Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

April 2016

In this issue

Remittance advice remark and claims adjustment reason code and Medicare Remit Easy Print and PC Print update

Provider types affected

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

Provider action needed

CR 9466 updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if they use that software.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment of a claim or service, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs and shared systems, if appropriate, to conduct updates based on the code update schedule that results in publication of updated code lists three times a year (around March 1, July 1, and November 1).

Medicare's shared system maintainers (SSMs) are responsible for implementing appropriate code deactivation, making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code

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

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

General Information

Provider enrollment requirements for writing prescriptions for Medicare Part D drugs

***Note**: This article was revised April 18, 2016, to show additional date changes related to the delayed enforcement of the Part D prescriber enrollment requirement until February 1, 2017. All other information remains the same. This information was previously published in the October 2015 Medicare B Connection, pages 26-29.*

Provider types affected

This *MLN Matters*® special edition article is intended for physicians, dentists, and other eligible professionals who write prescriptions for Medicare beneficiaries for Medicare Part D drugs. The article is also directed to Medicare Part D plan sponsors.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F, *Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs* May 23, 2014.

CMS later published CMS-6107-IFC, "Medicare Program; Changes to the Requirements for Part D Prescribers," an interim final rule with comment ("IFC"), that made changes to the final rule (CMS-4159-F), May 6, 2015.

Together, these rules require virtually all physicians and other eligible professionals, including dentists, who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be coverable under Part D, except in very limited circumstances.

To allow sufficient time for the prescribers to enroll in Medicare and the Part D sponsors and the pharmacy benefit managers (PBMs) to make the complex system enhancements needed to comply with the prescriber enrollment requirements, CMS announced a delay in enforcement of this rule until February 1, 2017.

Nevertheless, prescribers of Part D drugs should submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare administrative contractors (MACs) by August 1, 2016, or earlier, to ensure that MACs have sufficient time to process the applications and opt-out affidavits and avoid their patients' prescription drug claims from being denied by their Part D plans, beginning February 1, 2017 (Enrollment functions for physicians and other prescribers are handled by MACs).

The purpose of these rules is to ensure that Part D drugs are prescribed only by physicians and eligible professionals who are qualified to do so under state law and under the requirements of the Medicare program and who do not pose a risk to patient safety. By implementing these rules, CMS is improving the integrity of the Part D prescription drug program by using additional tools to reduce fraud, waste, and abuse in the Medicare program. Prescribers who are determined to have a pattern or practice of prescribing Part D drugs that are abusive and represents a threat to the health and safety of Medicare enrollees or fails to meet Medicare requirements will have their billing privileges revoked under 42 USC 424.535 (a)(14).

Background

If you write prescriptions for covered Part D drugs and you are not already enrolled in Medicare in an approved status or have a valid record of opting out, you should submit an enrollment application or an opt-out affidavit to your MAC by August 1, 2016, or earlier, so that the prescriptions you write for Part D beneficiaries are coverable on and after February 1, 2017.

To enroll in Medicare for the limited purpose of prescribing:

You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at *https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/internetbasedpecos.html* or by completing the paper CMS-855O application, which is available at *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855o.pdf*, which must be submitted to the MAC that services your geographic area. Note that there is no application fee required for your application submission. For step-by-step instructions, refer to the PECOS how-to guide, available at *https://go.cms.gov/orderreferhowtoguide* or watch an instructional video at *https://go.cms.gov/videotutorial*.

The CMS-855O is a shorter, abbreviated form and takes minimal time to complete. While the CMS-855O form states it is for physicians and non-physician practitioners who want to order and certify, it is also appropriate for use by prescribers, who want to enroll to also prescribe Part D drugs. (CMS is in the process of updating the CMS-855O form). If you do not see your specialty listed on the application, please select the undefined physician/non-physician type option and identify your specialty in the space provided.

Note: Dentists are recognized by Medicare as physicians and should select the "Part B Physician Specialties" option and specify general dentist in the free form text box.

The average processing time for CMS-855O applications submitted online is 45 days versus paper submissions which is 60 days. However, your application could be processed sooner depending on the MAC's current workload.

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To enroll to bill for services (and prescribe Part D drugs):

To enroll in Medicare to bill for your services, you may complete the CMS-855I application. The CMS-855R should also be completed if you wish to reassign your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries. All actions can be completed via PECOS or the paper enrollment application. For more information on enrolling in Medicare to bill for services refer to *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*. If you are a physician or non-physician practitioner who wants to opt-out of Medicare, you must submit an opt-out affidavit to the MAC that services your geographic area. Physicians and non-physician practitioners should be aware that if they choose to opt-out of Medicare, they are **not** permitted to participate in a Medicare advantage plan.

In addition, once a physician or non-physician practitioner has opted out they are not permitted to terminate their opt-out affidavit early. Section 1802(b)(3)(B)(ii) of the Act establishes the term of the opt-out affidavit. The Act does not provide for early termination of the opt-out term. Under CMS regulations, physicians and practitioners who have not previously submitted an opt-out affidavit under Section 1802(b)(3) of the Act, may choose to terminate their opt-out status within 90 days after the effective date of the opt-out affidavit, if the physician or practitioner satisfies the requirements of 42 CFR § 405.445(b). No other method of terminating opt-out status before the end of the two year opt-out term is available.

Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for two years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015, will automatically renew every two years. If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all Medicare administrative contractors (MACs) with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period. Valid opt-out affidavits signed before June 16, 2015, will expire two years after the effective date of the opt out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all MACs with which they would have filed claims absent the opt-out. For more information on the opt-out process, refer to *MLN Matters*® article SE1311, titled "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries," which is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf* and *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-06-25-eNews.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending&imagelink=y#_Toc422891549*.

