Medicare A CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

July 2016

In this issue

MLN Connects® Provider eNews – Special Edition for July 7, 2016

Physician Fee Schedule: Proposed 2017 Changes

Medicare also expands the diabetes prevention program

On July 7, CMS proposed changes to the physician fee schedule to transform how Medicare pays for primary care through a new focus on care management and behavioral health designed to recognize the importance of the primary care work physicians perform. The rule also proposes policies to expand the diabetes prevention program within Medicare starting January 1, 2018.

The annual physician fee schedule updates payment policies, payment rates, and quality provisions for services provided in 2017. These services include, but are not limited to visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services. In addition to physicians, the fee schedule pays a variety of practitioners and entities, including nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities. Additional policies proposed in the 2017 payment rule include:

- Primary care and care coordination
- Mental and behavioral health
- Cognitive impairment care assessment and planning
- Care for patients with mobility-related impairments

For More Information:

- *Proposed Rule (CMS-1654-P)*: Comments due no later than 5 pm on September 6, 2016
- *Fact Sheet*
- *Blog*

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Contents

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

Publication staff:
Liliana Chaves-Merchan
Terri Drury
Sofia Lennie
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

Processing time frames for enrollment applications

As the Medicare administrative contractor (MAC) for jurisdiction N (JN), First Coast Service Options Inc. (First Coast) is not only responsible for processing Medicare claims but also for processing enrollment applications for providers and suppliers located in Florida, Puerto Rico, and the U.S. Virgin Islands.

The Centers for Medicare & Medicaid Services (CMS) has established the following timeliness standards for contractors responsible for processing enrollment applications within their assigned jurisdictions:

- PECOS web applications (initial enrollment with no site visit) – 80 percent must be processed within **45 days**
- Paper-based applications (initial enrollment with no site visit) – 80 percent must be processed within **60 days**
- Paper-based applications (initial enrollment with site visit) – 80 percent must be processed within **80 days**
- Paper-based applications (changes to enrollment record or reassignment) – 80 percent must be processed within **60 days**

First Coast provider enrollment average YTD processing times (through June 30)		
	Part A	**Part B**
PECOS web applications		
No development	11 days	34 days
With development	18 days	48 days
Paper applications		
No development	13 days	44 days
With development	35 days	68 days

Factors affecting total processing times

Although First Coast processes each enrollment application as quickly as possible, the following key factors may affect the total processing time needed:

- **Provider type:**
  - **Part A** – institutional providers
  - **Part B** – physicians, non-physician practitioners, clinics, and group practices

Shortest processing times: *Enrollment applications for Part B providers and suppliers*

- **Application type:**
  - **PECOS Web application** – an electronic enrollment application submitted through *the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) website*.
  - **Paper-based application** – a paper enrollment application that is printed and submitted through the mail.

Shortest processing times: *PECOS web applications*

- **Development required:**
  - **No development** – the enrollment application (paper-based or electronic) is accurate, complete, and is submitted with all *required support documentation*.
  - **With development** – the enrollment application (paper-based or electronic) falls into one or more of the following categories:
    - Contains errors or inconsistencies
    - Incomplete (e.g., missing information or signature)
    - Support documentation missing or insufficient

Shortest processing times: *Enrollment applications that do not require development*

Revised CMS-855R application – Reassignment of Medicare benefits

Physicians and non-physician practitioners must use the revised CMS-855R (reassignment of benefits) application beginning January 1, 2017. The revised application will be posted on the CMS Forms List (*http://go.usa.gov/cuu5Y*) by mid-summer.

Medicare administrative contractors (MACs) will accept both the current and revised versions of the CMS-855R through December 31, 2016. Visit the Medicare Provider-Supplier Enrollment web page (*http://go.usa.gov/cuujB*) for more information about Medicare enrollment.

The revised form made the primary practice location section optional. However, this information is shared with other programs, such as the physician compare initiative, to help beneficiaries identify your practice.

