Medicare A Connection

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

March 2016

In this issue

Provider enrollment revalidation – cycle 2

Provider types affected

This *Medicare Learning Network* (*MLN*) *Matters*® special edition article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs), Medicare carriers, fiscal intermediaries, and the national supplier clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider action needed

Stop – impact to you

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements that are captured within this article.

Caution – what you need to know

Special note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

Go – what you need to do

1. Check *http://go.cms.gov/MedicareRevalidation* for the provider/suppliers due for revalidation;
2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either

See **REVALIDATION**, Page 3

Contents

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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.

REVALIDATION

From front page

of these occur:

- Submit a revalidation application through Internet-based PECOS located at *https://pecos.cms.hhs.gov/pecos/login.do*, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
- Complete the appropriate CMS-855 application available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html*;
- If applicable, pay your fee by going to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*; and
- Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Background

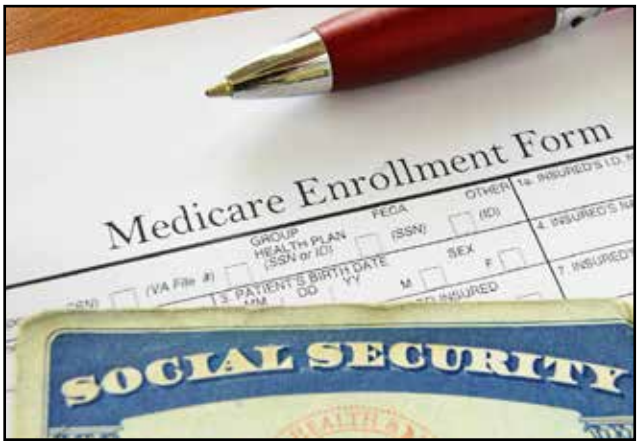
Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

What's ahead for your next Medicare enrollment revalidation?

Established due dates for revalidation

CMS has established due dates by which the provider/supplier's revalidation application must reach the MAC in order for them to remain in compliance with Medicare's provider enrollment requirements. The due dates will generally be on the **last day of a month** (for example, June 30, July 31, or August 31). Submit your revalidation application to your MAC within six months of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

- The list will be available at *http://go.cms.gov/MedicareRevalidation* and will include **all** enrolled providers/suppliers. Those due for revalidation will



display a revalidation due date, all other providers/suppliers not up for revalidation will display a "TBD" (to be determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at *http://go.cms.gov/MedicareRevalidation*.

***Important**: The list identifies billing providers/suppliers **only** that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list*.

- Due dates are established based on your last successful revalidation or initial enrollment (approximately three years for DME suppliers and five years for all other providers/suppliers).
- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier's due date.

  Revalidation notices sent via email will indicate "**URGENT: Medicare Provider Enrollment Revalidation Request**" in the subject line to differentiate from other emails. If all of the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

  Note: Providers/suppliers who are within two months of their listed due dates on *http://go.cms.gov/MedicareRevalidation* but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.
- To assist with submitting complete revalidation

See **REVALIDATION**, next page

REVALIDATION

From previous page

applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

Large group coordination

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming six month period. A spreadsheet detailing the applicable provider's name, national provider identifier (NPI) and specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on *http://go.cms.gov/MedicareRevalidation* to determine their provider/supplier's revalidation due dates.

Unsolicited revalidation submissions

All unsolicited revalidation applications submitted more than six months in advance of the provider/supplier's due date will be ***returned***.

- What is an unsolicited revalidation?
  - If you are not due for revalidation in the current 6 month period, your due date will be listed as "TBD" (to be determined). This means that you do not yet have a due date for revalidation. Please do not submit a revalidation application if there is NOT a listed due date.
  - Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
- If your intention is to submit a change to your provider enrollment record, you must submit a 'change of information' application using the appropriate CMS-855 form.

Submitting your revalidation application

Important: Each provider/supplier is required to revalidate their entire **Medicare enrollment record**.

A provider/supplier's enrollment record includes information such as the provider's individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided).This means the provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and provider transaction access numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to *https://pecos.cms.hhs.gov/pecos/login.do*. PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html*.

Getting access to PECOS:

To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as "I&A". The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.

To learn more about establishing an I&A account or to verify your ability to submit applications using PECOS, please refer to *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*.

If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the

See **REVALIDATION**, next page

REVALIDATION

From previous page

revalidation notice. You may also find a list of MAC's at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1-866-484-8049 or at *EUSSupport@cgi.com*.

Deactivations due to non-response to revalidation or development requests

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. **Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.**

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

Note: The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will not be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider's liability.

Revalidation timeline and example

Providers/suppliers may use the following table /chart as a guide for the sequence of events through the revalidation progression.

Action	Timeframe	Example
Revalidation list posted	Approximately six months prior to due date	March 30, 2016
Issue large group notifications	Approximately six months prior to due date	March 30, 2016
MAC sends email/letter notification	75-90 days prior to due date	July 2-17, 2016
MAC sends letter for undeliverable emails	75–90 days prior to due date	July 2-17, 2016
Revalidation due date		September 30, 2016
Apply payment hold/issue reminder letter (group members)	Within 25 days after due date	October 25, 2016
Deactivate	60–75 days after due date	November 29–December 14, 2016

Application fees

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $554.00 for calendar year (CY) 2016. CMS has defined "institutional provider" to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

Summary

- CMS will post the revalidation due dates for the upcoming revalidation cycle on *http://go.cms.gov/MedicareRevalidation* for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire **Medicare enrollment record, including all reassignment and practice locations**. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier's billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.

See **REVALIDATION**, next page

REVALIDATION

From previous page

- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.
- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional information

To find out whether a provider/supplier has been mailed a revalidation notice go to *http://go.cms.gov/MedicareRevalidation*. A sample revalidation letter is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf*. A revalidation checklist is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html*.

For more information about the enrollment process and required fees, refer to *MLN Matters*® article MM7350, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf*.

For more information about the application fee payment process, refer to *MLN Matters*® article SE1130, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf*.

The *MLN*® fact sheet titled *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations* is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare program and is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf*.

To access PECOS, your authorized official must register with the PECOS Identification and Authentication system. To register for the first time go to *https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin* and create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the *Medicare Provider-Supplier Enrollment* Web page at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*.

If you have questions, contact your MAC. Medicare provider enrollment contact information for each state can be found at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf*.

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Effective Date: N/A
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Implementation Date: N/A

New provider contact center hours

U.S. Virgin Islands providers

The provider contact center (PCC) hours of availability for U.S. Virgin Islands providers has been revised. The hours for calling into First Coast's PCC is 8:00 a.m. - 4:00 p.m. atlantic standard time (AST). This change coincides with the start of daylight saving time (DST) in the eastern United States.

Mandatory sequestration payment reduction continues indefinitely

Medicare fee-for-service (FFS) claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will continue to incur a 2 percent reduction in Medicare payment until further notice.

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

The claims payment adjustment will continue to be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare secondary payment adjustments. Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction.

The Centers for Medicare & Medicaid Services (CMS) encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries on the impact of sequestration on Medicare's reimbursement. Questions about reimbursement should be directed to your Medicare administrative contractor (*http://go.usa.gov/cymuF*).

Processing Issues

Issue with national coverage determination 230.9 – cryosurgery of the prostate

Issue

The fiscal intermediary shared system (FISS) narrative in reason codes (RCs) 34912, 59055, and 59056 incorrectly lists two procedure codes, 0V507ZZ (destruction of prostate, via natural or artificial opening), and 0V508ZZ (destruction of prostate, via natural or artificial opening endoscopic).

Resolution

Medicare administrative contractors (MACs) have been instructed to inactivate RCs 34912, 59055, and 59056, to allow claims to bypass the edit until it can be corrected. The Centers for Medicare & Medicaid Services (CMS) will include this fix in the October 2016 release via an upcoming change request (CR).

Status/date resolved

Open

Provider action

Your MAC shall identify and reprocess any incorrect denials pertaining to NCD 230.9 and procedure codes 0V507ZZ and 0V508ZZ that are brought to our attention.

Current processing issues

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

Pharmacogenomic testing for warfarin responsiveness claims editing incorrectly

Issue

A system error caused claims submitted with HCPCS code G9143 for dates of service on or after October 1, 2015, to edit incorrectly.

Resolution

Your Medicare administrative contractor (MAC) will correct all affected claims.

Status/date resolved

Closed; First Coast has no impacted claims.

Provider action

None. Your Medicare administrative contractor (MAC) will correct all affected claims.

Current processing issues

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

Timely response to additional documentation request

First Coast Service Options (First Coast), frequently requires a clinical review of records to determine the medical necessity of services. When documentation is required an additional documentation request (ADR) letter is mailed. Before records are returned, they should be reviewed to ensure billing accuracy. This includes verification of any conflicting patient information as well as claim form billing information. Your office should also verify that the appropriate signatures are included. When reviewing medical records, First Coast must be able to clearly identify who performed the services, especially in those situations where there are two signatures. If the record is unclear an attestation statement should be included to identify who rendered the services.
The Centers for Medicare & Medicaid Services (CMS) allows a provider 45 days to submit the records. The 45 day clock starts with the date of the ADR letter. The claims processing system is set to automatically deny on day 46 if the records have not been received and matched to the claim. Therefore, in order to prevent claims from denying, it is extremely important to allow ample time for records to be received and matched with the claim. First Coast has seen a tremendous increase in the number of claims denied for timeliness. Serious consideration should be given to the method of submission. When responding after day thirty, please take into consideration other means of submission such as SPOT (Secure Provider Online Tool), fax, esMD, etc. A minimum of five days should be allowed for mail time.

Providers must keep their addresses and phone numbers current through notification to provider enrollment to ensure that these letters are received timely. Delays resulting from having to deliver letters to a forwarding address will significantly decrease the timeframe for submitting the records.

For claims processed where the records have been submitted timely, CMS requires the contractor to make a determination within 30 days. Claims denied for timeliness cost the contractor additional resources to process and are allowed 60 days for processing.

It is the goal of First Coast to ensure that providers are properly reimbursed for medically reasonable and necessary services.