CMS would like to highlight the following limitations that apply to billing and non-billing providers:

- A resident is defined in 42 CFR § 413.75 as an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board. Interns, residents, and fellows may enroll in Medicare to prescribe if the state licenses them. Licensure can include a provisional license or similarly-regulated credential. Un-licensed interns, residents, and fellows must specify the teaching physician who is enrolled in Medicare as the authorized prescriber on a prescription for a Part D drug (assuming this is consistent with state law). Licensed residents have the option to either enroll themselves or use the teaching physician's name on prescriptions for Part D drugs, unless state law specifies which name is to be used. CMS strongly encourages teaching physicians and facilities to ensure that the NPI of the lawful prescriber under state law is included on prescriptions to assist pharmacies in identifying the correct prescriber and avoid follow up from the pharmacies, which experience rejected claims from Medicare Part D plans due to missing or wrong prescriber NPIs on the claims.
- The prescriber enrollment requirements also apply to physicians and non-physician practitioners who write prescriptions for Part D drugs and are employed by a Part A institutional provider (e.g., hospital, federally qualified health center (FQHC), rural health center (RHC)). Since Part A institutional providers may bill for services provided by an employed physician or non-physician practitioner, the physician or non-physician practitioner may not have separately enrolled, unless he or she is also billing for Part B services. Therefore, if the physician or non-physician practitioner prescribes Part D drugs as an employee of the institutional provider, he or she must be enrolled in an approved status for their prescriptions to be coverable under Part D beginning June 1, 2016.
- "Other authorized prescribers" are exempt from the Medicare Part D prescriber enrollment requirement. In other words, prescriptions written by "other authorized prescribers are still coverable under Part D, even if the prescriber is not enrolled in or opted out of Medicare. For purposes of the Part D prescriber enrollment requirement only, "other authorized prescribers" are defined as individuals other than physicians and eligible professionals who are authorized under state or other applicable law to write prescriptions but are not in a provider category that is permitted to enroll in or opt-out of Medicare under the applicable statutory language. CMS believes "other authorized prescribers"

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are largely pharmacists who are permitted to prescribe certain drugs in certain states, but based on the applicable statute, pharmacists are not able to enroll in or opt-out of Medicare.

If you believe you are an "other authorized prescriber" and are not a pharmacist, please contact *providerenrollment@cms.hhs.gov*. In addition, CMS strongly recommends that pharmacists in particular make sure that their primary taxonomy associated with their NPI in the National Plan & Provider Enumeration System (NPPES) reflects that they are a pharmacist. To review and update your NPPES information, please go to the National Plan & Provider Enumeration System Web page at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*. Upon enforcement of the regulation, Part D plans will need to be able to determine if the prescriber is a pharmacist in order to properly adjudicate the pharmacy claim at point-of-sale.

In an effort to prepare the prescribers and Part D sponsors for the February 1, 2017, enforcement date, CMS has made available an enrollment file that identifies physician and eligible professional who are enrolled in Medicare in an approved or opt-out status. However, the file does not specify if a particular prescriber is eligible to prescribe, as prescribing authority is largely determined by state law. The enrollment file is available at *https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx*. The file contains production data but is considered a test file since the Part D prescriber enrollment requirement is not yet applicable. An updated enrollment file will be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement.

The file displays physician and eligible professional eligibility as of and after November 1, 2014, (that is, currently enrolled, new approvals, or changes from opt-out to enrolled as of November 1, 2014). Any periods, prior to November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will not be displayed on the enrollment file. However, any gaps in enrollment after November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will be reflected on the file with its respective effective and end dates for that given provider. For opted out providers, the opt-out flag will display a Y/N (Yes/No) value to indicate the periods the provider was opted out of Medicare. The file will include the provider's:

- (NPI);
- First and last names;
- Effective and end dates; and
- Opt-out flag

Example 1– Dr. John Smith's effective date of enrollment is January 1, 2014. Since he was enrolled prior to the generation of the test file, his effective date will display as November 1, 2014. Dr. Smith submits an enrollment application to voluntarily withdraw from Medicare effective December 15, 2014. Dr. Smith will appear on the applicable file as:

NPI	First name	Last name	Eff date	End date	Opt out flag
123456789	John	Smith	11/1/14	12/15/14	N

Example 2 - Dr. Mary Jones submits an affidavit to opt-out of Medicare, effective December 1, 2014. Since she has opted out after the generation of the test file, her effective date will display as December 1, 2014. After the two year opt-out period expires, Dr. Jones decides she wants to enroll in Medicare to bill, order, and certify, or to write prescriptions. The enrollment application is received on January 31, 2017, and the effective date issued is January 1, 2017. Dr. Jones will display on the applicable file as:

NPI	First name	Last name	Eff date	End date	Opt out flag
987654321	Mary	Jones	12/1/14	12/1/16	Y
87654321	Mary	Jones	1/1/17		N

After the enforcement date of February 1, 2017, the applicable effective dates on the file will be adjusted to February 1, 2017, and it will no longer be considered a test file. All inactive periods prior to February 1, 2017, will be removed from the file and it will only contain active and inactive enrollment or opt-out periods as of February 1, 2017, and after. The file will continue to be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement. Part D sponsors may utilize the file to determine a prescriber's Medicare enrollment or opt-out status when processing Part D pharmacy claims. The file will not validate the provider's ability to prescribe under applicable laws. Please submit questions or issues encountered in accessing the file to *providerenrollment@cms.hhs.gov*.

Additional information

For more information on the enrollment requirements, visit *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*. If you have questions and need to speak with the Part B contractor that handles your enrollment, you may find their toll-free number at *MAC List*.

For a list of frequency asked questions (FAQs) refer to *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMS-4159_FAQs.pdf*.

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Document History

Date of change	Description
April 18, 2016	The article was revised to amend additional dates in the article to reflect the delayed enforcement date of February 1, 2017.
April 7, 2016	The article was revised to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until February 1, 2017, and to provide clarifying information regarding the enrollment process.
December 5, 2014	The article was revised to add language to emphasize that form CMS-855O is appropriate for use by prescribers.
October 20, 2015	The article was revised to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until June 1, 2016, and to provide clarifying information regarding the enrollment process.

