paid based on reasonable cost for dates of service beginning with April 13, 2015.

Additional information

The official instruction, CR 9403, was issued to your MAC via two transmittals. The first updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R190NCD.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Down loads/R3461CP.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: MM9403
Related Change Request (CR) #: CR 9403
Related CR Release Date: February 5, 2016
Effective Date: April 13, 2015
Related CR Transmittal #: R190NCD and R3461CP
Implementation Date: March 7, 2016 (non-shared A/B MAC edits); July 5, 2016 (CWF analysis and design); October 3, 2016 (CWF coding, testing, implementation, MCS, FISS implementation; January 3, 2017 – Requirement 9403-04.9 July 5, 2016 - for CWF and January 1, 2017, for full implementation

HPV

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on or after July 9, 2015, CMS will cover screening for cervical cancer with HPV co-testing under the following conditions:

CMS has determined that the evidence is sufficient to add HPV testing once every five years as an additional preventive service benefit under the Medicare program, for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test. CMS will cover screening for cervical cancer with the appropriate U.S. Food and Drug Administration (FDA)-approved/cleared laboratory tests, used consistent with FDA-approved labeling, and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations.

A new healthcare common procedure coding system (HCPCS) code, G0476 (HPV combo assay, CA screen), type of service (TOS) 5 (diagnostic lab), has been created for this benefit. This code will:

- Be effective retroactive back to the effective date of July 9, 2015;
- Be included in the January 2016, integrated outpatient code editor, outpatient prospective payment system, and Medicare physician fee schedule database;
- Be MAC-priced from July 9, 2015, through December 31, 2016, and during this period code G0476 is paid only when it is billed by a laboratory entity; and,
- Beginning January 1, 2017, this will be priced and paid according to the clinical laboratory fee schedule (CLFS).

In addition, you should be aware of the following:

1. Your MACs will not apply beneficiary coinsurance and deductibles to claim lines containing HCPCS G0476, HPV screening;
2. Part B MACs shall only accept claims with a Place of Service Code equal to '81', independent lab or '11', Office; and
3. Effective for claims with dates of service on or after July 9, 2015, your MACs will deny line-items on claims containing HCPCS G4076, HPV screening, when reported more than once in a five-year period [at least four years and 11 months (59 months total) must elapse from the date of the last screening]. The next eligible dates for this service are shown on all common working file (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN).

When denying a line-item on a claim for this requirement they will use the following messages:

- Claim adjustment reason code (CARC) 119 – "Benefit maximum for this time period or occurrence has been reached;"

- 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. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD;"
- Group code "CO" if the claim contains a GZ modifier to denote a signed advance beneficiary notice (ABN) is not on file or with group code "PR" (patient responsibility) if the claim has a GA modifier to show a signed ABN is on file.

4. HCPCS code G0476 will be paid only for institutional claims submitted on type of bill codes (TOB) 12x, 13x, 14x, 22x, 23x, and 85x. Institutional claims on other TOBs will be returned to the provider.
5. Effective for claims with dates of service on or after July 9, 2015, your MACs will deny line-items on claims containing HCPCS G4076, HPV screening, when the beneficiary is less than 30 years of age or older than 65 years of age.

When denying a line-item on claims for this requirement, they will use the following messages:

- CARC 6 – "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;"
- RARC N129 – "Not eligible due to the patient's age;"
- Group vode "CO" if the claim contains a GZ modifier to denote a signed advance beneficiary notice (ABN) is not on file or with group code "PR" (patient responsibility) if the claim has a GA modifier to show a signed ABN is on file.

6. Effective for claims with dates of service on or after July 9, 2015, you must report the following diagnosis codes when submitting claims for HCPCS G0476:

See **HPV**, next page

HPV

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- ICD-9 (for dates of service prior to October 1, 2015): V73.81, special screening exam, HPV (as primary), and V72.31, routine gynecological exam (as secondary)
- ICD-10: Z11.51, encounter for screening for HPV, and Z01.411, encounter for gynecological exam (general)(routine) with abnormal findings, OR Z01.419, encounter for gynecological exam (general)(routine) without abnormal findings.

Effective on this date, your MACs will deny line-items on claims containing HCPCS code G0476, HPV screening, when the claim does not contain these codes.

When denying a line-item on claim for this requirement, they will use the following messages:

- 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;"
- 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*. If you do not have web access, you may contact the contractor to request a copy of the NCD;" and
- Group code CO.

7. This NCD does not change current policy as it relates to screening for pap smears and pelvic exams as described in the *Medicare NCD Manual*, Section 210.2, or in the *Medicare Claims Processing Manual*, Chapter 18, Section 30, which you can find at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf*.

Additional information

The official instruction, CR 9434, was issued to your MAC via two transmittals. The first updates the *NCD Manual* and is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R189NCD.pdf* and the second transmittal updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3460CP.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: MM9434
Related Change Request (CR) #: CR 9434
Related CR Release Date: February 5, 2016
Effective Date: July 9, 2015
Related CR Transmittal #: R189NCD and R3460CP
Implementation Date: July 5, 2016 (CWF analysis and design), October 3, 2016 (CWF coding, testing, and implementation, MCS and FISS implementation; January 3, 2017 (requirement 9434-04.8.2), March 7, 2016 (non-shared MAC edits)

Medicare Learning Network®

The *Medicare Learning Network®* (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

Smoking cessation claims editing incorrectly

Note: *This article was revised January 27, 2016, to note that the NCD for cardiac pacemakers, "Single Chamber and Dual Chamber Permanent Cardiac Pacemakers" (NCD20.8.3) was effective August 13, 2013, and remains in effect. In order to address claims processing issues, the Centers for Medicare & Medicaid Services (CMS) has instructed Medicare administrative contractors (MACs) to implement this NCD at the local level until CMS is able to revise the formal claim processing instructions. All aspects of the NCD policy in the NCD Manual, Section 20.8.3, remain in effect. Additionally, CMS is temporarily removing the corresponding Medicare Claims Processing Manual, Chapter 32, Section 320, and all but two business requirements, to avoid confusion and better clarify that the MACs will use their discretionary authority to process these claims. This information was previously published in the November 2015 Medicare A Connection, Page 9.*