Billing non-covered hospital outpatient dental services

The Medicare program's coverage of dental services is limited. Medicare will pay for dental services if they are an integral part of a covered service or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Otherwise, items and services in connection with the care, treatment, filling, removal or replacement of teeth or structures supporting the teeth are not covered.

First Coast understands that providers may need to bill Medicare for the non-covered dental services to receive a denial in order to then bill a secondary insurance for the patient. Please make sure you are properly billing for these non-covered dental services to ensure the claims are processed correctly and inaccurate payments are not made.

Billing Part A and B

When billing for services that are statutorily excluded or do not meet the definition of any Medicare benefit, you may use the GY modifier. The GY modifier is appended to each line item on the claim that meets the definition.

Specifically for Part A only, these services should be listed on the claim itself as non-covered. The condition code 21 may also be used on the claim to obtain a denial from Medicare for submission to a subsequent insurer. These claims are referred to as no-payment claims.

If you have any additional questions about the coverage or non-coverage of dental services, please review the resources listed below.

Sources: The Centers for Medicare & Medicaid Services' (CMS') *Medicare Dental Coverage Web page*; Internet-only Manuals (IOMs) Pub. 100-02, *Chapter 1*, *Chapter 15*, & *Chapter 16*; Pub. 100-04, *Chapter 1*

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.

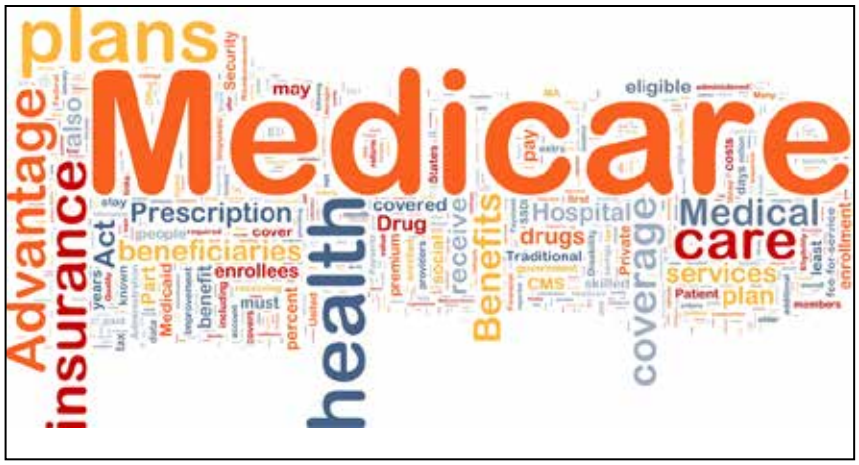
Effective and notice dates

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**

New LCD

BRCA1 and BRCA2 Genetic Testing – new Part A/B LCD

LCD ID number: L36499 (Florida, Puerto Rico/ U.S. Virgin Islands)

This local coverage determination (LCD), BRCA1 and BRCA2 genetic testing, has been adopted by MAC JN. Evidence in the published, peer-reviewed scientific literature indicates that BRCA1 and BRCA2 genetic testing is appropriate for a specific subset of adult individuals who have been identified to be at high risk for hereditary breast and ovarian cancers. BRAC1 and BRAC2 genetic testing is a covered service for a known mutation in a family for individuals with signs and/or symptoms of breast cancer, a personal history of epithelial ovarian, fallopian tube, or primary peritoneal cancer, personal history of pancreatic cancer or prostate cancer meeting certain criteria. Medicare is a defined benefit program and requires that testing is only performed on patients with signs and symptoms of disease. Therefore, testing of unaffected individuals or family members is not a covered Medicare service.

The LCD addresses a general overview of BRCA1 and BRCA2 testing, criteria for indications of coverage, limitations of coverage, multi-gene panel testing, and test results and management.

Effective date

This new LCD is effective for services rendered **on or after April 11, 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*.

Hyperbaric Oxygen (HBO) Therapy – new Part A/B LCD

LCD ID number: L36504 (Florida, Puerto Rico/ U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) Innovation Center has taken on responsibility for implementing a number of specific demonstration projects authorized and funded by statute. The findings from these demonstrations inform possible changes in health care payment and policy, as well as the development and testing of new models, if appropriate.

Non-emergent hyperbaric oxygen therapy was one focus due to the high incidences of improper payments for these services as reported by the Department of Health and Human Services Office of Inspector General, as well as concerns about beneficiaries receiving services that are not medically necessary. The prior authorization model for non-emergent hyperbaric oxygen therapy was implemented in Illinois, Michigan, and New Jersey [J6, J8, and JL-Novitas (First Coast sister company)]. First Coast (MAC JN) did not participate in the prior authorization model.

However, First Coast's data analysis identified an increase in utilization of hyperbaric oxygen therapy. The Medicare Part B Extraction Summary System (BESS) statistical medical data obtained for dates of service July 01, 2014, through December 31, 2014 indicated a carrier-to-nation ratio for Florida at *1.92 (between 50-100 percent above the national average) and for Puerto Rico *3.50 (between 200-250 percent above the national average) for procedure code 99183. Due to the risk of a high dollar claim payment error, First Coast took this opportunity to adopt Novitas' local coverage determination (LCD) given it is consistent with standards of care as identified during the demonstration project.

Hyperbaric Oxygen (HBO) Therapy LCD addresses indications and limitations of coverage and/or medical necessity, limitations, Current Procedural Terminology® (CPT®) codes, documentation guidelines, and utilization guidelines. Of note: ICD-10 codes are not included in this LCD. It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claims(s) submitted. For the list of CMS hard-coded diagnosis codes, please refer to National Coverage Determination (NCD) 20.29 Hyperbaric Oxygen Therapy for covered diagnoses and make reference to TN 1580 (CR 9252).

Effective date

This new LCD is effective for services rendered **on or after April 11, 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, please *click here*.

Revisions to LCDs

Bisphosphonates (IV) and monoclonal antibodies (HCPCS code J3489 [Reclast®]) – 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 change ICD-10-CM diagnosis code range M88.1-M88.9 to ICD-10-CM diagnosis code range M88.0-M88.9 for HCPCS code J3489 (Reclast®) in 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 March 10, 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*.

Botulinum toxins – revision to the Part A and Part B LCD (J0585, J0588)

LCD ID number: L33274 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was revised based on reconsideration requests to include the indication, upper limb spasticity in adult patients for Xeomin, which was approved by the Food and Drug Administration (FDA) on December 22, 2015, and the indication, lower limb spasticity in adult patients for Botox, which was FDA approved January 21, 2016. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add these indications.

Also, "spastic hemiplegia", and "spasticity related to stroke" were removed from the "Off Label Indications for Botox" section of the LCD and added to the "FDA Indications for Botox" section of the LCD. In addition, ICD-10-CM diagnosis codes G80.1, I69.061-I69.065, I69.161-I69.165, I69.261-I69.265 and I69.361-I69.365 were added under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure code J0585.

Effective date

The LCD revision for Xeomin is effective for claims processed **on or after March 29, 2016**, for services rendered **on or after December 22, 2015**. The LCD revision for Botox is effective for claims processed **on or after March 29, 2016**, for services rendered **on or after January 21, 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, please *click here*.

Botulinum Toxins – revision to the LCD

LCD ID number: L33274 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Botulinum Toxins was revised based on a reconsideration request to include the indication upper limb spasticity in adult patients for Dysport, which was FDA approved on July 15, 2015. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add this indication.

Effective date

This LCD revision is effective for claims processed **on or after February 24, 2016**, for services rendered **on or after July 15, 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*.

Erythropoiesis Stimulating Agents – revision to the LCD

LCD ID number: L36276 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Erythropoiesis Stimulating Agents was revised to remove ICD-10-CM diagnosis code D47.0 from "J0881 List 1" in the "ICD-10 Codes that Support Medical Necessity" section of the LCD and replace it with ICD-10-CM diagnosis code D47.1. ICD-10-CM diagnosis code D47.0 was mistakenly added to "J0881 List 1" when the ICD-9-CM diagnosis codes were crosswalked to ICD-10-CM.

Effective date

This LCD revision is effective for claims processed **on or after March 1, 2016**, for services rendered **on or after October 01, 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*.

Genetic testing for Lynch syndrome and special histochemical stains and immunohistochemical stains – revision to the LCDs

LCD ID number: L34912, L36234 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for genetic testing for Lynch syndrome was revised in the "Indications of Coverage" section of the LCD to update verbiage for Lynch syndrome tumor screening to align with the verbiage in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the special histochemical stains and immunohistochemical stains LCD. The updated language in both LCDs reads as follows:

The special histochemical stains and immunohistochemical stains LCD was revised to change the age for Lynch syndrome testing from ≤ 50 to ≤ 70, under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Effective date

This LCD revision for the genetic testing for Lynch syndrome is effective for services rendered **on or after March 8, 2016**. The LCD revision for special histochemical stains and immunohistochemical stains is effective for claims processed **on or after March 8, 2016**, for services rendered **on or after December 6, 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*.

Implantable Miniature Telescope – revision to the LCD

LCD ID number: L33377 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Implantable Miniature Telescope was revised to remove language related to ambulatory surgery centers (ASCs) and HCPCS code C1840 from the "*CPT*®/HCPCS Codes" section of the LCD as the language is no longer applicable since the LCD is now an A/B combined LCD.

Effective date

This LCD revision is effective for claims processed **on or after March 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, please *click here*.

Major Joint Replacement (Hip and Knee) – revision to the LCD

LCD ID number: L33618 (Florida, Puerto Rico/ U.S. Virgin Islands)

Following the October 1, 2015, implementation date of ICD-10-CM diagnosis code sets, First Coast Service Options, Inc., (First Coast) was made aware of inappropriate claims denials related to ICD-10-CM dual procedure code requirements. Since that time, the system editing has been corrected, and the local coverage determination (LCD) CPT® /HCPCS section has been revised to remove to dual procedure code requirement.

Additionally, the dual diagnosis requirement has been removed and ICD-10-CM diagnosis codes Z89.621-Z89.622 (acquired absence of right/left hip joint) were added to support medical necessity for Current Procedural Terminology (CPT®) codes 27130, 27132, 27134, 27137 and 27138. In addition, code range Z89.521-Z89.522 (acquired absence of right/left knee) was added to support medical necessity for CPT® codes 27445, 27447, 27486, and 27487.