MLN Matters® Number: SE1434
Revised Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

SPOT offers more efficient cost report filing option for Part A providers

Medicare Part A providers may save time and money by electronically filing annual cost report information and conducting other *provider audit and reimbursement transactions* through *SPOT* (Secure Online Provider Tool).

By using *SPOT to file cost reports and supporting documentation*, Part A providers will no longer need to mail large document packages and digital media files to First Coast Service Options (First Coast). SPOT is free to providers who serve the medical needs of beneficiaries covered by traditional fee-for-service Medicare.

Part A providers will be able to submit the following cost report documents through SPOT's secure messaging channel:

- Cost report
- Reopening
- Appeals
- SSI realignment request (DSH)
- Provider-based determination
- Wage index/Occupational mix submissions
- Desk review/Audit additional documentation
- Submit FOIA request
- Submit PS&R request
- General correspondence

To access SPOT, providers with an existing EIDM (enterprise identity management system) account will have to request access to SPOT. Most hospitals, nursing homes, skilled nursing facilities, end-stage renal disease treatment providers, federally-qualified health centers, and rural health centers already have an EIDM account through their use of the provider and statistical reimbursement (PS&R) system. For providers with established EIDM accounts seeking access to SPOT, First Coast provides a *step-by-step guide*.

You must have an EIDM account before you can request access to SPOT. First Coast provides a *tutorial to assist you in establishing your EIDM and SPOT accounts*. First Coast approves most requests for access to SPOT within 48 hours.

Besides streamlined cost report filing, SPOT also gives providers the ability to view claims status and patient eligibility information online. Providers may use SPOT to conduct detailed data analysis at the claim and provider levels, and reopen claims to make clerical corrections on multiple lines and submit redeterminations and additional development responses (ADRs).

The *SPOT User Guide* includes a full description of submitting cost report forms through the secure messaging tool.

Processing Issues

Rural health clinic claims processing incorrectly

Issue

The Centers for Medicare & Medicaid Services (CMS) is aware of an issue with rural health clinic claims processing incorrectly. These claims are being held by your Medicare administrative contractor (MAC) until this error can be corrected.

Resolution

A system fix is scheduled for April 25 to correct this problem. Once implemented, your MAC will release all affected claims to complete processing. Please contact your MAC with any questions.

Status/date resolved

Open

Provider action

No action is required by the provider.

Current processing issues

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

New drug testing laboratory codes editing incorrectly

Issue

The Centers for Medicare & Medicaid Services (CMS) discovered systems errors affecting claims with new drug testing laboratory codes (HCPCS codes G0477 through G0483) with dates of service on or after January 1, 2016.

Resolution

Your Medicare administrative contractor (MAC) will correct any claims previously returned to you in error with these codes and reason code W7006. Your Medicare administrative contractor (MAC) has released all held claims.

Status/date resolved

Closed

Provider action

No action is required by the provider.

Current processing issues

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

Check the status of claim redeterminations online

Don't wait up learn the status of your appeal. You may *check on its status at your convenience -- online*, which enables providers to check the status on active redeterminations to confirm if the appeal has been received by First Coast Service Options.

July 2016 changes to the laboratory NCD edit software

Provider types affected

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

What you need to know

Change request (CR) 9584 informs MACs about changes that will be included in the July 2016 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

For the July 2016 update, effective for services furnished on or after July 1, 2016, International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes E61.1, M79.641, M79.642, M79.644, and M79.645 are added to the list of ICD-10-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.

Additional information

The official instruction, CR 9584, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3485CP.pdf*.

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

MLN Matters® Number: MM9584
Related Change Request (CR) #: CR 9584
Related CR Release Date: March 25, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3485CP
Implementation Date: July 5, 2016

ICD-10-CM diagnosis codes for bone mass measurement

***Note**: This article was revised April 12, 2016, to clarify the removal of a code (originally stated as M85.8) from the list of codes that providers may report. The code that was removed is M85.80 (Other specified disorders of bone density and structure, unspecified site). All other information is the same. This information was previously published in the November 2015 Medicare A Connection, page 17.*

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) will implement change request (CR) 9252 on January 4, 2016, effective October 1, 2015. (See related *MLN Matters*® article MM9252.) This CR establishes the list of covered conditions and corresponding ICD-10-CM diagnosis codes approved for bone mass measurement studies according to the requirements set forth in national coverage determination (NCD) 150.3. CR 9252 and accompanying spreadsheet inadvertently omitted the condition of osteopenia and the ICD-10-CM codes that describe it which are classified to subcategory M85.8- Other specified disorders of bone density and structure. The codes and conditions identified within this subcategory are considered covered indications for bone mass measurement under NCD 150.3 and providers should report these appropriately according to medical documentation. Additional guidance and education as to the updated complete list of covered indications will be forthcoming as CMS continues to review this issue and the systems updates required.

Background

Under ICD-9-CM, the term “Osteopenia” was indexed to ICD-9-CM diagnosis code 733.90 (Disorder of bone and cartilage). This code was listed as a covered condition under the Business requirement 5521.1.1 for CR 5521/ NCD 150.3, dated May 11, 2007, when reported with CPT code 77080. (See related *MLN Matters*® article *MM5521*.) The accompanying *Benefit Policy Manual*, Publication 100-02, Chapter 15, Section 80.5.6, Beneficiaries Who May Be Covered, includes: “2. An individual with vertebral abnormalities as demonstrated by an X-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture”.

Under ICD-10-CM, the term “Osteopenia” is indexed to ICD-10-CM subcategory M85.8- Other specified disorders of bone density and structure, within the ICD-10-CM Alphabetic Index. The codes within this subcategory were inadvertently omitted from the CMS spreadsheet that accompanied CR 9252 containing the list of covered conditions and corresponding diagnosis codes. These are considered covered for NCD 150.3 indications.