Provider types affected

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

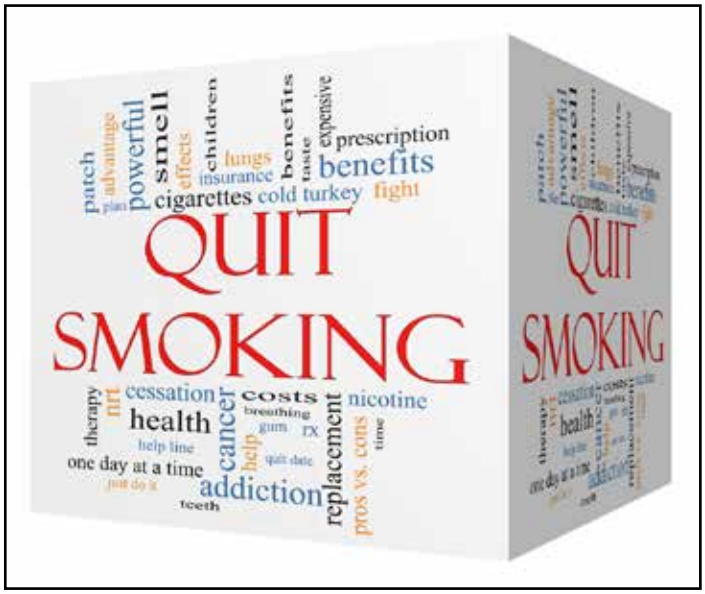
Additional information

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 *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3421CP.pdf*. The second updates the Medicare *National Coverage Determination Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R187NCD.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?

Document history

Date	Description
January 27, 2016	This article was revised to reflect the revised CR 9078 issued December 10, 2015. The CR was revised to further clarify that the MACs are to implement the NCD at the local level until Medicare system instructions are revised and Medicare system changes are implemented. The CR also included a specific implementation date of January 13, 2016 for local implementation.



Date	Description
November 13, 2015	All references to the old claim processing instructions were removed from the article.
October 28, 2015	This article was revised to reflect the revised CR 9078 issued October 26. The CR was revised to direct the MACs to implement the NCD at the local level until Medicare system instructions are revised and Medicare system changes are implemented.
May 26, 2015	This article was revised to add a reference to *MLN Matters*® article MM8525 which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for the indications outlined in the *Medicare National Coverage Determinations Manual*.

MLN Matters® Number: MM9078 *Revised*
Related Change Request (CR) #: CR 9078
Related CR Release Date: December 10, 2015
Effective Date: August 13, 2013
Related CR Transmittal #: R3421CP and R187NCD
Implementation Date: July 6, 2015

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**

Revisions to LCDs

Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the LCD

LCD ID number: L33270 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was revised to add ICD-10-CM diagnosis codes M80.00XA – M80.88XS to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) on or after February 11, 2016.

Effective date

This LCD revision is effective for claims processed **on or after February 8, 2016**, for services rendered **on or after October 1, 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*.

Carboplatin (Paraplatin®, Paraplatin-AQ®) – revision to the LCD

LCD ID number: L33275 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for carboplatin (paraplatin, paraplatin-AQ) was revised to add ICD-10-CM diagnosis code C45 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) on or after February 11, 2016.

Effective date

This LCD revision is effective for claims processed **on or after February 8, 2016**, for services rendered **on or after October 1, 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*.

Take action to combat the flu

Now is the perfect time for providers to vaccinate Medicare beneficiaries, as it can take two weeks after vaccination to develop antibodies that protect against seasonal influenza. As a health care provider, you play an important role in setting an example by getting yourself vaccinated and recommending and promoting influenza vaccination.

Computed tomographic angiography of the chest, heart, and coronary arteries – revision to the LCD

LCD ID number: L33282 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for computed tomographic angiography of the chest, heart, and coronary arteries was revised to include R07.9 in the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology*® (*CPT*®) codes *75571, 75572, 75573*, and *75574*.

Effective date

This LCD revision is effective for claims processed **on or after February 8, 2016**, for services rendered **on or after October 1, 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*.

Diagnostic and therapeutic esophagogastroduodenoscopy – revision to the Part AB LCD

LCD ID number: L33583 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for diagnostic and therapeutic esophagogastroduodenoscopy was revised to add ICD-10-CM diagnosis codes F45.8, F98.21, K44.9 and Z87.11 and ICD-10-CM diagnosis ranges T56.4X1A-T56.4X1S and T65.5X1A-T65.5X1S to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after February 3, 2016**, for services rendered **on or after October 1, 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*.

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp*. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Flow Cytometry – revision to the Part AB LCD

LCD ID number: L33661 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for flow cytometry was revised to add ICD-10-CM diagnosis codes to the "ICD-10 Codes that Support Medical Necessity" section of the LCD. ICD-10-CM code C20 was added for procedure code 88182 and ICD-10-CM diagnosis codes A18.01, C78.2, D46.4, D46.9, and M08.1 and ICD-10-CM diagnosis ranges C56.1-C56.9, K51.00-K51.019, T86.00-T86.819, T86.830-T86.839 and T86.850-T86.99 were added for procedure codes *88184, 88185, 88187, 88188*, and *88189*.

Effective date

This LCD revision is effective for claims processed **on or after February 4, 2016**, for services rendered **on or after October 1, 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, *click here*.

Multiple Part A/B local coverage determinations revised

LCD ID number: L33693, L33695, L33696, L33667 (Florida/Puerto Rico/U.S. Virgin Islands)

The following local coverage determinations (LCDs) are being revised. Review of the LCDs identified an invalid *Current Procedural Terminology*® (*CPT*®) code (*93381*) in the body of the LCDs. Therefore, the LCDs are being revised to replace *CPT*® code *93881* with *93882* in the "Limitations" and "Documentation Requirements" sections of the LCDs.