No action is required on the part of providers; a mass adjustment will be performed to correct any inappropriately denied claims.

Effective date

This LCD revision is effective for claims processed **on or after March 2, 2016**, for dates of service **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*.

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 based on data analysis by the Program Safeguards Communication Group (PSCG) at First Coast Service Options related to excessive utilization of breast sonography billed on the same day as mammography in Puerto Rico and in Florida. This policy does not outline complete indications and limitations of breast ultrasound but addresses the limitations of screening mammography with breast ultrasound. The Medicare benefit for screening mammography does not include breast ultrasound. As such, routine breast cancer screening with ultrasound (including patients with dense breast tissue) is not a Medicare covered service.

If breast ultrasound is medically reasonable and necessary and done with a screening mammography, the mammography is considered to be a diagnostic test. The request (order) for the ultrasound examination must be originated by a treating physician/NPP. (This requirement is not applicable to hospital based radiologists for inpatient or outpatient breast ultrasound.) If the testing facility has no order for breast ultrasound and cannot reach the treating physician/practitioner to obtain a new order for the addition of breast ultrasound, when needed, and documents this in the medical record, then the testing facility may furnish the additional diagnostic test under certain criteria, which are listed in the finalized LCD.

Effective date

This LCD revision is effective for services rendered **on or after April 11, 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, please *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.

Viscosupplementation therapy for knee – revision to the Part A and Part B LCD

LCD ID number: L33767 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee was revised based on a reconsideration request to remove the following language, "Per the Food and Drug Administration (FDA) package insert, the effectiveness of Monovisc™ has not been established for more than one course of treatment." from the "Limitations" section of the LCD.

Also, the language, "(the effectiveness of Monovisc™ has not been established for more than one course of treatment)" was removed from the "Utilization Guidelines" section of the LCD. In addition, "Monovisc™ was added indicating that it is administered as a single intra-articular injection per course of treatment in the "Utilization Guidelines" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 4, 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*.

Vitamin D; 25 Hydroxy, includes Fraction(s), if performed – revision to the LCD

LCD ID number: L33771 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Vitamin D; Hydroxy, includes Fraction(s), if performed was revised based on data analysis by the Program Safeguards Communication Group (PSCG) at First Coast Service Options, as well as, comprehensive error rate testing (CERT) issues related to the absence of documented medical necessity for vitamin D testing. As stated in the "Limitations" section of the LCD, vitamin D assay testing is not covered for routine screening; therefore, preventive care is not recognized as a covered indication for vitamin D serum testing. Tests that are performed in the absence of signs, symptoms, complaints, personal history of disease, or injury are not covered by Medicare except when there is a statutory provision that explicitly covers tests for screening, as described in the Medicare manual. The following sections of the LCD were revised: "Indications and Limitations of Coverage and/or Medical Necessity," "Documentation Requirements," and "Utilization Guidelines."

Effective date

This LCD revision is effective for services rendered **on or after April 11, 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, please *click here*.

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Additional Information

G-CSF (Neupogen®, Granix™, Zarxio™) – clarification related to HCPCS code Q5101

LCD ID number: L34002 (Florida, Puerto Rico/ U.S. Virgin Islands)

Change request (CR) 9205 (July 2015 Update of the Hospital Outpatient Prospective Payment System [OPPS]) and CR 9152 (Quarterly Update to the Medicare Physician Fee Schedule Database [MPFSDB] – July CY 2015 Update) listed the effective date for HCPCS code Q5101 as March 6, 2015. At that time, the local coverage determination (LCD) for G-CSF (Neupogen®, Granix™, Zarxio™) was updated to include HCPCS code Q5101 with an effective date of March 6, 2015.

Since that time, based on Centers for Medicare & Medicaid Services (CMS) direction, A/B MACs are to use July 1, 2015, as the effective date for HCPCS code Q5101. Therefore, this article serves to clarify that the effective date for the addition of HCPCS code Q5101 to the G-CSF (Neupogen®, Granix™, Zarxio™) LCD is July 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*.

Single chamber and dual chamber permanent cardiac pacemakers – Part A and Part B coding and billing

Article ID number: A54926 (Florida, Puerto Rico/U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) 20.8.3, single chamber and dual chamber permanent cardiac pacemakers, was effective on August 13, 2013.

The CMS A/B Medicare administrative contractors (MACs) have been instructed to implement the NCD at the local level until CMS is able to revise the formal claim processing instructions. All aspects of the NCD policy in Publication 100-03, *NCD Manual*, Section 20.8.3, remain in effect. This article serves as a 45-day notice for the coding and billing instructions for the implementation of NCD 20.8.3.

Effective date

This coding and billing article is effective for services rendered **on or after May 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*.

Left atrial appendage closure or occlusion – retired Part A and Part B draft LCD

LCD ID number: DL36620 (Florida, Puerto Rico/U.S. Virgin Islands)

The draft local coverage determination (LCD) for left atrial appendage closure or occlusion is being retired. The draft LCD was posted for the 45-day comment period the week of February 1, 2016, which was viewable to the public February 11, 2016.

The contractor became aware that the Centers for Medicare and Medicaid Services (CMS) published a final decision memorandum for percutaneous left atrial appendage (LAA) closure therapy (CAG-00445N) February 8, 2016, addressing LAA closure for non-valvular atrial fibrillation (NVAF) through coverage with evidence development (CED) under 1862(a)(1)(E) of the Social Security Act under certain conditions. Due to CMS' final decision memorandum addressing coverage of LAA closure under CED, the contractor has retired the current draft LCD.

Comprehensive care for joint replacement model provider education

Provider types affected

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

What You Need to Know

Change request (CR) 9533 supplies information to providers about the CJR model. The intent of the comprehensive care for joint replacement (CJR) model is to promote quality and financial accountability for episodes of care surrounding a lower-extremity joint replacement (LEJR) or reattachment of a lower extremity procedure. CJR will test whether bundled payments to certain acute care hospitals for LEJR episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. Make sure that your billing staffs are aware of these changes.

Background

Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. Under this authority, CMS published a rule to implement a new five year payment model called the comprehensive care for joint replacement (CJR) model April 1, 2016.

Under the CJR model, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. Episodes will begin with admission to an acute care hospital for an LEJR procedure that is paid under the inpatient prospective payment system (IPPS) through medical severity diagnosis-related group (MS-DRG) 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital.

Key points of CR 9533

CJR episodes of care

LEJR procedures are currently paid under the IPPS through: MS-DRG 469 or MS-DRG 470. The episode will include the LEJR procedure, inpatient stay, and all related care covered under Medicare Parts A and B within the 90 days after discharge. The day of discharge is counted as the first day of the 90-day bundle.

CJR participant hospitals

The model requires all hospitals paid under the IPPS in selected geographic areas to participate in the CJR model, with limited exceptions. A list of the selected geographic areas and participant hospitals is available at *https://innovation.cms.gov/initiatives/cjr*. Participant hospitals initiate episodes when an LEJR procedure is performed within the hospital and will be at financial risk for the cost of the services included in the bundle. Eligible beneficiaries who elect to receive care at these hospitals will automatically be included in the model.

CJR model beneficiary inclusion criteria

Medicare beneficiaries whose care will be included in the CJR model must meet the following criteria upon admission to the anchor hospitalization:

CJR model beneficiary inclusion criteria

- The beneficiary is enrolled in Medicare Part A and Part B;
- The beneficiary's eligibility for Medicare is not on the basis of the end-stage renal disease benefit;
- The beneficiary is not enrolled in any managed care plan;
- The beneficiary is not covered under a United Mine Workers of America health plan; and
- Medicare is the primary payer.

If at any time during the episode the beneficiary no longer meets all of these criteria, the episode is canceled.

CJR performance years

CMS will implement the CJR model for 5 performance years, as detailed in the table below. Performance years for the model correlate to calendar years with the exception of performance year 1, which is April 1, 2016, through December 31, 2016.

CJR model: Five performance years

Performance year	Date for episodes
Performance year one (2016)	Episodes that start on or after April 1, 2016, and end on or before December 31, 2016
Performance year two (2017)	Episodes that end between January 1, 2017, and December 31, 2017, inclusive
Performance year three (2018)	Episodes that end between January 1, 2018, and December 31, 2018, inclusive
Performance year four (2019)	Episodes that end between January 1, 2019, and December 31, 2019, inclusive

See **CJR**, next page

CJR

From previous page

Performance year	Date for episodes
Performance year five (2020)	Episodes that end between January 1, 2020, and December 31, 2020, inclusive

CJR episode reconciliation activities

CMS will continue paying hospitals and other providers and suppliers according to the usual Medicare fee-for-service payment systems during all performance years. After completion of a performance year, Medicare will compare or "reconcile" actual claims paid for a beneficiary during the 90 day episode to an established target price. The target price is an expected amount for the total cost of care of the episode. Hospitals will receive separate target prices to reflect expected spending for episodes assigned to MS-DRGs 469 and 470, as well as hip fracture status. If the actual spending is lower than the target price, the difference will be paid to the hospital, subject to certain adjustments, such as for quality. This payment will be called a reconciliation payment. If actual spending is higher than the target price, hospitals will be responsible for repayment of the difference to Medicare, subject to certain adjustments, such as for quality.

Identifying CJR claims

To validate the retroactive identification of CJR episodes, CMS is associating the demonstration code 75 with the CJR initiative. This code will also be utilized in future CRs to operationalize a waiver of the three-day stay requirement for covered skilled nursing facility (SNF) services, effective for CJR episodes beginning on or after January 1, 2017.

Medicare will automatically apply the CJR demonstration code to claims meeting the criteria for inclusion in the demonstration. **Participant hospitals need not include demonstration code 75 on their claims**. Instructions for submission of claims for SNF services rendered to beneficiaries in a CJR episode of care will be communicated once the waiver of the three-day stay requirement is operationalized.