Below is the list of ICD-10-CM diagnosis codes within subcategory M85.8- that providers may report as covered indications in addition to the current list provided in CR 9252 and its accompanying CMS spreadsheet.

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- M85.811 Other specified disorders of bone density and structure, right shoulder
- M85.812 Other specified disorders of bone density and structure, left shoulder
- M85.821 Other specified disorders of bone density and structure, right upper arm
- M85.822 Other specified disorders of bone density and structure, left upper arm
- M85.831 Other specified disorders of bone density and structure, right forearm
- M85.832 Other specified disorders of bone density and structure, left forearm
- M85.841 Other specified disorders of bone density and structure, right hand
- M85.842 Other specified disorders of bone density and structure, left hand
- M85.851 Other specified disorders of bone density and structure, right thigh
- M85.852 Other specified disorders of bone density and structure, left thigh
- M85.861 Other specified disorders of bone density and structure, right lower leg
- M85.862 Other specified disorders of bone density and structure, left lower leg
- M85.871 Other specified disorders of bone density and structure, right ankle and foot
- M85.872 Other specified disorders of bone density and structure, left ankle and foot
- M85.88 Other specified disorders of bone density and structure, other site
- M85.89 Other specified disorders of bone density and structure, multiple sites

Additional information

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

Document history

Date of change	Description
April 12, 2016	The article was revised to clarify the removal of a code (originally stated as M85.8) from the list of codes that providers may report. The code that was removed is M85.80 (Other specified disorders of bone density and structure, unspecified site).
April 6, 2016	The article was revised to remove the code M85.8 from the list of codes that may be reported by providers.
October 28, 2015	Initial issuance of article

MLN Matters® Number: SE1525 *Revised*
Related Change Request (CR) #: CR 9252
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.

NCD for single and dual chamber pacemakers

***Note**: This article was revised January 27, 2016, to note that the NCD for Cardiac Pacemakers, "Single Chamber and Dual Chamber Permanent Cardiac Pacemakers" (NCD 20.8.3) was effective August 13, 2013, and remains in effect. In order to address claim processing issues, the Centers for Medicare & Medicaid Services has instructed Medicare administrative contractors (MACs) to implement this NCD at the local level until CMS is able to revise the formal claim processing instructions. All aspects of the NCD policy in the NCD Manual, Section 20.8.3, remain in effect. Additionally, CMS is temporarily removing the corresponding Medicare Claims Processing Manual, Chapter 32, Section 320, and all but two business requirements, to avoid confusion and better clarify that the MACs will use their discretionary authority to process these claims. This information was previously published in the February 2016 Medicare A Connection, Page 19.*

Provider types affected

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

Additional information

The official instruction, CR 9078, was issued to your MAC via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3421CP.pdf*. The second updates the *Medicare National Coverage Determination Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R187NCD.pdf*.

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

Document history

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

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

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

This section of *Medicare B 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 (MAC) jurisdiction N (JN) 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.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the First Coast eNews mailing list. Simply go to *http://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

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

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? First Coast's LCD lookup, available at *http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp*, helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your Internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

Modifier GZ must be used when 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 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 must append the billed service with modifier GA or GZ.

"We are aware of the changes in medical policies via First Coast *eNews* we receive every week. We are continuously monitoring to identify changes and thus prevent claims to be denied."

Sign up for *eNews* by clicking *here*.

– Luis Rodríguez Félix,
Billing manager, Ashford Presbyterian Community Hospital

Retired LCDs

Intensity modulated radiation therapy (IMRT) – retired Part A and Part B LCD

LCD ID number: L33378 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for intensity modulated radiation therapy (IMRT) is being retired due to the coding information within the LCD, which is secondary to the National Correct Coding Initiative (NCCI) manual standard, and is in need of updating. The future coding information will be revised and updated in the June 2016 LCD cycle.

Effective date

This LCD retirement is effective for services rendered **on or after April 7, 2016**. This LCD retirement is effective for services rendered on or after April 7, 2016. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Articles for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Multiple Part A and Part B local coverage determinations (LCDs) being retired

LCD ID number: L33971, L33992, L33993, L33995, L34044 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on data analysis and a review of the local coverage determinations (LCDs), it was determined that the following LCDs are no longer required and, therefore, were retired.

- levocarnitine (Carnitor®, L-carnitine®) – Part A
- epirubicin hydrochloride - Part A and B
- floxuridine (FUDR) – Part A and B
- fludarabine (Fludara®) - Part A and B
- mitoxantrone hydrochloride - Part A and B

Effective date

The retirement of these LCDs is effective for services rendered **on or after April 14, 2016**. First Coast Service Options Inc. LCDs are available, through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Articles 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.

Revisions to LCDs

Bendamustine hydrochloride (Treanda®) – revision to the Part A and Part B LCD

LCD ID number: L33268 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Bendamustime hydrochloride (Treanda®) was revised based on a LCD reconsideration request to include Bendeka™ which was approved by the Food and Drug Administration (FDA) on December 7, 2015.The title of the LCD and the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD were revised to add Bendeka™. Also, Healthcare Common Procedure Coding System (HCPCS) codes C9399 and J9999 were added in the "CPT®/HCPCS Codes" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after April 14, 2016**, for services rendered **on or after December 7, 2015**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Articles 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*.

Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) – revision to the Part A and Part B LCD

LCD ID number: L33723 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) was revised based on reconsideration requests to include the ICD-10-CM diagnosis codes C7A.1 and C80.1 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure code J9181.

Effective date

This LCD revision is effective for claims processed **on or after April 6, 2016**, for services rendered **on or after October 1, 2015**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quicksearch.aspx*.

Articles 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*.