Protecting patient personal health information

Provider types affected

This *MLN Matters*® article is intended for physicians, including physician group practices, that are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) using electronic systems to store personal health information (PHI) of their Medicare patients.

Provider action needed

This *MLN Matters*® special edition article reminds physicians of the HIPAA requirement to protect the confidentiality of the PHI of their patients. Recently, the Centers for Medicare & Medicaid Services (CMS) learned of a potential security breach in which someone was *offering for sale over 650,000 records* of orthopedic patients. Remember that a covered entity must notify the Secretary of Health and Human Services if it discovers a breach of unsecured protected health information. See *45 C.F.R. § 164.408*. Also, keep abreast of any issues that your business associates, especially those entities that provide you with hardware and/or software support for your patient electronic health records. Be sure they are required to report any actual or potential security breaches to you, especially threats that compromise patient PHI.

Background

CMS is providing this information in response to a recent report from the cyber health working group. This group recently reported the detection of an offer to sell six databases, three of which were databases that appeared to be orthopedic databases. Providers need to be extremely conscious of their systems security, especially with systems that connect to the internet.

Additional information

The report on the advertised sale of patient databases is available at *http://hothardware.com/news/hacker-reportedly-infiltrates-three-us-healthcare-companies-offers-650000-patient-records-for-sale*.

45 CFR 164.408 is available at *https://www.gpo.gov/fdsys/granule/CFR-2011-title45-vol1/CFR-2011-title45-vol1-sec164-408*.

Information on reporting breaches of security is available at *http://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html*.

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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 *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf*.

Fax machine settings can lead to "timed-out" claim denials

First Coast Service Options (First Coast) is experiencing an increase in claim denials due to providers not responding timely to additional development requests (ADRs). If you have received this type of claim denial even though you responded via fax by the due date, your fax machine settings may be causing these unnecessary denials. First Coast identified this as an issue particularly for providers faxing documentation to multiple ADRs during the same time period.

When documentation is required to continue processing claims, an ADR letter is sent and the provider has 45 days to respond. If the records are not received timely, the claim automatically denies on day 46. The messages for these timed-out claim denials include:

- Part A: Reason codes 56900 or 39721
- Part B: Claim adjustment reason code (CARC) CO 50 with remittance advice remark code (RARC) M127
- Part B: CARC CO 226 with RARC N517

Check your fax settings

If you have received these types of denials but have responded by fax timely, the issue may be the batch setting for your fax machine or fax system. If the batch setting is active, transmissions will batch, or bundle, all documents sent to the same destination number within a specific time frame as one transmission. This occurs even if you scan and receive confirmation pages separately for each fax transmission because your fax machine/system holds the records in its memory for a period of time.

First Coast's automated imaging process receives batch transmissions as only one submission. This means that only the first claim of the batch submission is controlled and received as timely. Documents for other ADRs included in the batched submission are not controlled, which causes the claims to eventually time out and deny.

Avoid using batch transmissions when responding to ADRs

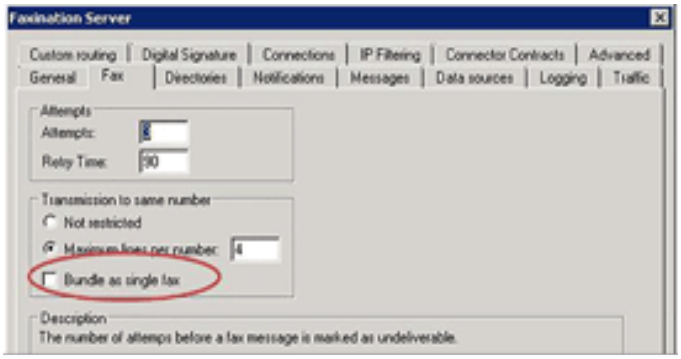
First Coast must receive the documents for each ADR separately to be matched to the appropriate claim timely; therefore, providers should ensure that batch transmissions are not occurring when faxing. Some fax machine models allow the "#" key to be pressed at the end of your document(s) scanning for each ADR, which signals the machine to finish the transmission before starting the next one. However, every machine is different, so check the user manual or contact the manufacturer's customer service for assistance on deactivating the batch setting. At the end of this article, we provide examples with technical details for certain types of fax systems or manufacturers.