Waivers and amendments of Medicare program rules

The CJR model waives certain existing payment system requirements to provide additional flexibilities to hospitals participating in CJR, as well as other providers that furnish services to beneficiaries in CJR episodes. The purpose of such flexibilities would be to increase LEJR episode quality and decrease episode spending or provider and supplier internal costs, or both, and to provide better, more coordinated care for beneficiaries and improved financial efficiencies for Medicare, providers, and beneficiaries.

Post-discharge home visits

In order for Medicare to pay for home health services, a beneficiary must be determined to be "home bound." A beneficiary is considered to be confined to the home if the beneficiary has a condition, due to an illness or injury, that restricts his or her ability to leave home except with the assistance of another individual or the aid of a supportive device (that is, crutches, a cane, a wheelchair or a walker) or if the beneficiary has a condition such that leaving his or her home is medically contraindicated. Additional information regarding the homebound requirement is available in the *Medicare Benefit Policy Manual*; *Chapter 7*, Home Health Services, Section 30.1.1, Patient Confined to the Home.

Medicare policy allows physicians and non-physician practitioners (NPPs) to furnish and bill for visits to any beneficiary's home or place of residence under the Medicare physician fee schedule (MPFS). Medicare policy also allows such physicians and practitioners to bill Medicare for services furnished incident to their services by licensed clinical staff. Additional information regarding the "incident to" requirements is available in *42 CFR 410.26*.

For those CJR beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment, CMS will waive the "incident to" direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence any time during the episode, subject to the following conditions:

- Licensed clinical staff will provide the service under the general supervision of a physician or NPP. These staff can come from a private physician office or may be either an employee or a contractor of the participant hospital.
- Services will be billed under the MPFS by the supervising physician or NPP or by the hospital or other party to which the supervising physician has reassigned his or her billing rights.
- Up to 9 post discharge home visits can be billed and paid per beneficiary during each CJR episode, defined as the 90-day period following the anchor hospitalization.
- The service cannot be furnished to a CJR beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.
- All other Medicare rules for coverage and payment of services incident to a physician's service continue to apply.

See **CJR**, next page

CJR

From previous page

As described in the *Medicare Claims Processing Manual*, *Chapter 12*, Sections 40-40.4, Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for CJR, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions. All other Medicare rules for global surgery billing during the 90-day post-operative period continue to apply.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

The service will be billed under the MPFS with a HCPCS G-code (G9490) specific to the CJR post-discharge home visit, as listed in Attachment A. The post-discharge home visit HCPCS code will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for post-discharge home visits for the CJR model will be accepted only when the claim contains the CJR specific HCPCS G-code. Although CMS is associating the demonstration code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code.

Additional information on billing and payment for the post-discharge home visit HCPCS G-code will be available in the April 2016 release of the MPFS recurring update. Future updates to the relative value units (RVUs) and payment for this HCPCS code will be included in the MPFS final rules and recurring updates each year.

Billing and payment for telehealth services

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service. Additional information regarding Medicare telehealth services is available in the *Medicare Benefit Policy Manual*, *Chapter 15*, Section 270 and the *Medicare Claims Processing Manual*, *Chapter 12*, Section 190.

Under CJR, CMS will allow a beneficiary in a CJR episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in a CJR episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

- Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the CJR model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the CJR model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.
- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the CJR episode definition.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).
- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the CJR model that reflect the home setting.
- For CJR telehealth home visits billed with HCPCS codes G9484, G9485, G9488, and G9489, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient's home during the visit or document the reason that such a high-level visit would not require such personnel.
- Physicians billing distant site telehealth services under

See **CJR**, next page

CJR

From previous page

these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.

- The facility fee paid by Medicare to an originating site for a telehealth service will be waived if the service was originated in the beneficiary's home.

The telehealth home visits will be billed under the MPFS with one of nine HCPCS G-code specific to the CJR telehealth home visits. Those codes are G9481, G9482, G9483, G9484, G9485, G9586, G9487, G9488, and G9499. **Attachment A of *CR 9533* provides the long descriptors of these codes**. The telehealth home visit HCPCS codes will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for telehealth home visits for the CJR model will be accepted only when the claim contains one of nine of the CJR specific HCPCS G-Code. **Although CMS is associating the demonstration code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-code**. Additional information on billing and payment for the telehealth home visit HCPCS G-codes will be available in the April 2016 release of the MPFS recurring update. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

Additional information

The official instruction, CR 9533, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R140DEMO.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: MM9533
Related Change Request (CR) #: CR 9533
Related CR Release Date: February 19, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R140DEMO
Implementation Date: April 4, 2016

Payments to long-term care hospitals that do not submit required quality data – replaces CR 9105

Provider types affected

This *MLN Matters*® article is intended for long-term care hospitals (LTCHs) submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 9544 revises Chapter 3, Section 60 of the *Medicare Quality Reporting Incentive Programs Manual* to reflect changes to the payment reduction reconsideration process. It also includes general clarifications to the section. Make sure your billing staffs are aware of these revisions and clarifications.

Background

Section 3004 of the Affordable Care Act amended the Social Security Act (the Act) to authorize a quality reporting program for LTCHs. Section 1886(m)(5)(A)(i) of the Act requires application of a 2 percent reduction of the applicable market basket increase factor for LTCHs that fail to comply with the quality data submission requirements. Fiscal year (FY) 2014 was the first year that the mandated reduction was applied for LTCHs that failed to comply with the data submission requirements during the data collection period of October 1, 2012, though December 31, 2012.

Beginning with FY 2014, and each subsequent year, if an LTCH does not submit required quality data, their payment rates for the year are reduced by 2 percentage points for that fiscal year. Application of the 2-percent reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. In addition, reporting-based reductions to the market basket increase factor will not be cumulative, they will only apply for the fiscal year involved.

Every year, in late Spring/Summer, the Centers for Medicare & Medicaid Services (CMS) will provide MACs with a list of those LTCHs not meeting the quality data reporting requirements. The MAC will then notify the LTCHs that they have been identified as not complying with the requirements of submitting quality data and are scheduled to have Medicare payments to their facility reduced by 2 percentage points. The notification letter will

See **LTCH**, next page

LTCH

From previous page

inform the LTCH that they were identified as not complying with the LTCH quality reporting requirements. The notification letter will also inform the LTCH regarding the process to request a reconsideration of their payment reduction if they disagree with the determination. The reconsideration process will be outlined within that initial notification letter.

There is a 30-day period from the date of the notification letter for the LTCH to submit a letter requesting reconsideration and documentation to support a finding of compliance.

CMS will then review all reconsideration requests received and provide a determination to the MAC typically within a period of two to three months. In its review of the LTCH documentation, CMS will determine whether evidence to support a finding of compliance has been provided by the LTCH. The determination will be made based solely on the documentation provided. If clear evidence to support a finding of compliance is not present, the 2 percentage point reduction will be upheld. If clear evidence of compliance is present, the reduction will be reversed.

After the reconsideration process has occurred and prior to October 1 of each FY, CMS will provide the MACs with a final list of LTCHs that failed to comply with the data submission requirements. The MACs will then be responsible for notifying each LTCH that failed to comply with the quality data submission requirements that it will receive a 2 percentage point reduction in the annual payment update. The MACs will send this second letter only to LTCHs that requested reconsideration. Additionally, the MACs will include information regarding the LTCHs right to further appeal the 2 percentage point reduction via the Provider Reimbursement Review board (PRRB) appeals process.

Additional information

The official instruction, CR 9544 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R55QRI.pdf*.

MLN Matters® Number: MM9544
Related Change Request (CR) #: CR 9544
Related CR Release Date: March 4, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R55QRI
Implementation Date: April 1, 2016

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July update to annual update of HCPCS codes used for SNF consolidated billing enforcement

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries during a skilled nursing facility (SNF) stay.

Provider action needed

Change request (CR) 9561 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing (CB) provision of the SNF prospective payment system (PPS), effective January 1, 2016. Make sure your billing staffs are aware of these HCPCS code updates.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS.

You should be aware that providers other than SNFs may be paid for services that are excluded from SNF PPS and CB, even for those provided to beneficiaries in a SNF stay. However, Medicare will only pay SNFs for claims for services that do not on the exclusion lists.

Additionally, SNF CB applies to non-therapy services only when furnished to a SNF resident during a covered Part A stay; however, it applies to physical and occupational therapies, and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems edit for services provided to SNF beneficiaries, both those that are included and those excluded from SNF CB.

The updated lists for institutional and professional billing are available at *https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*.

CR 9561 adds CPT® codes 93600, 93602, 93603, 93609, 93610, 93612, 93613, 93615, 93616, 93618-93624, 93631, 93640 - 93642, 93644, 93650, 93653, 93654, 93655, 93656, 93657, 93660, and 93662 to the Major Category 1.B Coding List for SNF consolidated billing, effective for dates of service on or after January 1, 2016.

Note: If you have claims with dates of service on or after January 1, 2016, that are impacted by these changes and that were denied/rejected prior to the implementation of CR 9561, your MAC will re-open and re-process those claims that you bring to your MAC's attention.

Additional information

The official instruction, CR 9561 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3473CP.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: MM9561
Related Change Request (CR) #: CR 9561
Related CR Release Date: March 4, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3473CP
Implementation Date: July 5, 2016

Payments to IRFs that do not submit required quality data - replaces CR 9106

Provider types affected

This *MLN Matters*® article is intended for inpatient rehabilitation facilities (IRFs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9543 advises IRFs of changes and clarifications to the payment reduction reconsideration process for fiscal year (FY) 2017 and after. Make sure that your billing staffs are aware of these changes.

Background

Section 1886 (j)(7)(A)(i) of the Social Security Act requires application of a 2 percentage reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. FY 2014 was the first year that the mandated reduction was applied for IRFs that failed to comply with the data submission requirements during the data collection period October 1, 2012, through December 31, 2012.

Beginning with FY 2014 and each subsequent year, if an IRF agency does not submit required quality data, their payment rates for the year are reduced by 2 percentage points for that fiscal year. Application of the 2 percentage reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. In addition, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the fiscal year involved.

Information about the *Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP)* and the *IRF Quality Reporting Reconsideration and Exception & Extension process* is available on the Centers for Medicare & Medicaid Services (CMS) website.