Hemophilia clotting factors – revision to the Part A and Part B LCD

LCD ID number: L33684 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Hemophilia clotting factors was revised based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 9549 (April 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS) and CR 9557 (April 2016 Update of the Ambulatory Surgical Center (ASC) Payment System). Healthcare Common Procedure Coding System (HCPCS) codes C9137 (Injection, Factor VIII [antihemophilic factor, recombinant] [Adynovate], PEGylated, 1 I.U.) and C9138 (Injection, Factor VIII [antihemophilic factor, recombinant] [Nuwiq], 1 I.U.) were added to the "CPT®/HCPCS Codes" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD.

In addition, HCPCS code J7199, for Adynovate and Nuwiq, was added to the "CPT®/HCPCS Codes" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD.

Effective date

This LCD revision is effective for services rendered on or after April 1, 2016. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://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*.

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 the Centers for Medicare & Medicaid Services (CMS) change request (CR) 9549 (April 2016 Update of the Hospital Outpatient Prospective Payment System [OPPS]) and CR 9557 (April 2016 Update of the Ambulatory Surgical Center [ASC] Payment System). The LCD was revised to include Healthcare Common Procedure Coding System (HCPCS) code C9471 in the "CPT®/HCPCS Codes", "ICD-10 Codes that support Medical Necessity", and "Utilization Guidelines" sections of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after April 1, 2016**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Articles 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*.

Additional Information

Self-administered drug (SAD) list – revision to the Part A and Part B article: asfotase alfa (Strensiq™) J3490/ J3590/C9399

LCD ID number: A52571 (Florida, Puerto Rico/ U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered **on or after May 23, 2016**, asfotase alfa (Strensiq™) (HCPCS codes J3490/ J3590/C9399) has been added to the MAC Jurisdiction N (JN) SAD list.

The evaluation of drugs for addition to the self-administered drug (SAD) list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options Inc. (First Coast) SAD lists are available at: *http://medicare.fcso.com/Self-administered_drugs/*.

Quarterly provider update

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

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

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

Enforcement of the partial hospitalization program 20 hours per week billing requirement

Provider types affected

This *MLN Matters*® special edition article is intended for outpatient prospective payment system (OPPS) providers submitting partial hospitalization program (PHP) claims to Medicare A/B Medicare administrative contractors (MACs) for partial hospitalization program services to Medicare beneficiaries.

What you need to know

This article conveys enforcement editing requirements for the *Medicare Benefit Policy Manual*, (Internet-Only Manual 100-02) Chapter 6, Section 70.3 that describes coverage of PHP services. Make sure your billing staff is aware of these changes. This guidance updates the operational mechanism PHP providers should use to bill Medicare for PHP services furnished on or after July 1, 2016.

New editing will be implemented in the July 2016 quarterly release of the integrated outpatient code editor (IOCE).

This advance notice is being given to assist PHP providers to prepare for these changes.

Background

PHPs are structured to provide intensive outpatient psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act). The treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization.

Patients must meet benefit requirements for receiving the partial hospitalization services as defined in §1861(ff) and §1835(a)(2)(F) of the Act. Patients admitted to a PHP must be under the care of a physician who certifies the need for partial hospitalization and require a minimum of 20 hours per week of therapeutic services, as evidenced by their plan of care. The patients also require a comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature. In addition, PHP patients must be able to cognitively and emotionally participate in the active treatment process, and be capable of tolerating the intensity of a PHP program.

To enforce the required minimum of 20 hours per week of therapeutic services, the Centers for Medicare & Medicaid Services (CMS) is instituting three new edits into the IOCE in its July 2016 quarterly release. These new edits will enforce a weekly billing requirement. CMS is giving this advance notice to PHP providers so they can prepare the systems to submit claims correctly and plan accordingly.

July 2016 IOCE editing

IOCE edit	FISS reason code	Narrative	Disposition
95	W7095	Partial hospitalization claim span is equal to or more than 4 days with insufficient number of hours of service	RTP claim
96	W7096	Partial hospitalization interim claim from and through dates must span more than 4 days	RTP claim
97	W7097	Partial hospitalization services are required to be billed week	RTP claim

Initially, for the first quarter all edits will be set up to return to provider (RTP). After the first quarter, CMS will set edit 95 to deny claims.

MLN Matters® Number: SE1607
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: July 1, 2016
Related CR Transmittal #: N/A
Implementation Date: July 5, 2016

Required billing updates for rural health clinics

***Note**: This article was revised March 24, 2016, due to a revised change request (CR). In the article, the transmittal number, CR issue date, and the Web address for accessing CR 9269 are revised. All other information is unchanged. This information was previously published in the March 2016 Medicare A Connection, pages 22-24.*

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

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

Caution – what you need to know

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

Go – what you need to do

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

Background

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

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

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

CR 9269 changes

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

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

Qualified preventive health services include the IPPE, the AWV, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. For a complete list of preventive services and their coinsurance and deductible requirements, see the *RHC Preventive Services Chart* on the *CMS RHC 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 below. 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.
- 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

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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 below 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 18)

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 18)

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 18)

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 19)

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 19)

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 19)

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.
- 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.

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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/R1637OTN.pdf*.

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

MLN Matters® Number: MM9269 *Revised*
Related CR Release Date: March 23, 2016
Related Transmittal #: R1637OTN
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	$76.402	AIR	Yes
0300	36415	4/1/16	1	$3.003	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	$76.402	AIR	Yes
052x	G0101	4/1/16	1	$38.673	Included in the AIR	No
0300	36415	4/1/16	1	$3.003	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

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]	04/01/2016	1	$38.672	AIR	No

[1]Preventive service HCPCS code from the *RHC Qualifying Visit List*
[2]Total charges for encounter
[3]Coinsurance and deductible are waived when appropriate

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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	$110.632	AIR	Yes
0900	90863	04/01/2016	1	$25.423	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charges for encounter
[3]Coinsurance and deductible are waived when appropriate

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	$183.322	AIR	Yes
052x	12002	4/1/16	1	$109.923	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charges for the counter
[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	$139.112	AIR	Yes
0300	36415	4/1/16	1	$3.003	Included in the AIR	No
0636	90746	4/1/16	1	$59.713	Included in the AIR	No
0771	G0010	4/1/16	1	$5.003	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

What is Medicare Fraud?

Fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. Learn more at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf*.

Manual updates to correct remittance advice messages

Provider types affected

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

What you need to know

Change request (CR) 9562 informs MACs about revisions to Chapters 3, 6, 7, and 15 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 the manual. CR 9562 does not reflect any change in Medicare policy.

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 Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. CR 8424 established a standard format for presenting these code combinations in the *Medicare Claims Processing Manual*. CR 9562 updates Chapters 3, 6, 7, and 15 of the manual to reflect the standard format and to correct any non-compliant code combinations. CR 9562 does not reflect any change in Medicare policy.

Additional information

The official instruction, CR 9562, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3481CP.pdf*. The revised manual chapters are included in CR 9562.

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

MLN Matters® Number: MM9562
Related Change Request (CR) #: CR 9562
Related CR Release Date: March 18, 2016
Effective Date: June 20, 2016
Related CR Transmittal #: R3481CP
Implementation Date: June 20, 2016

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on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 9466, MACs will implement on the date specified on the WPC website. The WPC website is available at *https://www.wpc-edi.com/Reference*.

In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version should be implemented.

CR 9466 advises the SSMs and MACs to perform the updates posted on the WPC based on the March 1, 2016, CARC and RARC code change lists.

Additional information

The official instruction, CR 9466, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3489CP.pdf*.

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

MLN Matters® Number: MM9466
Related Change Request (CR) #: CR 9466
Related CR Release Date: April 1, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3489CP
Implementation Date: July 5, 2016

Reporting principal and interest amounts when refunding previously recouped money on the remittance advice

***Note**: This article was revised April 19, 2016, to reflect the revised change request (CR) 9168 issued March 24. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the November 2015 Medicare A Connection, page 44.*

Provider types affected

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

Provider action needed

Change request (CR) 9168 explains to providers who received a favorable appeals decision that it will be easier and consequently more transparent to identify the claim and/or the refund of principal and interest paid by Medicare. Your MAC will make sure that the remittance advices are reporting the refunded principal and interest amounts separately, and provide individual claim information. CR 9168 applies to electronic remittance advice (ERA) only.

Background

Currently reporting of refunded principal and interest amounts for all related claims on the remittance advice (RA) is shown as one lump sum amount. This practice creates problems for the provider community as this is not conducive to posting payment properly. Providers have the money but are not able to identify the claim and/or the refund of principal and interest paid by Medicare.

CR 9168 instructs MACs to report the principal and interest separately and also to provide individual claim information. Specifically, the reporting will be in the provider level balance (PLB) segment of the 835 with an example as follows:

PLB details - reporting principal refunds

PLB03-1: WW to report overpayment recovery (negative sign for the amount in PLB04) being refunded

PLB 03-2 Positions 1 – 25: Account payable (AP) invoice number

PLB 03-2 Positions 26 – 50: Claim adjustment account receivable (AR) number

PLB 04: Refund amount (principal refund amount)

PLB details - reporting interest refunds

PLB 03-1: RU to report interest paid (negative sign for the amount in PLB04)

PLB 03-2 Positions 1 – 25: AP invoice number

PLB 03-2 Positions 26 – 50: Claim adjustment AR number

PLB 04: Interest amount on refund

Additional information

The official instruction, CR 9168 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1639OTN.pdf*.

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

Document history

- The article was revised April 19, 2016 to reflect the revised CR 9168 issued March 24.

MLN Matters® Number: MM9168
Revised Related Change Request (CR) #: CR 9168
Related CR Release Date: March 24, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R1639OTN
Implementation Date: July 5, 2016

Your Feedback Matters

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

Updates to Medicare's organ acquisition and donation payment policy

Provider types affected

This *MLN Matters*® special edition article is intended for all providers and suppliers who submit claims or Medicare cost reports (MCRs) to Medicare administrative contractors (MACs) for organ procurement, transplant, and histocompatibility laboratory services provided to Medicare beneficiaries.

What you need to know

This article is intended to assist providers and suppliers by offering information and resources to clarify Medicare's organ acquisition and donation payment policy for organ procurement, transplant, and histocompatibility laboratory services provided to Medicare beneficiaries. The information does not convey any new or changed policy, but conveys clarification language in the *Provider Reimbursement Manual (PRM)*, CMS Pub. 15-1, Chapter 31. This clarification is provided to ensure appropriate reporting of organ acquisition costs, including those in a living kidney paired donation (KPD) exchange, to achieve proper Medicare reimbursement.

Background

CMS issued Chapter 31 of the PRM to clarify Medicare's payment policy regarding organ acquisition costs, formerly found in Chapter 27, Sections 2770 through 2775.4. In response to questions raised by the transplant community, chapter 31 clarifies the accounting and reporting of KPD exchange costs in the MCR. The chapter also clarifies the appropriate methodology for counting organs.

- Section 3106 clarifies the accounting for costs of services in a living KPD exchange, provides a detailed example of an exchange, and summarizes the example in a chart.
- Section 3115 clarifies the methodology for counting organs, including those procured and transplanted en bloc.