- Non-Invasive Evaluation of Extremity Veins
- Non-Invasive Extracranial Arterial Studies
- Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries
- Duplex Scan of Lower Extremity Arteries

Effective date

This LCD revision is effective for claims processed **on or after November 12, 2015**, for services rendered **on or after October 1, 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*.

Psychiatric partial hospitalization program – revision to the LCD

LCD ID number: L33972 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for psychiatric partial hospitalization program was revised to add the following ICD-10-CM diagnosis codes to the "ICD-10 Codes that Support Medical Necessity" section of the LCD:

F01.50, F03.90, F03.91, F06.2, F10.230-F10.99, F11.121, F11.122, F11.150-F11.19, F11.920-F11.99, F12.120-F12.19, F12.920-F12.99, F13.121-F13.19, F13.920-F13.99, F14.121-F14.19, F14.920-F14.99, F15.121-F15.19, F15.920-F15.99, F16.121-F16.19, F16.920-F16.99, F17.203-F17.209, F17.213-F17.219, F17223-F17.229, F17.293-F17.299, F18.121-F18.19, F18.920-F18.99, F19.121-F19.19, F19.920-F19.99, F20.0-F20.9, F22-F32.8, F33.0-F33.9, F34.8-F39, F53, F84.0, F84.3-F84.9, G44.209, H93.25, R37, R45.1, R45.2, R45.5 – R45.82, R48.0, and Z87.890.

The updated LCD will be available on the Medicare coverage database (MCD) on or after February 18, 2016.

Effective date

This LCD revision is effective for claims processed **on or after February 4, 2016**, for services rendered **on or after October 1, 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*.

Scanning computerized ophthalmic diagnostic imaging – revision to the LCD

LCD ID number: L33751 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) was revised to add ICD-10-CM diagnosis codes H40.032 and H40.033 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology*® (*CPT*®) code *92132*. In addition, the LCD was revised to add language to the "Indications of Coverage for Posterior Segment SCODI" section of the LCD to clarify retinal disease coverage.

Effective date

The LCD revision related to the addition of ICD-10-CM diagnosis codes H40.032 and H40.033 is effective for claims processed **on or after February 18, 2016**, for services rendered **on or after October 1, 2015**. The LCD revision related the addition of language to clarify retinal disease coverage is effective for claims processed **on or after February 18, 2016**. 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, *click here*.

Screening and diagnostic mammography – revision to the LCD

LCD ID number: L36342 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for screening and diagnostic mammography was revised to add the following additional national ICD-10-CM diagnosis codes to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) code G0279:

C43.52, C43.59, C44.501, C44.509, C44.511, C44.519, C44.521, C44.529, C44.591, C44.599, C45.9, C56.1-C56.9, C78.00-C78.02, C78.1, C78.2, C78.7, C79.31-C79.32, C79.40-C79.49, C79.51-C79.52, C79.60-C79.62, C80.0, C80.1, D03.52, D03.59, D04.5, D22.5, D23.5, D48.5, D49.1, D49.2, D49.6, D49.7, M70.80, M70.88, M70.89, M70.90, M70.98, M70.99, M79.5, M79.81-M79.89, M79.9, N64.81, N64.9, N65.0, N65.1, R59.0-R59.9, R92.0, R93.9, S20.00xA, S20.01xA, S20.02xA, S21.001A, S21.002A, S21.009A, S21.011A, S21.012A, S21.019A, S21.021A, S21.022A, S21.029A, S21.031A, S21.032A, S21.039A, S21.041A, S21.042A, S21.049A, S21.051A, S21.052A, S21.059A, S28.211A, S28.212A, S28.219A, S28.221A, S28.222A, S28.229A, S29.001A, S29.009A, S29.091A, S29.099A, S29.8xxA, S29.9xxA, S39.001A, S39.091A, S39.81xA, S39.91xA, T85.41xA, T85.42xA, T85.43xA, T85.44xA, T85.49xA, T85.79xA, Z03.89, Z08, Z77.123, Z77.128, Z77.9, Z85.831, Z85.89, Z91.89, Z92.89, Z98.82, and Z98.86.

Effective date

This LCD revision is effective for claims processed **on or after February 1, 2016**, for services rendered **on or after October 1, 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, *click here*.

Medicare signature requirements

The Medicare requirement to authenticate the medical record is to ensure the services rendered have been thoroughly documented and authenticated by the author of the medical record entry. *Click here* for information on Medicare's signature requirements and how adhering to these requirements can prevent impacts to your claims.

Transthoracic echocardiography (TTE) – revision to the LCD

LCD ID number: L33768 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for transthoracic echocardiography (TTE) was revised to add ICD-10-CM diagnosis code Z08 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) **on or after February 11, 2016**.

Effective date

This LCD revision is effective for claims processed **on or after January 27, 2016**, for services rendered **on or after October 1, 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, *click here*.

Additional information

Computed tomography – multiple coding guidelines (new and existing)

LCD ID number: L33284, L33285, L33721, L33282, L33283 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 9250, three coding guidelines were developed related to services that do not meet the National Electrical Manufacturers Association (NEMA) Standard. In addition, two coding guidelines were revised to add language related to services that do not meet the NEMA Standard. New coding guidelines were developed for the following local coverage determinations (LCDs): computed tomography of the abdomen and pelvis (L33284), computed tomography of the thorax (L33285), and computed tomography scans of the head or brain (L33721). Two existing coding guidelines were revised for the following LCDs: computed tomographic angiography of the chest, heart and coronary arteries (L33282) and computed tomographic colonography (L33283).

Effective date

This LCD revision is effective for services rendered **on or after January 1, 2016**. 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, *click here*.

Open public meeting notification draft list amended – one draft deleted

Local coverage determination (LCD) draft, NSCLC, Comprehensive Genomic Profile Testing, will not be posted for comment at this time. The draft may be presented in a later policy cycle. The LCD drafts that will be available for a 45-day comment period beginning February 12, 2016, are listed below.