CMS will provide the MACs with a list of IRFs potentially subject to the reductions. If your facility is on that list, your MAC will, send you a letter advising you about that potential reduction. You will have the opportunity to request a reconsideration by CMS of your reduction. Once CMS makes a decision on your request for reconsideration, your MAC will notify you of such decision.

Additional information

The official instruction, CR 9543, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R54QRI.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: MM9543
Related Change Request (CR) #: CR 9543
Related CR Release Date: February 19, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R54QRI
Implementation Date: April 1, 2016

Medicare Learning Network®

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Required billing updates for rural health clinics

Note: *This article was revised February 29, 2016, to clarify the billing instructions, especially in the examples provided in the article. All other information is unchanged. This information was previously published in the February 2016 Medicare A Connection, pages 28-30.*

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 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 center Web page*.

Beginning 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. Services furnished through March 31, 2016, should be billed without a HCPCS code under the previous guidelines.

A RHC visit must include one of the services listed on the RHC qualifying visit list, which is shown in this article. 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. Updates to the qualifying visit list are generally made on a quarterly basis and posted on the *CMS RHC center 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 using revenue code 052x.
- Qualifying mental health services are billed using revenue code 0900.

See **RHC**, next page

RHC

From previous page

- Telehealth originating site facility fees are billed using revenue code 0780.

Billing qualifying visits under the HCPCS reporting requirement

An encounter must include one of the services listed under the RHC qualifying visit list. The total charges for the encounter must be included on the qualifying visit line minus any charge for an approved preventive service. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying visit line. All other RHC services furnished during the encounter are also reported with a charge and payment for these lines is included in the AIR.

Note: The examples listed include form locators (FL) from the UB-04.

Example 1: 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. All other RHC services furnished during the encounter are also reported with the charge for the service. (See Example 1, page 25)

Example 2: 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. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service. 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 26)

Example 3: Preventive service only encounter

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 26)

Example 4: 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. The qualifying mental health visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service. (See Example 4, page 26)

Example 5: 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. Each additional medical service furnished should be reported with revenue code 052x. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. (See Example 5, page 26)

Example 6: 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 payable as stand-alone services. 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. RHCs should report the most appropriate revenue code for the services being performed. (See Example 6, page 26)

For any service line included in the AIR payment, the following remittance codes will be received:

- **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; and
- **RARC M15:** Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

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.

See **RHC**, next page

RHC

From previous page

- 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 qualifying medical visit line should include the total charges for the medical services and the qualifying mental health visit line should include the total charges for the mental health services.
- 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 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.

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 29, 2016	Revised to provide clarifying information, especially in the billing examples provided.
February 10, 2016	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.
February 1, 2016	Initial issuance

MLN Matters® Number: MM9269 *Revised*
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

Example 1: Medical Services

FL 42 revenue code	FL 44 HCPCS	FL 45 service date	FL 46 service units	FL 47 total charges	Payment	Coinsurance/deductible applied
052x	*99213*[1]	4/1/16	1	$76.40[2]	AIR	Yes
0300	*36415*	4/1/16	1	$3.00[3]	Included in the AIR	No

[1]HCPCS code from the RHC qualifying visit list
[2]Total charges for the encounter
[3]Charge for the service

Example 2: Medical services and preventive services

FL 42 revenue code	FL 44 HCPCS	FL 45 service date	FL 46 service units	FL 47 total charges	Payment	Coinsurance/deductible applied
052x	*99213*[1]	4/1/16	1	$76.40[2]	AIR	Yes

See **RHC**, next page

RHC

From previous page

FL 42 revenue code	FL 44 HCPCS	FL 45 service date	FL 46 service units	FL 47 total charges	Payment	Coinsurance/ deductible applied
052x	G0101	4/1/16	1	$38.67[3]	Included in the AIR	No
0300	*36415*	4/1/16	1	$3.00[3]	Included in the AIR	No

[1]HCPCS code from the RHC qualifying visit list
[2]Total charges minus charge for approved preventive service
[3]Charge for the service

See the *Coinsurance* section for information applicable to Example 2.

Example 3: Preventive service only encounter

FL 42 revenue code	FL 44 HCPCS	FL 45 service date	FL 46 service units	FL 47 total charges	Payment	Coinsurance/ deductible applied
052x	G0101[1]	4/1/16	1	$38.67[2]	AIR	No[3]

[1]Preventive service HCPCS code from the RHC qualifying visit list
[2]Total charges for encounter
[3]Coinsurance and deductible are waived when appropriate

Example 4: Mental health services

FL 42 revenue code	FL 44 HCPCS	FL 45 service date	FL 46 service units	FL 47 total charges	Payment	Coinsurance/deductible applied
0900	*90834*[1]	4/1/16	1	$110.63[2]	AIR	Yes
0900	*90863*	4/1/16	1	$25.42[3]	Included in the AIR	No

[1]HCPCS code from the RHC qualifying visit list
[2]Total charge for the encounter
[3]Charge for the service

Example 5: Multiple medical services

FL 42 revenue code	FL 44 HCPCS	FL 45 service date	FL 46 service units	FL 47 total charges	Payment	Coinsurance/deductible applied
052x	*99213*[1]	4/1/16	1	$183.32[2]	AIR	Yes
052x	*12002*	4/1/16	1	$109.92[3]	Included in the AIR	No

[1]HCPCS code from the RHC qualifying visit list
[2]Total charge for the encounter
[3]Charge for the service

Example 6: Medical services and incident to services

FL 42 revenue code	FL 44 HCPCS	FL 45 service date	FL 46 service units	FL 47 total charges	Payment	Coinsurance/ deductible applied
052x	*99213*[1]	4/1/16	1	$139.11[2]	AIR	Yes
0300	*36415*	4/1/16	1	$3.00[3]	Included in the AIR	No
0636	*90746*	4/1/16	1	$59.71[3]	Included in the AIR	No
0771	G0010	4/1/16	1	$5.00[3]	Included in the AIR	No

[1]HCPCS code from the RHC qualifying visit list
[2]Total charge for the encounter
[3]Charge for the service

Telehealth services expanded to include certified registered nurse anesthetists

Provider types affected

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

What you need to know

Change request (CR) 9428:

- Informs MACs that the list of telehealth services that were once available through the manual updates will now be displayed at *http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/*.
- Adds certified registered nurse anesthetists (CRNAs) to the list of Medicare practitioners who may bill for covered telehealth services.
- Removes the telehealth language from *Chapter 15*, Section 270 of the *Medicare Benefit Policy Manual* and puts a reference in the text to see *Chapter 12*, Section 190 of the *Medicare Claims Processing Manual* for further information regarding telehealth service.

The text added to Chapter 12 of the *Medicare Claims Processing Manual* addresses the following topics:

- Payment for ESRD-related services as a telehealth service;
- Payment for subsequent hospital care services and subsequent nursing facility care services as telehealth services;
- Payment for diabetes self-management training (DSMT) as a telehealth service;
- Originating site facility fee payment methodology; and
- Payment methodology for physician/practitioner at the distant site.

Several conditions must be met for Medicare to make payments for telehealth services under the Medicare physician fee schedule (MPFS). The service must be on the list of Medicare telehealth services and meet **all** of the following additional requirements:

- The service must be furnished via an interactive telecommunications system;
- The service must be furnished by a physician or authorized practitioner;
- The service must be furnished to an eligible telehealth individual; and
- The individual receiving the service must be located in a telehealth originating site.

Additional information

The official instruction, CR 9248, was issued to your MAC via two transmittals. The first updates the *Medicare Benefit Policy Manual* and it is at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R221BP.pdf*. The second transmittal updates *Medicare Claims Processing Manual* and it is at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3476CP.pdf*. The actual manual updates are attached to each transmittal.

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: MM9428
Related Change Request (CR) #: CR 9428
Related CR Release Date: March 11, 2016
Effective Date: January 1, 2015
Related CR Transmittal #: R221BP and R3476CP
Implementation Date: April 11, 2016

Healthcare provider taxonomy code set update

Provider types affected

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

What you need to know

Change request (CR) 9461 instructs MACs to obtain the most recent healthcare provider taxonomy code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective

April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

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

CR 9461 implements the NUCC HPTC code set that is effective on April 1, 2016, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at *http://www.wpc-edi.com/codes*.

When reviewing the HPTC set online, you can identify revisions made since the last release by the color code:

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

Additional information

The official instruction, CR 9461, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3467CP.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: MM9461
Related Change Request (CR) #: CR 9461
Related CR Release Date: February 19, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3467CP
Implementation Date: As soon as April 1, 2016, but no later than July 5, 2016

Manual updates to correct remittance advice messages

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) 9424 revises Chapters 4 and 5 of the *Medicare Claims Processing Manual* to ensure that all remittance advice coding is consistent with nationally standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual.

CR 9424 directs MACs to use remittance coding that is compliant with nationally standard Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules.

Background

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs regulates the way in which group codes, claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) may be used. The rule requires specific codes, which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the CAQH CORE.

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages.

With CR 9424, the Centers for Medicare & Medicaid Services (CMS) makes the following adjustments to CARC/RARC usage:

- MACs will use CARC 54 without an associated RARC when denying assistant at surgery services.
- MACs will use CARC 54 without an associated RARC when denying co-surgery services.
- MACs will use CARC 16 with RARCs MA66 and N56 when returning as unprocessable claims for Outpatient Intravenous Insulin Therapy (OIVIT) billed with HCPCS code 99199.
- MACs will use CARC 16 with RARCs MA66 and N56 when returning as unprocessable claims for OIVIT billed with the incorrect diagnosis code.
- MACs will also apply reformatted, but not changed, remittance advice coding as described in the revised Chapters 4 and 5 of the *Medicare Claims Processing Manual*.

Additional information

The official instruction, CR 9424, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3475CP.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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Implementation Date: June 6, 2016

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.

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."