Highlights from Section 3106, kidney paired donations

- KPDs are similar to directed living donations; however, when the living donor and recipient do not match, they can consent to participate in a KPD matching program that matches living donor/recipient pairs with other living donor/recipient pairs. KPD exchanges can occur when two or more living donor/recipient pairs match each other; often, the living donor and matched recipient are at different certified transplant centers (CTCs).
- The costs of all hospital and physician services for pre-transplant living donor and recipient evaluations become acquisition costs and are included in the MCR of the recipient's CTC. Similarly, when a recipient and donor do not match and elect to participate in a KPD matching program, the costs of the initial living donor evaluations are incurred by the original intended recipient's CTC, regardless of whether the living donor actually donates to their original intended recipient, a KPD matched recipient, or does not donate at all.
- In a KPD exchange, once the donor is matched with a recipient, any additional tests requested by the recipient's CTC, but performed by the donor's CTC are billed as charges reduced to cost to the recipient's CTC and included as acquisition costs on the MCR of the recipient CTC. This is true regardless of whether an actual donation occurs.
- When a donor's CTC procures and sends a kidney to a recipient's CTC, the donor's CTC bills the recipient's CTC the donor CTC's charges reduced to cost for the reasonable costs associated with procuring, packaging, and transporting the kidney. The donor's CTC records these costs on its MCR as kidney acquisition costs and offsets any payments received from the recipient's CTC against its kidney acquisition costs. The recipient's CTC records as part of its kidney acquisition costs, the amounts billed by the donor's CTC for the reasonable costs associated with procuring, packaging, and transporting the organ as well as any additional testing performed and billed by the donor's CTC. These costs must be reasonable and necessary.
- When a donor's CTC does not procure a kidney, but the donor travels to the recipient's CTC for the procurement, the reasonable costs associated with the procurement are included on the MCR of the recipient's CTC. Travel expenses of the living donor are not allowable Medicare costs.

Highlights from Section 3115, counting organs

- Organ procurement organizations (OPOs) and CTCs are responsible for accurately counting both Medicare and non-Medicare organs to ensure that costs are properly allocated on the MCR. The OPO and CTC must count organs procured and transplanted en bloc (two organs transplanted as one unit) as one organ. This can include, but is not limited to, en bloc kidneys and en bloc lungs.
- Medicare usable organs include organs transplanted into Medicare beneficiaries (excluding Medicare Advantage beneficiaries), organs that had partial payments by a primary insurance payer in addition to Medicare, organs sent to other CTCs, organs sent to OPOs and kidneys sent to military renal transplant centers (MRTCs) that have a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the contractor. Medicare usable organs do not include organs used for research, organs sent to veterans' hospitals, organs sent outside the United States, organs transplanted into non-Medicare beneficiaries, organs that were

ORGAN

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totally paid by primary insurance other than Medicare, organs that were paid by a Medicare advantage plan, organs procured from a non-certified OPO and kidneys sent to MRTCs that do not have a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the contractor.

- Kidneys counted as Medicare kidneys include those sent to CTCs, certified OPOs, or MRTCs (with a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the contractor). It does not include kidneys sent to foreign countries, VA hospitals, or MRTCs (without a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the contractor), or those used for research.

Information and resources

The following resources are available to find additional information regarding Medicare's organ acquisition and donation payment policy:

- PRM Transmittal 471 containing – CMS Pub. 15-1, Chapter 31;
- PRM – CMS Pub. 15-2, Chapters 33 and 40;
- *Medicare Claims Processing Manual* – CMS Pub. 100-04; and
- *Medicare Benefit Policy Manual* – CMS Pub. 100-02.

Additional information

If you have any questions, please contact your MAC at their toll-free number. To find MAC toll-free numbers, please refer to the Review Contractor Interactive Map located at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: SE1608
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: April 1, 2016
Related CR Transmittal #: N/A
Implementation Date: N/A

April 2016 integrated outpatient code editor specifications version 17.1

***Note**: This article was revised March 23, 2016, to reflect the revised change request (CR) 9553, issued March 22. In the article, the transmittal number, CR issue date, and the Web address for accessing CR 9553 are revised. In addition, a row was added to the table to show added editing for NCD effective date for code G0475. All other information remains the same. This information was previously published in the March 2016 Medicare A Connection, pages 36-39.*

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

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 *https://www.cms.gov/OutpatientCodeEdit/*. These specifications contain the appendices mentioned in the 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
1/1/15	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.

See **I/OCE**, next page

I/OCE

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Effective date	Edits affected	Modification
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).
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).

See **I/OCE**, next page

I/OCE

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Effective date	Edits affected	Modification
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).
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
1/1/16		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.

See **I/OCE**, next page

I/OCE

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Effective date	Edits affected	Modification
11/24/15	67	Add mid-quarter editing for Food and Drug Administration (FDA) approval of code 90653 (SI changed to L).
4/13/15	68	Add mid-quarter editing for NCD effective date for code G0475
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)
4/1/16		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
4/1/2016	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/R3483CP.pdf*. If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work.

MLN Matters® Number: MM9553 *Revised*
Related Change Request (CR) #: CR 9553
Related CR Release Date: March 22, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3483CP
Implementation Date: April 4, 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.

Upcoming provider outreach and educational event May-June 2016

Save money and time using SPOT to file annual cost report

Date: Thursday, May 19
Time: 10:30-11:30 a.m.
Type of Event: Webcast
http://medicare.fcso.com/Events/0338255.asp

Medicare Part A changes and regulations

Date: Tuesday, June 14
Time: 10:00-11:30
Type of Event: Webcast
http://medicare.fcso.com/Events/0325460.asp

Note: Unless otherwise indicated, all First Coast educational offerings are considered to be "ask-the-contractor" events, "webcast" type of event, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at *http://www.fcsouniversity.com*, log on 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 User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. 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 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 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues 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 the First Coast Medicare training website, 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 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. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

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 March 31, 2016

MLN Connects® Provider eNews for March 31, 2016

View this edition as a PDF

In this edition:

MLN Connects® Events

- Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Last Chance to Register
- 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
- 2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments Call — Registration Now Open
- National Partnership to Improve Dementia Care and QAPI Call — Registration Now Open
- New Video Slideshow Available