- Chiropractic services (new LCD)
- Left atrial appendage closure or occlusion (new LCD)
- Noncovered services (revised LCD)

Revision to editing to include new specimen collection code G0471

Provider types affected

This *MLN Matters*® article is intended for independent clinical laboratories, skilled nursing facilities (SNFs) and home health agencies (HHAs) submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 9471, from which this article was developed, updates fiscal intermediary shared system (FISS) reason code 32436 to include HCPCS code G0471 in the list of specimen collection fee codes that will allow the travel allowance to be paid on outpatient claims. **Notify your MAC if your claims for lab travel allowance (HCPCS codes P9603 or P9604), for dates of service on or after April 1, 2014, were returned or rejected when billed with specimen collection fee HCPCS code G0471.**

Background

Medicare covers a specimen collection fee and travel allowance for laboratories that collect samples from nursing home or homebound patients (see detail in *Chapter 16*, Section 60.2 of the *Medicare Claims Processing Manual*). FISS reason code 34236 requires a specimen collection fee Healthcare Common Procedure coding System (HCPCS) code to be present on all outpatient claims when a lab travel allowance HCPCS (P9603 or P9604) is also present.

CR 8837, issued August 29, 2014, provided instructions for adjusting payment for a sample collected from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA). CR 9471 implements a new HCPCS code for specimen collection, G0471 – "Collection of venous blood by Venipuncture or urine sample by catheterization from an individual in a SNF or by a laboratory on behalf of a home health agency (HHA)." It has come to CMS' attention that claims for lab travel allowance codes P9603 and P9604 are being returned to providers (RTP) when billed with G0471.

CR 9471 updates FISS reason code 32436 to include HCPCS code G0471 in the list of specimen collection fee codes that will allow the lab travel allowance to be paid on outpatient claims.

Note: Upon implementation of CR 9471, your MAC will:

- Reprocess claims that are brought to their attention for dates of service on and after April 1, 2014, which were previously returned to you in error.
- Override timely filing, if necessary, to reprocess claims previously returned to you in error.

Additional information

The official instruction, CR 9471, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1619OTN.pdf*.

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

MLN Matters® Number: MM9471
Related Change Request (CR) #: CR 9471
Related CR Release Date: February 5, 2016
Effective Date: April 1, 2014
Related CR Transmittal #: R1619OTN
Implementation Date: For claims processed on or after July 5, 2016

Applying therapy caps to Maryland hospitals and billing requirement for rehabilitation agencies and CORFs

Provider types affected

This *MLN Matters*® article is intended for rehabilitation agencies and comprehensive outpatient rehabilitation facilities (CORFs) and to Maryland hospitals that provide therapy services and submit claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 9489 contains no new policy. It corrects the implementation of the policy established in *CR 9223*.

- Modifies the requirements of CR 9223 to ensure therapy caps are applied correctly to claims from certain Maryland hospitals. This does not constitute a change in policy for Maryland hospitals.
- Adds instructions to the *Medicare Claims Processing Manual* to clarify billing requirements for rehabilitation agencies and CORFs when these providers operate multiple sites in differing payment localities.

Make sure your billing staffs are aware of these changes and clarifications.

Background

CR 9223 applied the therapy caps and related policies to Maryland outpatient hospital claims (types of bill (TOB) 012x and 013x submitted with CMS certification numbers (CCNs) beginning with 21). The CR applied cap amounts based on the submitted charge amount on covered outpatient therapy service lines, before applying coinsurance or deductible. This is the correct application of the cap amounts for the majority of Maryland hospitals.

Certain specialty hospitals in Maryland are not paid under the Maryland all-payer model. These hospitals are paid for therapy services using the Medicare physician fee schedule (MPFS) amounts. The therapy cap amounts for these claims should be the MPFS amount, before applying coinsurance or deductible, not the submitted charge. Since these hospitals also have CCNs beginning with 21, the implementation of CR 9223 caused Medicare systems to begin using the submitted charge amount instead.

As a result of this error, the therapy cap and threshold total for beneficiaries served by these specialty hospitals is incorrect. In many cases the totals may be overstated.

The requirements in CR 9489 correct the error in Medicare systems and instruct the MACs to adjust claims to correct the therapy cap totals for affected beneficiaries. These adjustments will be made within 30 days of the implementation date of CR 9489.

In addition, CR 9489 adds instructions to the *Medicare Claims Processing Manual* to add a new billing requirement for rehabilitation agencies and CORFs when these providers operate multiple sites in differing payment localities as determined by the MPFS. These MPFS payment localities are determined by the nine-digit ZIP code where services are provided. Specifically, when rehabilitation agencies and CORFs furnish a service in an off-site location that is in a different nine-digit ZIP code from that of the primary or parent location, the off-site location ZIP code must be reported on the claim. Since these providers are paid subject to the MPFS, the new billing requirement ensures that payments are adjusted based on the applicable payment locality. Until now, rehabilitation agencies and CORFs did not have a mechanism to accurately report the nine-digit ZIP code for the services they provide in off-site locations with differing payment localities. Where a rehabilitation agency or CORF has only one service location, the ZIP code of the primary site of record is used as the MPFS payment locality.

Additional information

The official instruction, CR 9489, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3454CP.pdf*.

MLN Matters® Number: MM9489
Related Change Request (CR) #: CR 9489
Related CR Release Date: February 4, 2016
Effective Date: Dates of service on or after January 1, 2016 for Maryland hospitals; dates of service on or after July 1, 2016, for rehabilitation agencies and CORFs
Related CR Transmittal #: R3454CP
Implementation Date: July 5, 2016

Required billing updates for rural health clinics

Provider types affected

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

Provider action needed

Stop – impact to you

Change request (CR) 9269 provides instructions to the MACs to accept Healthcare Common Procedure Coding System (HCPCS) coding on RHC claims.

Caution – what you need to know

Effective April 1, 2016, RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), are required to report the appropriate HCPCS code for each service line along with the revenue code, and other required billing codes. Payment for RHC services will continue to be made under the all-inclusive rate (AIR) system when all of the program requirements are met. There is no change to the AIR system and payment methodology, including the "carve out" methodology for coinsurance calculation, due to this reporting requirement.