Please DO NOT contact First Coast's Customer Service department for assistance with your faxination setting.

Another option for preventing claim denials is to utilize First Coast's SPOT (Secure Provider Online Tool) to respond to ADRs for claims on prepayment medical reviews. For instructions on how to respond to ADRs through SPOT, please review the *SPOT: User Guide*. If you don't already have a SPOT account, visit the *SPOT page* to learn about requesting one.

Examples with technical details for certain fax machines/systems

1. **Faxination server installation:**



2. **Ricoh multi-function device:**

Batch Transmission

If you send a fax message by Memory Transmission and there is another fax message waiting in memory to be sent to the same destination, that message is sent along with your message. Several fax messages can be sent with a single call, thus eliminating the need for several several separate calls. This helps save communication costs and reduces transmission time.

Fax messages for which the transmission time has been set in advance are sent by Batch Transmission when time is reached.

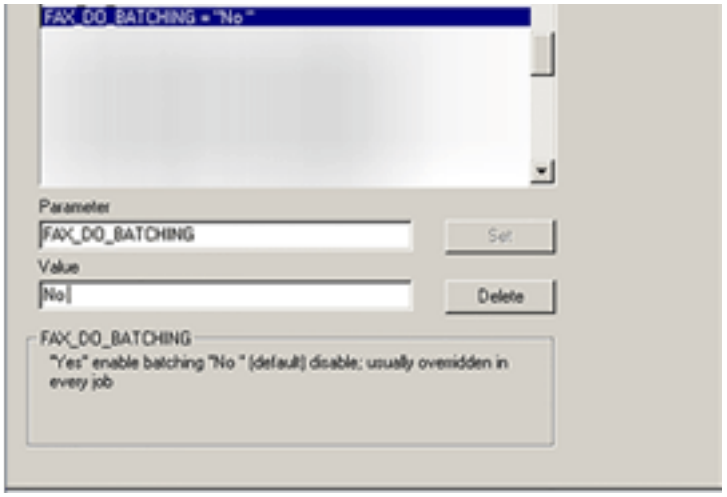
Note

- You can switch this function on or off with User Parameters. See p. 85 "User Parameters" (Switch06, Bit4).

Note also that the switches and bits listed above may vary from machine to machine.

3. **Biscom fax service:**

- Set "FAX_DO_BATCHING" to "No" under the Advanced Parameter Configurations



Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2016, must be paid before the end of business March 31, 2016.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department web page *https://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/rates.htm* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 1.875 percent is in effect through December 31, 2016.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

TECENTRIQ™ – billing instructions

On May 18, 2016, the U. S. Food and Drug Administration approved atezolizumab (TECENTRIQ™ injections, Genentech, Inc.) for the treatment of patients with locally advanced or metastatic urothelial carcinoma who: Have disease progression during or following platinum-containing chemotherapy or have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

The recommended dose and schedule for TECENTRIQ™ is 1200 mg administered as an intravenous infusion over 60 minutes every three weeks until disease progression or unacceptable toxicity.

Submit

- **HCPCS code** C9399
- **Diagnoses**: C65.1-C65.9 (Malignant neoplasm of renal pelvis), or C66.1-C66.9 (Malignant neoplasm of the ureter), or C67.0-C67.9 (Malignant neoplasm of the bladder), or C68.0-C68.9 (Malignant neoplasm of other and unspecified urinary organs).

Narrative field

Name of the drug, strength, dosage, and NDC (national drug code) number.