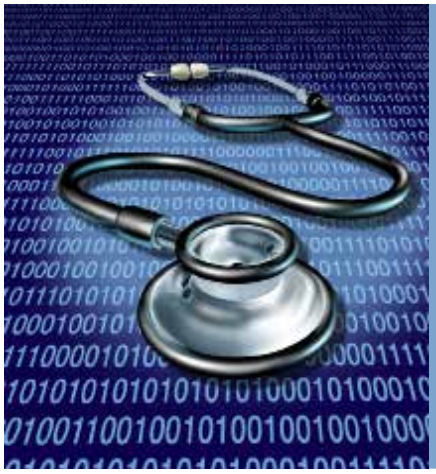
The new EDI forms are designed to be completed online, and can be signed electronically. There are three methods for submitting your EDI forms:

- **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*



Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

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

April 2016 hospital OPPS update

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs), including home health and hospice (HH&H) MACs, for services provided to Medicare beneficiaries paid under the outpatient prospective payment system (OPPS).

Provider action needed

Change request (CR) 9549 describes changes to and billing instructions for various payment policies implemented in the April 2016 OPPS update.

The April 2016 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 9549. The I/OCE update is in CR 9553. Upon release of that CR, an *MLN Matters*® article (MM9553) related to the updated I/OCE will be posted on the Centers for Medicare & Medicaid Services (CMS) website. Make sure your billing staffs are aware of these changes.

Key points of CR 9549

Key changes to and billing instructions for various payment policies implemented in the April 2016 OPPS updates are as follows:

Neurostimulator HCPCS Codes C1822 and C1820

HCPCS code C1822

As described in the January 2016 update of the OPPS (see *MM9486*, January 2016 OPPS Update), HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system) was added to the OPPS pass-through list as a new pass-through device effective January 1, 2016. HCPCS code C1822 is based on a clinical trial that demonstrated that a high frequency spinal cord stimulator operated at 10,000 Hz and paresthesia-free provides a substantial clinical improvement in pain management versus a low-frequency spinal cord stimulator.

HCPCS code C1820

In the January 2016 OPPS update, CMS added the words “non-high-frequency” to the descriptor of C1820. CMS is revising the descriptor for C1820 back to its original language and deleting “non-high-frequency” from the descriptor such that the descriptor again states the following: Generator, neurostimulator (implantable), with rechargeable battery and charging system. Neurostimulator generators that are not high frequency should be reported with C1820.

The latest short and long descriptors for HCPCS codes C1822 and C1820 are available at *https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html*.

Billing instructions for intensity modulated radiation therapy (IMRT) planning

Payment for the services identified by CPT® codes 77014, 77280, 77285, 77290, 77295, 77305 through 77321, 77331, and 77370 are included in the ambulatory payment classification (APC) payment for CPT® code 77301 (IMRT planning). These codes should not be reported in addition to CPT® code 77301 when provided prior to or as part of the development of the IMRT plan.

Laboratory drug testing HCPCS codes G0477-G0483, effective January 1, 2016

HCPCS codes G0477-G0483 were published on the CMS website after the release of the January 2016 I/OCE. Consequently, CMS was unable to include them in the January 2016 I/OCE release. These codes are being added to the April 2016 I/OCE release with an effective date of January 1, 2016, and are assigned to status indicator (SI) of “Q4” (Conditionally packaged laboratory tests) under the hospital OPPS. The descriptors for codes G0477-G0483 are listed in Table 1 (page 33).

Drugs, biologicals, and radiopharmaceuticals

Drugs and biologicals with payments based on average sales price (ASP), effective April 1, 2016

For 2016, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In 2016, a single payment of ASP + 6 percent for pass-through drugs, biologicals nd radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated

See **OPPS**, next page

OPPS

From previous page

payment rates effective April 1, 2016, and drug price restatements are available in the April 2016 update of the OPPS Addendum A and Addendum B at *http://www.cms.gov/HospitalOutpatientPPS/*.

Drugs and biologicals with OPPS pass-through status, effective April 1, 2016

Ten drugs and biologicals have been granted OPPS pass-through status effective April 1, 2016. See codes listed in Table 2.

Table 2 – Drugs and biologicals with OPPS pass-through status, effective April 1, 2016

HCPCS code	Long descriptor	APC	SI
C9137	Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.	1844	G
C9138	Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U.	1846	G
C9461	Choline C 11, diagnostic, per study dose	9461	G
C9470	Injection, aripiprazole lauroxil, 1 mg	9470	G
C9471	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	9471	G
C9472	Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)	9472	G
C9473	Injection, mepolizumab, 1 mg	9473	G
C9474	Injection, irinotecan liposome, 1 mg	9474	G
C9475	Injection, necitumumab, 1 mg	9475	G
J7503	Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg	1845	G

Revised status indicator for HCPCS codes

The status indicator for *CPT*® code 90653 (Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=L (Not paid under OPPS paid at reasonable cost, not subject to deductible or coinsurance).

The status indicator for HCPCS code J0130 (Injection abciximab, 10 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

The status indicator for HCPCS code J0583 (Injection, bivalirudin, 1 mg) will change from SI K (Paid under OPPS; separate APC payment) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

The status indicator for HCPCS code J1443 (Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

The status indicator for HCPCS code J2704 (Injection, Propofol, 10mg) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

These codes and the effective dates for the status indicator changes are listed in Table 3.

Table 3 – Drugs and biologicals with revised status indicators

HCPCS code	Long descriptor	Status indicator	Effective date
90653	*Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for*	L	11/24/2015
J0130	Injection abciximab, 10 mg	N	1/1/2016
J0583	Injection, bivalirudin, 1 mg	N	1/1/2016
J1443	Injection, Ferric	N	1/1/2016
J2704	Injection, Propofol, 10mg	N	1/1/2016

Drugs and biologicals based on ASP methodology with restated payment rates

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

See **OPPS**, next page

OPPS

From previous page

basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html*.

Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

Revised billing instruction for stereotactic radiosurgery (SRS) planning and delivery

Effective for cranial single session stereotactic radiosurgery procedures (CPT® code 77371 or 77372) furnished on or after January 1, 2016, until December 31, 2017, costs for certain adjunctive services (for example, planning and preparation) are not factored into the APC payment rate for APC 5627 (Level 7 Radiation Therapy). Rather, the ten planning and preparation codes listed in Table 4, will be paid according to their assigned status indicator when furnished 30 days prior or 30 days post SRS treatment delivery.

In addition, hospitals must report modifier "CP" (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification C-APC] procedure) on type of bill (TOB) 13x claims for any other services excluding the ten codes in table 4) that are adjunctive or related to SRS treatment but billed on a different claim and within either 30 days prior or 30 days after the date of service for either CPT® code 77371 (Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment cranial lesion(s) consisting of 1 session; multi-source Cobalt 60-based) or *CPT*® code 77372 (Linear accelerator based). The "CP" modifier need not be reported with the ten planning and preparation CPT® codes listed in Table 4. Adjunctive/related services include but are not necessarily limited to imaging, clinical treatment planning/preparation, and consultations. Any service related to the SRS delivery should have the CP modifier appended. CMS does not expect the "CP" modifier to be reported with services such as chemotherapy administration as this is considered to be a distinct service that is not directly adjunctive, integral, or dependent on delivery of SRS treatment.

Table 4 – Excluded planning and preparation CPT® codes

CPT® code	2016 short descriptor	2016 status indicator
70551	Mri brain stem w/o dye	Q3
70552	Mri brain stem w/dye	Q3
70553	Mri brain stem w/o & w/dye	Q3
77011	Ct scan for localization	N
77014	Ct scan for therapy guide	N
77280	Set radiation therapy field	S
77285	Set radiation therapy field	S
77290	Set radiation therapy field	S
77295	3-d radiotherapy plan	S
77336	Radiation physics consult	S

Changes to OPPS pricer logic

Effective April 1, 2016, there will be four diagnostic radiopharmaceuticals (1 newly approved) and one contrast agent receiving pass-through payment in the OPPS pricer logic. For APCs containing nuclear medicine procedures, pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical or contrast agent payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical or contrast agent with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical or contrast agent expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals and contrast agents are the "policy-packaged" portions of the 2016 APC payments for nuclear medicine procedures and are available on the CMS website. MACs will adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the April 2016 OPPS pricer.

Coverage determinations

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

These HCPCS codes will be included with the April 2016 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the April 2016 update of the OPPS Addendum A and Addendum B at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Additional information

The official instruction, CR 9549, issued to your MAC

See **OPPS**, next page

OPPS

From previous page

regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3471CP.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: MM9549

Related Change Request (CR) #: CR 9549
Related CR Release Date: February 26, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3471CP
Implementation Date: April 4, 2016

Table 1 − Laboratory drug testing HCPCS codes G0477-G0483

HCPCS code	Short descriptor	Long descriptor	OPPS SI
G0477	Drug test	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay)capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service	Q4
G0478	Drug test	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.	Q4
G0479	Drug test	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.	Q4
G0480	Drug test def 1-7 classes	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.	Q4
G0481	Drug test def 8-14 classes	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA EMIT, FPIA), and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed.	Q4
G0482	Drug test def 15-21 classes	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed.	Q4
G0483	Drug test def 22+ classes	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed.	Q4

April 2016 Medicare physician fee schedule database update

Provider types affected

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

Provider action needed

Change request (CR) 9531 amends payment files that were issued to your MAC based upon the 2016 Medicare physician fee schedule (MPFS) final rule published in the *Federal Register* November 16, 2015. These payment files are to be effective for services furnished between January 1, 2016, and December 31, 2016. Please make sure your billing staff is aware of these changes.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims, however, they will adjust claims that you bring to their attention.

The key changes for the April update that are effective as of January 1, 2016 are as follows:

- CPT®/HCPCS code G0464 is assigned a procedure status of I;
- CPT® 10030 is assigned global period days of 000;
- CPT® 77014 is assigned a PC/TC Indicator of 1; and
- CPT® 80055 is assigned a procedure status of X.