Go – what you need to do

Make sure that your billing staffs are aware of these RHC-related changes for 2016.

Background

Beginning on April 1, 2005, through December 31, 2010, RHCs billing under the AIR system were not required to report HCPCS coding when billing for RHC services, absent a few exceptions. Generally, it has not been necessary to require reporting of HCPCS since the AIR system was designed to provide payment for all of the costs associated with an encounter for a single day.

Provisions of the Affordable Care Act of 2010 further modified the billing requirements for RHCs. Effective January 1, 2011, Section 4104 of the Affordable Care Act waived the coinsurance and deductible for the initial preventive physical examination (IPPE), the annual wellness visit (AWV), and other Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. In accordance with this provision, RHCs have been required to report HCPCS codes when furnishing certain preventive services since January 1, 2011.

CMS regulations require covered entities to report standard medical code sets for electronic health care transactions, although CMS program instructions have directed RHCs to submit HCPCS codes only for preventive services. Such standard medical code sets are defined as Level I and Level II of the HCPCS. In the 2016 physician fee schedule (PFS) proposed rule (80 FR 41943), CMS proposed that all RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), be required to submit HCPCS and other codes as required on claims for services furnished. The requirements for RHCs to submit HCPCS codes were finalized in the 2016 PFS final rule with comment period (80 FR 71088).

CR 9269 changes

Basic guidelines on RHC visits and billing for 71x types of bills (TOBs)

An RHC visit is defined as a medically necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and an RHC practitioner during which time one or more RHC services are furnished. A transitional care management (TCM) service can also be an RHC visit. Additional information on what constitutes a RHC visit can be found in the *Medicare Benefit Policy Manual* Chapter 13.

Qualified preventive health services include the IPPE, the AWV, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. For a complete list of preventive services and their coinsurance and deductible requirements, see the "RHC Preventive Services Chart" on the CMS RHC Web page at: *https://www.cms.gov/center/provider-type/rural-health-clinics-center.html*.

Beginning on April 1, 2016, RHCs are required to report the appropriate HCPCS code for each service line along with a revenue code on their Medicare claims. RHC qualifying medical visits are typically evaluation and management (E/M) type of services or screenings for certain preventive services. RHC qualifying mental health visits are typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis. Refer to the RHC qualifying visit list below for a list of HCPCS codes that are defined as qualifying visits, which corresponds with the following guidance on service level information. Updates to the qualifying visit list are generally made on a quarterly basis and posted on the *CMS RHC Web page*. RHCs can subscribe to the center page for email updates.

Service level information

- The professional component of qualifying medical services and approved preventive health services are billed under revenue code 052x.
- Qualifying mental health services are billed under revenue code 0900.
- Telehealth originating site facility fees are billed under revenue code 0780.

See **RHC**, next page

RHC

From previous page

Billing qualifying visits under the HCPCS reporting requirement

Medical services

RHCs shall report one service line per encounter/visit with revenue code 052x and a qualifying medical visit from the RHC qualifying visit list. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line. (See Example 1, page 30)

Medical services and preventive services

If an approved preventive service is furnished with a medical visit, the RHC shall report the preventive service on an additional 052x service line with the associated charges.

Preventive services furnished with a medical visit are ineligible to receive an additional encounter payment at the AIR, except for the IPPE. (See Example 2, page 30)

Preventive services

When a preventive health service is the only qualifying visit reported for the encounter, the payment and applicable coinsurance and/or deductible will be based upon the associated charges for this service line. Frequency edits will apply. (See Example 3, page 31)

Mental health services

RHCs shall report one service line per mental health encounter/visit with revenue code 0900 and a qualifying mental health visit from the RHC qualifying visit list. (See Example 4, page 31)

Multiple medical services

RHCs shall report one service line per encounter/visit with revenue code 052x and a qualifying medical visit from the RHC qualifying visit list, and one service line for each additional medical service. (See Example 5, page 31)

Medical services and incident to services

Services and supplies furnished incident to a RHC visit are considered RHC services. They are included in the payment of a qualifying visit and are not separately billable. The qualifying visit line must include the total charges for all the services provided during the encounter/visit. RHCs can report incident to services using all valid revenue codes except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x. Payment for these service lines is included in the AIR and the service lines will receive CARC 97 for the covered lines not receiving the AIR payment on RHC claims. (See Example 6, page 31)

Billing for multiple visits on the same day

Encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day, constitute a single RHC visit and is payable as one visit, except for the following circumstances:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit, revenue code 052x, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.
- The patient has a qualifying medical visit and a qualifying mental health visit on the same day. The RHC shall follow the guidelines in the *Billing Qualifying Visits* under the *HCPCS Reporting Requirement* section of this article to bill for a medical and mental health visit.
- The patient has an IPPE and a separate medical and/or mental health visit on the same day. IPPE is a once in a lifetime benefit and is billed using HCPCS code G0402 and revenue code 052x. The beneficiary coinsurance and deductible are waived.

Coinsurance

When reporting a qualifying medical visit and an approved preventive service, the 052x revenue line with the qualifying medical visit must include the total charges for all of the services provided during the encounter, minus any charges for the approved preventive service.

The charges for the approved preventive service must be deducted from the qualifying medical visit line for the purposes of calculating beneficiary coinsurance correctly. For example, if the total charge for the visit is $150.00, and $50.00 of that is for a qualified preventive service, the beneficiary coinsurance is based on $100.00 of the total charge.

Returned claims

MACs will return to the RHC all claims with service lines that do not contain a valid HCPCS code. MACs will also return to the RHC all claims that contain more than one qualifying visit HCPCS code (from the RHC qualifying visit

See **RHC**, next page

RHC

From previous page

list) billed under revenue code 052x for medical service lines (excluding approved preventive services and modifier 59) and mental health services billed under revenue code 0900 with the same date of service.