Processing Issues

Overpayments resulting from sequestration error

Issue

Claims for “statement through” date on or after April 1, 2016, and received prior to April 27, 2016, did not incur a 2 percent reduction as directed by the Center for Medicare & Medicaid Services, resulting in overpayments. This reduction (also known as “sequestration”) covers all payments for services with dates of service or dates on or after April 1, 2013, until further notice.

Resolution

The error was corrected April 26, 2016. All impacted claims haven been adjusted to recoup the overpaid amounts. The overpayment will be recouped in the normal process of immediate offset or demand letter.

Status/date resolved

Closed/July 26, 2016

Provider action

No provider action is required.

Current processing issues

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

Medicare coverage of diagnostic testing for Zika virus

Provider types affected

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

Provider action needed

This *MLN Matters*® special edition article informs the public that Medicare covers Zika virus testing under Medicare Part B as long as the clinical diagnostic laboratory test is reasonable and necessary for the diagnosis or treatment of a person's illness or injury. This article reminds laboratories furnishing Zika virus tests to contact their MACs for guidance on the appropriate billing codes to use on claims for Zika virus testing. Furthermore, laboratories should provide resources and cost information as may be requested by the MACs in order for the MACs to establish appropriate payment amounts for the tests.

Background

On February 1, 2016, the World Health Organization (WHO) declared the Zika virus a Public Health Emergency of International Concern (PHEIC)[1]. According to the Centers for Disease Control and Prevention (CDC), the Zika virus disease is a nationally notifiable condition that has caused outbreaks in many countries and territories. The virus is primarily spread through the bite of an infected Aedes species mosquito, although other modes of transmission include mother-to-child transmission, blood transfusion and sexual transmission[2].

1 United States. Centers for Disease Control and Prevention. (2016) About Zika virus. Retrieved from http://www.cdc.gov/Zika/about/index.html.
2 United States. Centers for Disease Control and Prevention. (2016) Zika Virus. Retrieved from http://www.cdc.gov/Zika/about/index.html

Currently there are a few diagnostic tests that can determine the presence of the virus. These tests are available through the CDC and CDC-approved state health laboratories. A small number of tests have been issued an emergency use authorization by the Food and Drug Administration (FDA) and may be available through commercial laboratories.

Medicare Part B pays for clinical diagnostic laboratory tests that are reasonable and necessary for the diagnosis or treatment of a person's illness or injury. Presently there are no specific HCPCS codes for testing of the Zika virus; however, laboratories should contact their local MACs for guidance on the appropriate billing codes to use on claims for Zika virus testing. Furthermore, laboratories

should provide resources and cost information as may be requested by the MACs in order for the MACs to establish appropriate payment amounts for the tests.

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.

More information is available in the "Clinical Laboratory Fee Schedule: Payment System Series" at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Clinical-Laboratory-Fee-Schedule-Fact-Sheet-ICN006818.pdf* and in the "CY 2016 Clinical Laboratory Fee Schedule; 16CLAB" at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html*.

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How to bill non-covered self-administered drugs

The Centers for Medicare & Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident-to a physician's service. The instructions also provide the contractor with a process for understanding if an injectable drug is "usually" self-administered (to mean a drug you would normally take on your own) and therefore not covered by Medicare.

The term "usually" means that the drug is self-administered more than 50 percent of the time for all Medicare beneficiaries who use the drug, and are considered excluded from coverage.