Other changes that are effective for services performed on or after April 1, 2016, are as follows:

- CPT® G9678 is assigned a procedure status of X;
- G9481 (Remote E/M new pt 10mins) has a PE RVU = 0, all other MPFS indicators/values = code 99201;
- G9482 (Remote E/M new pt 20mins) has a PE RVU = 0, all other MPFS indicators/values = 99202;
- G9483 (Remote E/M new pt 30mins) has a PE RVU = 0, all other MPFS indicators/values = 99203;
- G9484 (Remote E/M new pt 45mins) has a PE RVU = 0, all other MPFS indicators/values = 99204;
- G9485 (Remote E/M new pt 60mins) has a PE RVU = 0, all other MPFS indicators/values = 99205;
- G9486 (Remote E/M est. pt 10mins) has a PE RVU = 0, all other MPFS indicators/values = 99212;
- G9487 (Remote E/M est. pt 15mins) has a PE RVU = 0, all other MPFS indicators/values = 99213;
- G9488 (Remote E/M est. pt 25mins) has a PE RVU = 0, all other MPFS indicators/values = 99214;
- G9489 (Remote E/M est. pt 40mins) has a PE RVU = 0, all other MPFS indicators/values = 99215; and
- G9490 (Joint replac mod home visit) with all MPFS indicators & RVUs = those of G9187.

Codes G9481-G9490 are new and are assigned type of service of 1. See the *MLN Matters*® article MM9533 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9533.pdf* for further details of these new codes.

Additional information

The official instruction, CR 9531 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3469CP.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: MM9531
Related Change Request (CR) #: CR 9531
Related CR Release Date: February 19, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3469CP
Implementation Date: April 4, 2016

April update for 2016 DMEPOS fee schedule

Provider types affected

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

What you need to know

Change request (CR) 9554 provides the April quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. Because there are no updates from the previous quarter (January through March 2016), an April update to the 2016 DMEPOS and parenteral and enteral nutrition (PEN) fee schedule files is not scheduled for release. However, an April 2016 DMEPOS rural ZIP code file containing quarter two, 2016 rural ZIP code changes is being provided to the MACs.

The *April 2016 DMEPOS rural ZIP code public use file (PUF)*, containing the rural ZIP codes effective for Quarter 2, 2016, will be available for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the above file.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, *Chapter 23*, Section 60.

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

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. Section 1842(s)(3)(B) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. CMS issued a final rule November 6, 2014 (79 FR 66223), on the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs.

CMS issued a final rule November 6, 2014 (79 FR 66223), on the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. The CBP product categories, HCPCS codes and single payment amounts (SPAs) included in each round of the CBP are available on the *competitive bidding implementation contractor (CBIC) website*.

The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments. To apply the adjusted fees rural payment rule for areas within the contiguous United States, the DMEPOS and PEN fee schedule files have been updated, effective January 1, 2016, to include rural payment amounts for certain HCPCS codes.

Beginning January 1, 2016, the ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts based on information from the competitive bidding program. ZIP codes for non-continental metropolitan statistical areas (MSA) are not included in the DMEPOS rural ZIP code file.

The DMEPOS rural ZIP code file is updated on a quarterly basis as necessary. Program instructions on these changes are available in *MLN Matters*® 9431 (*MM9431*) titled "Calendar Year (CY) 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule" based on Transmittal 3416, change request (CR) 9431, dated November 23, 2015.

Additional information

The official instruction, CR 9554, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3472CP.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: MM9554
Related Change Request (CR) #: CR 9554
Related CR Release Date: February 26, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3472CP
Implementation Date: April 4, 2016

April 2016 integrated outpatient code editor specifications version 17.1

Provider types affected

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

What you need to know

Change request (CR) 9553 provides the integrated outpatient code editor (I/OCE) instructions and specifications that will be used under the outpatient prospective payment system (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the home health prospective payment system or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes. The I/OCE specifications will be posted at *http://www.cms.gov/OutpatientCodeEdit/*. These specifications contain the appendices mentioned in the following table.

Key changes for April 2016 I/OCE

The modifications of the IOCE for the April 2016 v17.1 release are summarized in the following table. Note that some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective date' column.

Effective date	Edits affected	Modification
10/1/15	2, 3, 86	Update diagnosis editing for ICD-10 diagnosis codes (see quarterly data files, Dx10Map): - Removes age restrictions for specific newborn and pediatric diagnosis codes that are to be used throughout the patient's lifetime; - Additions and removal of age edits for specific maternity diagnosis codes; - Removes sex restriction for specific diagnosis codes currently restricted for female patients; and - Additional codes added to the list of manifestation diagnosis codes.
1/1/16		Implement new logic to identify pass-through drugs and biologicals present for payment offset; output each offset amount condition present with payer value codes QR, QS, QT and identify the pass-through drug or biological procedures for payment offset with new payment adjustment flag values (see OPPS special processing logic, Table 5, Table 7 and Appendix G).
1/1/16		Implement new logic to identify terminated device intensive procedures reported with modifier 73; output the device portion amount with Payer Value code QQ and identify the device intensive procedure reported with modifier 73 with a payment adjustment flag (see OPPS special processing logic, Table 5, Table 7 and Appendix G).
1/1/16		Implement new logic to identify device credit conditions for device intensive ambulatory payment classifications (APCs) when condition code 49, 50, or 53 is present; output the device credit amount with payer value code QQ and identify the device intensive procedure with a payment adjustment flag (see OPPS special processing logic, Table 5, Table 7, and Appendix G).

See **I/OCE**, next page

I/OCE

From previous page

Effective date	Edits affected	Modification
4/1/16	6, 91	Implement edit 91 for rural health clinic (RHC) claims with bill type 71x to be returned if non-covered services are reported (see special processing logic for FQHC PPS claims, Appendix F (a) and Appendix M); update the description for edit 91 to include RHC. Implement edit 6 for RHC (see Appendix F (a)).
1/1/16		Update the program logic for CT scan payment reduction when not meeting National Electrical Manufacturers Association (NEMA) standards to assign payment adjustment flag 14 to the multiple imaging composite APC line if CT modifier is not present but there are composite constituent codes present that do report modifier CT (see OPPS special processing logic and Appendix K).
1/1/16	45	Update the logic for edit 45 to include criteria for inpatient separate procedures reported on the same claim as a comprehensive APC procedure with a status indicator (SI) = J1.
1/1/16		Update Appendix L to include procedure codes with SI = C in the list of non-allowed procedures by SI for OPPS claims.
1/1/16		Update the program logic for pass-through device payment offset to not provide the offset if the primary comprehensive APC procedure (SI = J1) is not paired with a pass-through device code present on the claim (see OPPS special processing logic and Appendix L).
1/1/16		Update Appendix E with a note for setting the payment method flag to 2 for laboratory codes with SI = Q4 that result in final assignment of SI = A.
1/1/16		Update the program logic for comprehensive APC 5881 (inpatient procedure where patient expired) to correctly exclude services designated as comprehensive APC exclusions when reported on the same day when APC 5881 is assigned.
1/1/15		Update program logic for comprehensive APC processing to recognize modifier 50 for comprehensive APC procedures that may be eligible for complexity adjustment (see Appendix L).
1/1/16		Update the program logic for grandfathered tribal federally qualified health center (FQHC) claims to identify the single payable visit (payment indicator 14) for each day if the claim contains multiple days (see Appendix M).
1/1/16		Update the program logic for grandfathered tribal FQHC claims to assign the composite adjustment flag only for the single payable visit for the day (see Appendix M).
1/1/16		Modify the output of the payer value code and amount field to pass blanks for the value code label (QN-QW) and zero-fill the amount portion of the field if conditions for payment offset are not present on the claim (see Table 5 of the I/OCE specifications). Note: If conditions for edit 24 (date out of OCE range) are present, payer value code and amount is blank (no zero-fill).

See **I/OCE**, next page

I/OCE

From previous page

Effective date	Edits affected	Modification
1/1/16		**Add** the following new payer value codes to the field output (see Table 5): **- QP**: Placeholder reserved for future use **- QQ**: Terminated procedure with pass-through device OR condition for device credit present **- QR**: First APC pass-through drug or biological offset **- QS**: Second APC pass-through drug or biological offset **- QT**: Third APC pass-through drug or biological offset **Revise** the following payer value code descriptions: **- QN**: First APC device offset **- QO**: Second APC device offset **Add** the following new payment adjustment flag values (see Table 7 and Appendix G): **- 15**: Placeholder reserved for future use **- 16**: Terminated procedure with pass-through device **- 17**: Condition for device credit present **- 18**: Offset for first pass-through drug or biological **- 19**: Offset for second pass-through drug or biological **- 20**: Offset for third pass-through drug or biological **Revise** the following payment adjustment flag descriptions: **- 12**: Offset for first device pass-through **- 13**: Offset for second device pass-through
1/1/16		Correction of the issue with the interactive PC IOCE product that caused claims to not complete processing to the output report when the pass-through device offset amount was greater than $999.99.
1/1/16		The following clarifying information is added (no change to software program logic): - Direct referral logic to include J1 procedures (page 46) with the SI = T criteria - Critical care packaged ancillary codes (page 11): update SI values for codes subject to modifier 59 exception. - Conditionally packaged laboratory codes (page 12): laboratory codes that are always packaged with SI = N, and removal of SI J1 and J2 (comprehensive APCs) from list of OPPS services by SI under which laboratory codes with SI = Q4 are changed to SI = A for claims with bill type 13x.
11/24/15	67	Add mid-quarter editing for Food and Drug Administration (FDA) approval of code *90653* (SI changed to L).
4/1/16		Update the following procedure lists for the release (see quarterly data files): - Procedures not recognized under OPPS (SI=B) - Conditionally packaged laboratory services (SI=Q4) - FQHC non-covered services - Device offset pairs - Device list (edit 92) - Comprehensive APC exclusions - New pass-through drug and biological/APC offset - New device intensive procedures for terminated procedure and device credit (value code QQ)

See **I/OCE**, next page

I/OCE

From previous page

Effective date	Edits affected	Modification
4/1/16		Make all HCPCS/APC/SI changes as specified by CMS quarterly data files).
4/1/16	20, 40	Implement version 22.1 of the NCCI (as modified for applicable outpatient institutional providers

Note: Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software.

Additional information

The official instruction, CR 9553, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3477CP.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: MM9553
Related Change Request (CR) #: CR 9553
Related CR Release Date: March 11, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3477CP
Implementation Date: April 4, 2016

Claims resubmitted after a clinical review of records

As part of First Coast Service Options' (First Coast) routine data analysis process we have identified and are monitoring an increased number of providers that are cancelling and/or resubmitting claims that should be submitted via the appeals process. First Coast views this as an abuse of the process and is considering additional actions to address the problem.