Medicare Learning Network® Publications and Multimedia

- Basics of Medicare Series of Web-Based Training Courses — New
- Long-Term Care Hospital Prospective Payment System Booklet — Revised
- Medicare Ambulance Transports Booklet — Revised

- Clinical Laboratory Fee Schedule Fact Sheet — Revised
- Hospital Outpatient Prospective Payment System Fact Sheet — Revised

Announcements

- CMS Launches New Effort to Improve Care for Nursing Facility Residents
- Advance Care Planning: New FAQs

Claims, Pricers, and Codes

- Modifications to HCPCS Code Set
- Medicare Payment for PAP Devices

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

MLN Connects® Provider eNews for April 7, 2016

MLN Connects® Provider eNews for April 7, 2016

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In this edition:

MLN Connects® Events

- Open Payments 2016: Prepare to Review Reported Data Call — Last Chance to Register
- IMPACT Act: Data Element Library Call — Last Chance to Register
- Medicare Shared Savings Program ACO Application Process Call — Register Now
- 2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments Call — Register Now
- National Partnership to Improve Dementia Care and QAPI Call — Register Now

Other CMS Events

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

Medicare Learning Network® Publications and Multimedia

- Medicare Shared Savings Program and Rural Providers Fact Sheet — Revised
- ACOs: What Providers Need to Know Fact Sheet — Revised
- Improving Quality of Care for Medicare Patients: ACOs Fact Sheet — Revised
- Federally Qualified Health Center Fact Sheet – Revised
- Critical Access Hospital Booklet — Revised
- DMEPOS Information for Pharmacies Fact Sheet — Reminder
- Safeguard Your Identity and Privacy Using PECOS Fact Sheet — Reminder

Announcements

- Comprehensive Care for Joint Replacement Model Launched
- CMS Invites QIN-QIOs to Submit Special Innovation Projects
- Open Payments: Physician and Teaching Hospital Review and Dispute Period Began April 1
- Join the Million Hearts® Model: Letter of Intent due April 15
- CMS to Release a CBR on Modifiers 24 and 25 for General Surgeons in April
- 2016 PQRS GPRO Registration Open through June 30
- 2015 Mid-Year QRURs Available
- Find Information on the SNF Value-Based Purchasing Program
- April Quarterly Provider Update Available
- Help Prevent Alcohol Misuse or Abuse

Claims, Pricers, and Codes

- April 2016 Outpatient PPS Pricer File Available

MLN Connects® Provider eNews for April 14, 2016

MLN Connects® Provider eNews for April 14, 2016

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In this edition:

MLN Connects® Events

- Medicare Shared Savings Program ACO Application Process Call — Last Chance to Register
- 2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments Call — Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- How to Register for the 2016 PQRS Group Practice Reporting Option Call — Registration Now Open
- 2015 Mid-Year QRURs Webcast — Registration Open

Other CMS Events

- Learn about the SNF Value-Based Purchasing Program at Open Door Forum
- IRF Quality Reporting Program Provider Training

Medicare Learning Network® Publications and Multimedia

- Enforcement of the PHP 20 Hours per Week Billing Requirement *MLN Matters*® Article — New
- Updates to Medicare's Organ Acquisition and Donation Payment Policy *MLN Matters*® Article — New
- CMS Provider Minute: CT Scans Video — New
- *Medicare Learning Network* LM/POS FAQs Booklet — New
- Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
- Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs *MLN Matters*® Article — Revised
- ICD-10-CM Diagnosis Codes for Bone Mass Measurement *MLN Matters*® Article — Revised
- Medicare Secondary Payer Provisions Web-Based Training Course — Revised

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MLN Connects® Provider eNews for April 21, 2016

MLN Connects® Provider eNews for April 21, 2016

View this edition as a PDF

In this edition:

MLN Connects® Events

- National Partnership to Improve Dementia Care and QAPI Call — Last Chance to Register
- How to Register for the 2016 PQRS Group Practice Reporting Option Call — Register Now
- 2015 Mid-Year QRURs Webcast — Register Now
- New Audio Recording and Transcript Available

Other CMS Events

- Hospice Quality Reporting Program Webinar
- EHR Incentive Programs: March HIMSS16 Presentations

Medicare Learning Network® Publications and Multimedia

- Screening Pap Tests and Pelvic Examinations Booklet — New
- Hospital Value-Based Purchasing Program Fact Sheet — Revised

Announcements

- Hospital Inpatient PPS and LTCH PPS Proposed Rule for FY 2017
- Check Your 2015 Open Payments Data
- IRF Quality Reporting Program Data Submission Deadline: May 15 — Updated
- LTCH Quality Reporting Program Data Submission Deadline: May 15 — Updated
- 2017 Medicare Shared Savings Program: Notice of Intent to Apply Due by May 31
- CMS to Release a Comparative Billing Report on Psychotherapy and E/M Services in May
- 2016 Clinical Quality Measure Electronic Reporting: Updated Files
- April is STI Awareness Month: Talk, Test, Treat

Claims, Pricers, and Codes

- Rural Health Clinic Claims Processing Incorrectly

eNews

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- Infection Control: Injection Safety Web-Based Training Course — Revised

Announcements

- CMS Launches Largest-Ever Multi-Payer Initiative to Improve Primary Care in America
- Submit Comments on QRDA Implementation Guide for HQR by April 18
- IRF Quality Reporting Program Data Submission Deadline: May 15
- LTCH Quality Reporting Program Data Submission Deadline: May 15
- 2016 eCQMs Annual Update Available
- EHR Incentive Programs 2016 Program Requirements: New Resources
- ICD-10 Coding Resources
- National Healthcare Decisions Day is April 16
- April is National Minority Health Month

Claims, Pricers, and Codes

- April 2016 OPPS Pricer File Update
- Updates to HCPCS Code Set

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) (*https://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