For any service lines not receiving the AIR payment on RHC claims, the following remittance codes will be used:

- **Group code CO** – contractual obligation
- **CARC 97** – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
- **RARC M15** – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

Additional information

The official instruction, CR 9269, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1596OTN.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.

Document history

Date of change	Description
February 10, 2016	The article was revised to add examples 5 and 6 on page 5 and to correct the language regarding the coinsurance amount in the text under “Coinsurance” on page 6.

MLN Matters® Number: MM9269
Related CR Release Date: January 26, 2016
Related Transmittal #: R1596OTN
Change Request (CR) #: CR 9269
Implementation Date: April 1, 2016
Effective Date: April 4, 2016

Examples

Example 1

Revenue code	HCPCS	Service date	Service units	Total charges	Payment	Coinsurance/deductible applied
052x	*99213*[1]	04/01/2016[2]	1	$XX.XX[3]	AIR	Yes

[1]HCPCS code from the RHC qualifying visit list
[2]Any date of service on or after 04/01/2016
[3]Enter charge amount

Example 2

Revenue code	HCPCS	Service date	Service units	Total charges	Payment	Coinsurance/deductible applied
052x	*99213*[1]	04/01/2016[2]	1	$XX.XX[3]	AIR	Yes
052x	G0101	04/01/2016[2]	1	$XX.XX[3]	Included in the AIR	No

[1]HCPCS code from the RHC qualifying visit list
[2]Any date of service on or after 04/01/2016
[3]Enter charge amount

See **RHC**, next page

RHC

From previous page

Example 3

Revenue code	HCPCS	Service date	Service units	Total charges	Payment	Coinsurance/deductible applied
052x	G0101	04/01/2016[1]	1	$XX.XX[2]	AIR	No[3]

[1]Any date of service on or after 04/01/2016
[2]Enter charge amount
[3]Coinsurance and deductible are waived when appropriate

Example 4

Revenue code	HCPCS	Service date	Service units	Total charges	Payment	Coinsurance/deductible applied
0900	90834[1]	04/01/2016[2]	1	$XX.XX[3]	AIR	Yes

[1]HCPCS code from the RHC qualifying visit list
[2]Any date of service on or after 04/01/2016
[3]Enter charge amount

Example 5

Revenue code	HCPCS	Service date	Service units	Total charges	Payment	Coinsurance/deductible applied
052x	*99213*[1]	04/01/2016[2]	1	$XX.XX[3]	AIR	Yes
052x	*12002*	04/01/2016[2]	1	$XX.XX[3]	Included in the AIR	No

[1]HCPCS code from the RHC qualifying visit list
[2]Any date of service on or after 04/01/2016
[3]Enter charge amount

Example 6

Revenue code	HCPCS	Service date	Service units	Total charges	Payment	Coinsurance/deductible applied
052x	*99213*[1]	04/01/2016[2]	1	$XX.XX[3]	AIR	Yes
0300	*36415*	04/01/2016[2]	1	$XX.XX[3]	Included in the AIR	No

[1]HCPCS code from the RHC qualifying visit list
[2]Any date of service on or after 04/01/2016
[3]Enter charge amount

Accredited Standards Committee healthcare claims acknowledgement flat file update

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.

What you need to know

Change request (CR) 9454 updates the Accredited Standards Committee (ASC) X12 Healthcare Claims Acknowledgement (277CA) flat file to allow for larger monetary amounts to meet Medicare's needs. The 277CA amount fields are currently the same size as the size used for the input files.

Additional information

The official instruction, CR 9454, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals-Items/R1609OTN.*

MLN Matters® Number: MM9454
Related Change Request (CR) #: CR 9454
Related CR Release Date: February 4, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R1609OTN
Implementation Date: July 5, 2016

Authorized officials signatures on EDI enrollment and DDE request for access forms

First Coast Service Options Inc. (First Coast) would like to remind providers that only an authorized official or a delegated official, as listed on the CMS 855, can sign the electronic data interchange (EDI) enrollment form, direct data entry (DDE) access request form and other EDI forms.

The CMS defines an authorized official as "*an appointed official, such as a chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner, to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and commit the organization to fully abide by the statutes, regulations, and instructions of the Medicare program.*"

The EDI forms certification statement states that "by signing the form the signee certifies that he or she have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.), and to commit the provider to abide by the laws, regulations, and the program instructions of Medicare."

The new EDI forms are designed to be completed online, and can be signed electronically. There are three methods for submitting your EDI forms:

- **By mail to**: First Coast Medicare EDI, P.O. Box 44071, Jacksonville, FL 32231-4071
- **By fax to**: (904) 361-0470
- **By email to**: *EDIenrollmentteamfaxes@fcso.com*

Starting on March 15, 2016, any DDE Request for Access form or any other EDI forms submitted on an outdated form or not signed by an authorized or delegated official will be returned for corrections. A new form will be required.

For questions contact First Coast Medicare EDI Support team at (888) 670-0940.

Source: *IOM 100-04, Chapter 24, Section 30.2.C* and *IOM 100-08, Chapter 15, Section 15.1.1*

Off-cycle update to the inpatient prospective payment system fiscal year 2016 pricer

Provider types affected

This *MLN Matters*® article is intended for hospitals submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries and which are paid using the fiscal year (FY) 2016 inpatient prospective payment system (IPPS) pricer.

Provider action needed

Change request (CR) 9523 implements changes to the FY 2016 IPPS pricer in compliance with Section 601 of the Consolidated Appropriations Act 2016. Make sure that your billing staff are aware of these changes.

Background

On December 18, 2015, the *Consolidated Appropriations Act, 2016* was signed into law. As part of that act, Section 601 - Modification of Medicare Inpatient Hospital Payment Rate for Puerto Rico Hospitals modifies the payment calculation with respect to operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for discharges on or after January 1, 2016.

The amount of the payment (with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges on or after January 1, 2016) will be based on 100 percent of the national standardized amount. Puerto Rico hospitals will no longer be paid with a Puerto Rico specific standardized amount.