The Part A claim processing system (fiscal intermediary shared system or FISS) is designed to allow providers to cancel and resubmit a claim when appropriate. The appropriate instances include those situations where a claim has been rejected due to incomplete submissions, missing information, and invalid submissions.

The Part B claims processing system (multi-carrier system or MCS) is not designed to allow a provider to cancel a claim, but does allow a claim to be resubmitted if appropriate.

A claim that has been clinically reviewed and/or denied should never be resubmitted as a claim, but submitted as a redetermination.

When a letter (additional development request) is sent to your office asking for patient records, a claim has failed one of the preprogramed edits in our claims processing systems. This editing may include procedure codes, code combinations, modifiers, national or local coverage determination, billing patterns, utilization parameters, etc. Although there is provider-specific auditing ,the majority of requests are service specific and set to look at anyone billing one of the subsets mentioned above. Record reviews are completed initially by the company's staff of clinicians or MDs in the Program Integrity department. Once a claim decision has been made to deny based on a service being "not medically reasonable and necessary," the correct process or next step is to follow the appeals process. By following the appeals process you are given an opportunity to include attestations, signature logs, missing or omitted records, add addenda, etc. Additionally, it allows for a different set of clinical reviewers to take a look at your records. Resubmitting the claim rather than requesting an appeal (redetermination) is considered an abuse of the program and adds additional scrutiny for medical review to your practice by our data analysis department.

Educational Events

Provider outreach and educational events – April 2016

Medicare Internet-based PECOS training by appointment

Type of Event: Face-to-face
http://medicare.fcso.com/Events/0324673.asp

LCD coverage criteria for drug assays

Date: Thursday, April 28
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast
http://medicare.fcso.com/Events/0331284.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*.

MLN Connects®

CMS MLN Connects® Provider eNews

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

MLN Connects® Provider eNews for February 25, 2016

MLN Connects® Provider eNews for February 25, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- Provider Enrollment Revalidation Call — Last Chance to Register
- Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebasing Methodology — New

Medicare Learning Network® Publications and Multimedia

- Guidance on the PQRS 2014 Reporting Year and 2016 Payment Adjustment for RHCs, FQHCs, and CAHs *MLN Matters*® Article – Released
- Ambulatory Surgical Center Fee Schedule Fact Sheet — Revised
- New Educational Web Guides Fast Fact

Announcements

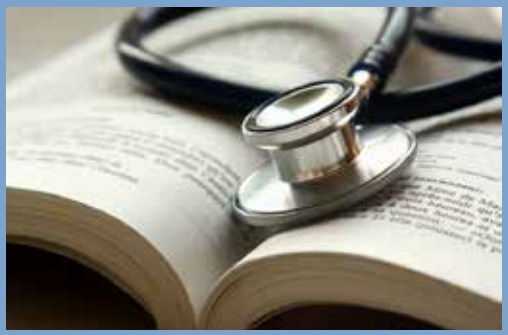
- Alignment and Simplification of Quality Measures
- CMS Publishes Medicare FFS Provider and Supplier Lists
- Strengthening Provider and Supplier Enrollment Screening
- CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1
- Quality of Patient Care Star Ratings TEP: Nomination Period Open through March 18
- EHR Hardship Exception Application: New FAQ

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 March 3, 2016

MLN Connects® Provider eNews for March 3, 2016
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In this edition:

MLN Connects® Events

- Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebasing Methodology— Reminder

Medicare Learning Network® Publications and Multimedia

- Provider Enrollment Revalidation: Cycle 2 *MLN Matters®* Article — New
- CMS Quality Conference 2015: Industry Leaders Discuss IMPACT Act Video — New
- CMS Provider Minute: Multiple Same Day Surgeries and Modifier 51 Video — New
- Home Health Prospective Payment System Booklet — Revised
- Suite of Products & Resources for Rural Health Providers Educational Tool — Revised
- DMEPOS Quality Standards Booklet — Reminder

Announcements

- Major Commitments from Healthcare Industry to Make Electronic Health Records Work Better
- Program Integrity Enhancements to the Provider Enrollment Process
- CMS to Release a Comparative Billing Report on Non-invasive Vascular Studies in March
- EHR Incentive Program Hardship Application Deadline Extended to July 1
- EHR Incentive Programs: FAQs on Public Health Reporting Requirements
- ICD-10 Next Steps Toolkit
- Antipsychotic Drug use in Nursing Homes: Trend Update
- "Savor the Flavor of Eating Right" During National Nutrition Month® and Beyond

Claims, Pricers, and Codes

- Mandatory Payment Reduction of 2% Continues until Further Notice for the Medicare FFS Program – "Sequestration"

MLN Connects® Provider eNews for March 10, 2016

MLN Connects® Provider eNews for March 10, 2016

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In this edition:

MLN Connects® Events

- Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Registration Opening Soon
- IMPACT Act: Data Element Library Call — Registration Now Open
- Medicare Shared Savings Program ACO Application Process Call — Registration Opening Soon

Medicare Learning Network® Publications and Multimedia

- Videos on Medicare Quality Reporting — New
- Swing Bed Services Fact Sheet — Revised
- Rural Health Clinic Fact Sheet — Revised
- Diagnosis Coding: Using the ICD-9 Web-Based Training — Revised

Announcements

- CMS Proposes to Test New Medicare Part B Prescription Drug Models
- HHS Reaches Goal of Tying 30 Percent of Medicare Payments to Quality Ahead of Schedule
- 2016 Value Modifier Results and Upward Payment Adjustment Factor
- Open Payments System Registration for Physicians and Teaching Hospitals

See **CONNECTS**, next page

MLN Connects® Provider eNews for March 17, 2016

MLN Connects® Provider eNews for March 17, 2016
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In this edition:

MLN Connects® Events

- Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Registration Now Open
- Open Payments 2016: Prepare to Review Reported Data Call — Registration Now Open
- IMPACT Act: Data Element Library Call — Register Now
- Medicare Shared Savings Program ACO Application Process Call — Registration Now Open
- New Audio Recording and Transcript Available

Other CMS Events

- Comparative Billing Report on Modifier 25: Internal Medicine Webinar
- Comparative Billing Report on Non-invasive Vascular Studies Webinar

Medicare Learning Network® Publications and Multimedia

- February 2016 Catalog Available
- Dual Eligible Beneficiaries Fact Sheet and *MLN Matters*® Article — Revised
- Health Professional Shortage Area Physician Bonus Program Fact Sheet — Revised
- SNF Consolidated Billing Web-Based Training Course — Reminder
- HIPAA EDI Standards Web-Based Training Course — Reminder
- Medicare-Required SNF PPS Assessments Educational Tool — Reminder

Announcements

- Medicare SNF Transparency Data for CY 2013
- DMEPOS Competitive Bidding Payment Amounts and Contract Offers for Round 2 Recompete and the National Mail-Order Recompete
- Eligible Professionals and Hospitals: Submitting QRDA Files in the 2016 Reporting Period
- ICD-10: Track and Improve Your Progress
- CMS Acting Administrator Andy Slavitt's Comments at HIMSS
- HCAHPS: Measurement of the Patient Experience in Hospitals
- It Is Still Influenza Season

CONNECTS

From previous page

- 2015 PQRS Data Submission Deadlines
- EHR Incentive Programs: Attest to 2015 Program Requirements by March 11
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- Quality of Patient Care Star Ratings TEP Call for Nominations through March 18
- Home Health Agencies: Register for HHCAHPS before April 1
- Next Generation ACO Model Second Application Cycle: Letter of Intent due May 2
- New ST PEPPER Available
- Five Ways Patients Can Become Informed Medicare Consumers
- March is Colorectal Cancer Awareness Month

Claims, Pricers, and Codes

- April 2016 Average Sales Price Files Available

MLN Connects® Provider eNews for March 24, 2016

MLN Connects® Provider eNews for March 24, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Register Now
- Open Payments 2016: Prepare to Review Reported Data Call — Register Now
- IMPACT Act: Data Element Library Call — Register Now
- Medicare Shared Savings Program ACO Application Process Call — Register Now
- New Audio Recording and Transcript Available

Other CMS Events

- March ICD-10 Coordination and Maintenance Committee: Comments on Proposals due April 8

Medicare Learning Network® Publications and Multimedia

- Series *of MLN Matters®* Special Edition Articles for Chiropractors — New
- Medicare Costs at a Glance: 2016 Educational Tool — Revised
- PECOS for Physicians and Non-Physician Practitioners — Reminder
- Medicare Enrollment for Institutional Providers Fact Sheet — Reminder
- New Educational Web Guides Fast Fact

Announcements

- CMS Releases Interactive Mapping Medicare Disparities Tool
- Delivery System Reform: Making Health Care Work Better
- CMS to Release a CBR on Subsequent Nursing Facility E/M Services in April
- Next Generation ACO Model Second Application Cycle: LOI due May 2
- 2016 PQRS Educational Materials Available
- DMEPOS Suppliers: List of HCPCS Codes Affected by Section 2 of PAMPA

Claims, Pricers, and Codes

- Update to the RHC Qualifying Visit List

Top educational resources to avoid billing errors

The following list of resources has been compiled to assist providers with some of the top billing errors.

Determine if a procedure is bundled

Fee schedule lookup: This tutorial demonstrates how to use this popular tool in determining if a procedure is part of a bundled service: *http://medicare.fcso.com/Fee_resources/0323300.asp*

Validate if QW is needed

Clinical Laboratory Improvement Amendments (CLIA) – this tutorial provides step-by-step instructions in finding out if a *CPT®* code requires the QW modifier: *http://medicare.fcso.com/Clinical_lab/0321651.asp*

Code denial due to NCCI

National Correct Coding Initiative (NCCI) – code pair denials – this tutorial takes a confusing process and makes it simple by demonstrating how to use CMS's files to determine if a code pair will be denied due to NCCI: *http://medicare.fcso.com/NCCI/0326651.asp*

Find procedure to diagnosis relationship

Procedure to diagnosis lookup – this tutorial will demonstrate the diagnosis relationship lookup tool to assist in determining if a procedure to diagnosis relationship exists for the procedure performed: *http://medicare.fcso.com/Claim_submission_guidelines/0326666.asp*

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