At this time, there are no changes to the IPPS payment calculation for capital-related costs of inpatient hospital services of Puerto Rico hospitals, and the capital IPPS payment for Puerto Rico hospitals for all discharges occurring during FY 2016 continue to be based on a blend of 25 percent of the capital IPPS Puerto Rico rate and 75 percent of the capital IPPS federal rate.

The IPPS FY 2016 pricer will include conforming changes to certain FY 2016 IPPS operating rates and factors that result from the application of the new Puerto Rico hospital operating IPPS payment calculation requirement. These changes are applicable to all IPPS hospital discharges on or after January 1, 2016. MACs will reprocess all IPPS claims with a discharge date on or after January 1, 2016 through the implementation of the revised pricer by May 31, 2016.

In addition, new state code '84' for Puerto Rico (assigned in *CR 9300* will be added to the IPPS Pricer.

Also, In the 2016 outpatient PPS final rule (and implemented in *CR 9408, Transmittal 3390, issued November 2, 2015*), the Centers for Medicare & Medicaid / Services (CMS) provided for a transition period for certain former Medicare-dependent, small rural hospitals (MDHs) to mitigate the financial impact of losing MDH status in FY 2015 as a result of the loss of their rural status under the new OMB delineations. Under this transitional payment, for FY 2016 discharges occurring on or after January 1, 2016, through September 30, 2016, qualifying former MDHs receive an add-on payment equal to two-thirds of "the MDH add-on" (that is, two-thirds of 75 percent of the amount by which the federal rate payment is exceeded by the hospital's hospital-specific rate payment). The Pricer logic for hospitals that CMS identified as qualifying for this add-on payment for FY 2016 has been revised to correct an inadvertent technical error in the calculation of certain payment amounts for such hospitals.

MACs will reprocess all inpatient claims from the former MDHs that CMS identified as eligible for the transition payment (as described in *CR 9408*) with a discharge date on or after October 1, 2015, through the implementation of the revised FY 2016 IPPS pricer in CR 9523 by May 31, 2016.

Additional information

The official instruction, CR 9523, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3449CP.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: MM9523
Related Change Request (CR) #: CR 9523
Related CR Release Date: February 4, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3449CP
Implementation Date: April 4, 2016

Off-cycle update to the LTCH PPS FY 2016 pricer

Provider types affected

This *MLN Matters*® article is intended for hospitals that submit claims to Medicare administrative contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries and paid for under the long-term care hospital (LTCH) prospective payment system (PPS) using the LTCH PPS fiscal year (FY) 2016 pricer.

Provider action needed

Change request (CR) 9527 updates certain rates and factors used in the inpatient prospective payment system (IPPS) comparable amount calculation in the LTCH PPS FY 2016 pricer applicable to discharges occurring on or after January 1, 2016. It also updates the LTCH PPS FY 2016 high-cost outlier fixed-loss amount for site-neutral rate discharges, and modifies the IPPS comparable amount calculation for Puerto Rico hospitals consistent with the new IPPS payment requirement. Please make sure your billing staffs are aware of these updates.

Background

Section 601 of Public Law 114-113, The Consolidated Appropriations Act of 2016, modified the IPPS payment calculation with respect to operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges on or after January 1, 2016, to use 100 percent of the applicable federal payment rate. Certain payment adjustments under the LTCH PPS are calculated using IPPS payment rates and factors, which are updated as a result of this new IPPS payment calculation requirement.

In addition, new state code "84" for Puerto Rico (assigned in *CR 9300*) will be added to the LTCH pricer.

CR 9527:

- Updates certain rates and factors in the LTCH PPS FY 2016 pricer used in the calculation of the IPPS comparable amount under Section 412.529(d)(4), which is used to determine short-stay outlier (SSO)-adjusted standard federal rate payment amounts and site neutral payment rate amounts;
- Updates the LTCH PPS FY 2016 high-cost outlier fixed-loss amount for site-neutral rate discharges to $22,538, which is the same as the updated IPPS outlier fixed-loss cost threshold for FY 2016; and
- Modifies the IPPS comparable amount calculation for Puerto Rico hospitals consistent with the new IPPS payment requirement.

The updated LTCH PPS payment rate and factor changes are applicable to discharges occurring on or after January 1, 2016. Your MAC will reprocess all LTCH inpatient claims with a discharge date on or after January 1, 2016, through the implementation of the pricer revised by CR 9527 by May 31, 2016.

The Centers for Medicare & Medicaid Services (CMS) reminds providers that fiscal year changes to the LTCH PPS system occur annually in October. Specific instructions will be published shortly after the publication of the LTCH final rule each year. In addition, other changes to the LTCH PPS system may occur in January, April, or July, as necessary.

Additional information

The official instruction, CR 9527, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3445CP.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: MM9527
Related Change Request (CR) #: CR 9527
Related CR Release Date: January 29, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3445CP
Implementation Date: April 4, 2016

April 2016 quarterly ASP Medicare Part B drug pricing files

Provider types affected

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

Provider action needed

Medicare will use the April 2016 quarterly average sales price (ASP) and not otherwise classified (NOC) pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 4, 2016, with dates of services from April 1, 2016, through June 30, 2016.

Change request (CR) 9536 instructs MACs to implement the April 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January 2016, October 2015, July 2015, and April 2015 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are in the *Medicare Claims Processing Manual*, Chapter 4, Section 50.

The following table shows how the files will be applied.

Files	Effective date for dates of service
April 2016 ASP and ASP NOC	April 1, 2016, through June 30, 2016
January 2016 ASP and ASP NOC	January 1, 2016, through March 31, 2016
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015

Additional information

The official instruction, CR 9536 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3450CP.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: MM9536
Related Change Request (CR) #: CR 9536
Related CR Release Date: February 4, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3450CP
Implementation Date: April 4, 2016

Additional changes to the 2016 Medicare physician fee schedule database

Revised 2016 Medicare physician fee schedule database (MPFSDB) files were made available to the Medicare administrative contractors (MACs) January 6, 2016.
Since then, the Centers for Medicare & Medicaid Services (CMS) has identified additional updates to the *Current Procedural Terminology* (*CPT*®) codes:

41530: the non-facility PE (practice expense) RVU (relative value units) is changed to 24.63

76948 and *76948*-26: the work RVU is changed to 0.67

These changes result in revised allowances for these codes. The revised fees, effective retroactive to January 1, may be found using our *fee lookup tool*.

Educational Events

Provider outreach and educational events – March 2016

Medicare Part A changes and regulations

When: Tuesday, March 15
Time: 10:00 a.m. -11:30 a.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/0316267.asp

Two easy ways to register

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

Please note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects® Provider eNews

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

MLN Connects® Provider eNews for January 28, 2016

MLN Connects® Provider eNews for January 28, 2016
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In this edition:

MLN Connects® Events

- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Last Chance to Register

Other CMS Events

- Special Open Door Forum: Understanding the IMPACT Act
- LTCH Quality Reporting Program Webinar
- Physician Compare Public Reporting Information Sessions

Medicare Learning Network® Publications and Multimedia

- CMS Provider Minute: Duplicate Professional Claims Video — New
- Medicare Advance Beneficiary Notices Booklet — Revised
- Skilled Nursing Facility Billing Reference Fact Sheet — Revised
- Suite of Products & Resources for Billers & Coders Educational Tool — Revised
- Suite of Products & Resources for Compliance Officers Educational Tool — Revised
- Suite of Products & Resources for Educators & Students Educational Tool — Revised
- Suite of Products & Resources for Inpatient Hospitals Educational Tool — Revised
- Updated MLN Matters® Search Indices
- New Educational Web Guides Fast Fact

Announcements

- CMS Releases Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries
- PQRS: Submission Timeframes for 2015 Data
- Comment Period for IMPACT Act Measures Extended to January 29
- PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31
- CMS to Release a Comparative Billing Report on Modifier 25: Internal Medicine in February
- CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1
- Prior Authorization for Certain DMEPOS Items: FAQs on the Final Rule
- PEPPERs Available for SNFs, HHAs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
- Payment for Group 3 Power Wheelchair Cushions and Accessories
- Changes to the Medicare EHR Incentive Program Hardship Exception Process
- Testing QRDA I Release 2 and QRDA III Release 1 Files

Claims, Pricers, and Codes

- New Drug Testing Laboratory Codes Editing Incorrectly

MLN Connects® Provider eNews for February 4, 2016

MLN Connects® Provider eNews for February 4, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- New Audio Recordings and Transcripts Available

Other CMS Events

- Medicare Quality Reporting Programs Webinar: What Eligible Providers Need to Know in 2016

Medicare Learning Network® Publications and Multimedia

- Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the QMB Program *MLN Matters®* Article – Revised
- Implementation of Fingerprint-Based Background Checks *MLN Matters®* Article – Revised
- The Medicare Home Health Benefit Web-Based Training Course – Revised
- Remittance Advice Information: An Overview Fact Sheet – Revised
- Medicare Advance Beneficiary Notices Booklet – Revised
- How to Use the Searchable Medicare Physician Fee Schedule Booklet – Revised

Announcements

- CMS Announces Proposed Improvements to Medicare Shared Savings Program
- CMS Releases Home Health Patient Experience of Care Star Ratings
- New Proposal to Give Providers and Employers Access to Information to Drive Quality and Patient Care Improvement
- Comment Period for IMPACT Act Measures Extended to February 5
- Comment Period for RFI on Reporting of Quality Measures Extended to February 16
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- Register in Open Payments System to Review and Dispute 2015 Data
- 2015 PQRS Data: Submission Deadlines
- Applying for an EHR Hardship Exception: FAQs
- Temporary Moratoria Extended on Enrollment of New Home Health Agencies and Part B Ambulance Suppliers
- Stop Hepatitis C Virus Transmission in Patients Undergoing Hemodialysis
- Flu Season Begins: Severe Influenza Illness Reported
- February is American Heart Month

Expand your knowledge of Medicare

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

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

Click here to explore educational Web guides.

MLN Connects® Provider eNews for February 11, 2016

MLN Connects® Provider eNews for February 11, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- Provider Enrollment Revalidation Call — Registration Now Open

Other CMS Events

- Physician Compare Public Reporting Information Sessions

Medicare Learning Network® Publications and Multimedia

- Telehealth Services Fact Sheet — Revised
- Ambulance Fee Schedule Fact Sheet — Revised
- Reading a Professional Remittance Advice Booklet — Reminder

Announcements

- 39 Million Medicare Beneficiaries Utilized Free Preventive Services in 2015
- Nursing Facility Initiative Annual Report
- EHR Incentive Programs: Clinical Decision Support Interventions
- EHR Incentive Programs: New Tipsheet on Eligibility for Broadband Access Exclusions
- Implementation of Section 2 of the Patient Access and Medicare Protection Act
- Influenza Activity Continues

Claims, Pricers, and Codes

- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

MLN Connects® Provider eNews for February 18, 2016

MLN Connects® Provider eNews for February 18, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- Provider Enrollment Revalidation Call — Register Now
- New Audio Recording and Transcript Available

Other CMS Events

- Comparative Billing Report on Electrodiagnostic Testing Webinar

Medicare Learning Network® Publications and Multimedia

- Medicare Basics Commonly Used Acronyms Educational Tool — Revised
- PECOS Technical Assistance Contact Information Fact Sheet – Reminder
- Medicare Enrollment for Physicians and Other Part B Suppliers Fact Sheet – Reminder

Announcements

- Medicare Reporting and Returning of Self-Identified Overpayments
- IMPACT Act Technical Expert Panel Call for Nominations through February 26
- Submitting Comments on MACRA Episode Groups: Deadline Extended to March 1
- 2015 PQRS EHR Submission Deadline Extended to March 11
- EHR Incentive Programs Attestation Deadline Extended to March 11
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- EHR Incentive Programs: Updated FAQs Available

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
904-791-8123

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