Refer to the list of excluded *self-administered drugs (SAD)* incident to a physician's service

Guidelines for reviewing injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, 100-02, Chapter 15, Section 50.2

Additional information on services excluded from coverage are outlined in the *Medicare Benefits Policy Manual*, 100-02, Chapter 16

Billing outpatient prospective payment system (OPPS) and non-OPPS

Providers are not required to bill non-covered self-administered drugs, unless requested by the beneficiary or secondary insurance. If a line item denial is required that holds the beneficiary liable for the non-covered self-administered pharmacy services, the outpatient claim should be submitted as follows:

- Revenue code 0637
- HCPCS code that describes the services rendered; or,
  - Use A9270 (non-covered item or service) when there is no other appropriate code
- Modifier GY (item or service statutorily excluded or does not meet the definition of any Medicare benefit)
  - Reason code 31324 will append to the line item when the GY modifier is present, and holds the beneficiary liable

  - Reason code 31947 will apply to the line item when the GY modifier is not present, and holds the provider liable
  - Advanced beneficiary notice (ABN) is not required
- Charges non-covered
  - Do *not* submit the charges as covered
- Additional guidance on reporting covered and non-covered charges on the same claim are outlined in the *Medicare Claims Processing Manual*, 100-04, *Chapter 1*, Section 60

The outpatient code editor (OCE) status indicator is 'E' (non-covered) when revenue code 0637 is submitted without a HCPCS. In order to bypass the return to provider (RTP) reason code W7050 (non-covered based on statutory exclusion), the charges must be submitted as non-covered or as outlined above.

- Reason code 31947 will apply to the line item when the charges are submitted as non-covered without a HCPCS, and holds the provider liable
- Refer to the most recent *OCE quarterly release files*, Attachment A - Integrated OCE specs, Table 3: Edit return buffers

Billing for nursing visits in home health shortage areas by a RHC or FQHC

Section 1861(aa)(1)(C) of the Social Security Act authorizes rural health clinics (RHCs) and federally qualified health centers (FQHCs) located in areas with a shortage of home health agencies to furnish part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) by a registered professional nurse (RN) or licensed practical nurse (LPN) to a homebound individual under a written plan of treatment. The current evaluation and management codes for home health visits are not billable by RNs or LPNs furnishing RHC or FQHC home health visits. Beginning with dates of service on or after October 1, 2016, RHCs and FQHCs should bill Healthcare Common Procedure Coding System (HCPCS) code G0490 for these visits. HCPCS code G0490 will be paid as a visit:

- Under the RHC all-inclusive rate payment system when reported on a RHC claim with revenue code 052x and modifier CG, or
- Under the FQHC prospective payment system when reported on a FQHC claim with revenue code 052x and HCPCS code G0466 or G0467.

Medicare coverage of screening for lung cancer with low dose computed tomography (LDCT)

***Note**: This article was revised June 24, 2016, to add a link to a related article MM9540. That article provides a ICD-10 code that has been added for lung cancer with low dose computed tomography (LDCT). All other information is unchanged. This information was previously published in the November 2015 Medicare A Connection, pages 18-20.*

Provider types affected

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

Provider action needed

Change request (CR) 9246 informs MACs that Medicare covers lung cancer screening with LDCT if all eligibility requirements listed in the national coverage determination (NCD) are met. Make sure that your billing staffs are aware of these changes.

Background

Section 1861(ddd)(1) of the *Social Security Act (the Act)* authorizes the Centers for Medicare & Medicaid Services (CMS) to add coverage of "additional preventive services" through the NCD process. The "additional preventive services" must meet all of the following criteria:

- Be reasonable and necessary for the prevention or early detection of illness or disability;
- Be recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- Be appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the evidence for lung cancer screening with low dose computed tomography (LDCT) and determined that the criteria listed above were met, enabling CMS to cover this "additional preventive service" under Medicare Part B.

On August 21, 2105, CMS issued NCD 210.14 which provides for Medicare coverage of screening for lung cancer with LDCT. Effective for claims with dates of service on and after February 5, 2015, Medicare beneficiaries must meet all of the following criteria:

- Be 55–77 years of age;
- Be asymptomatic (no signs or symptoms of lung cancer);
- Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; one pack = 20 cigarettes);
- Be a current smoker or one who has quit smoking within the last 15 years; and,
- Receive a written order for lung cancer screening with LDCT that meets the requirements described in the NCD.

Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary's medical record, and must contain the following information:

- Date of birth;
- Actual pack–year smoking history (number);
- Current smoking status, and for former smokers, the number of years since quitting smoking;
- A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and,
- The national provider identifier (NPI) of the ordering practitioner.

Counseling and shared decision-making visit

Before the first lung cancer LDCT screening occurs, the beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision-making visit that includes the following elements and is appropriately documented in the beneficiary's medical records:

- Must be furnished by a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) as defined in Section 1861(aa)(5) of the Act); and
- Must include all of the following elements:
  - Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
  - Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
  - Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;
  - Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and,
  - If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

Written orders for subsequent annual LDCT screens may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (PA, NP, or CNS)

There is also specific criteria that the reading radiologist and radiology imaging facility must meet. The radiology

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imaging facility must collect and submit data to a CMS-approved registry for each LDCT lung cancer screening performed. The data collected and submitted to a CMS-approved registry must include specific elements. Information regarding CMS-approved registries is posted at: *https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Cancer-Screening-Registries.html*.

Coinsurance and deductibles

Medicare coinsurance and Part B deductible are waived for this preventive service.

Health Care Common Procedure Coding System (HCPCS) codes

Effective for claims with dates of service on and after February 5, 2015, the following HCPCS codes are used for lung cancer screening with LDCT:

- **G0296** – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)
- **G0297** – Low dose CT scan (LDCT) for lung cancer screening

In addition to the HCPCS code, these services must be billed with ICD-10 diagnosis code Z87.891 (personal history of tobacco use/personal history of nicotine dependence), ICD-9 diagnosis code V15.82.

Note: Contractors shall apply contractor-pricing to claims containing HCPCS G0296 and G0297 with dates of service February 5, 2015, through December 31, 2015.

Institutional billing requirements

Effective for claims with dates of service on and after February 5, 2015, providers may use the following types of bill (TOBs) when submitting claims for lung cancer screening, HCPCS codes G0296 and G0297: 12x, 13x, 22x, 23x, 71x (G0296 only), 77x (G0296 only), and 85x.

Medicare will pay for these services as follows:

- **Outpatient hospital departments** – TOBs 12x and 13x - based on outpatient prospective payment system (OPPS);
- **Skilled nursing facilities (SNFs)** – TOBs 22x and 23x – based on the Medicare physician fee schedule (MPFS);
- **Critical access hospitals (CAHs)** – TOB 85x – based on reasonable cost;
- **CAH Method II** – TOB 85x with revenue code 096x, 097x, or 098x based on the lesser of the actual charge or the MPFS (115 percent of the lesser of the fee schedule amount and submitted charge) for HCPCS G0296 only;
- **Rural health clinics (RHCs)** - TOB 71x -

based on the all-inclusive rate for HCPCS G0296 only; and

- **Federally qualified health centers (FQHCs)** – TOB 77x - based on the PPS rate for HCPCS G0296 only.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

Claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes

MACs will use the following CARCs, RARCs, and group codes when denying payment for LDCT lung cancer screening, HCPCS G0296 and G0297:

Submitted on a TOB other than 12x, 13x, 22x, 23x, 71x, 77x, or 85x:

- **CARC 170** – Payment is denied when performed/ billed by this type of provider. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N95** – This provider type/provider specialty may not bill this service.
- **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

For TOBs 71x and 77x when HCPCS G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71x TOBs):

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

Note: 77x TOBs will be processed through the integrated outpatient code editor under the current process.

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- **Group code CO** assigning financial liability to the provider.

Where a previous HCPCS G0297 is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening):

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached.
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code CO** assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered (line-level):

- **CARC 6** – "The procedure/revenue code is inconsistent with the patient's age. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **Group code: CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Because the claim line was not billed with ICD-10 diagnosis Z87.891:

- **CARC 167** – This (these) diagnosis(es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code: CO** assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Additional information

The official instruction, CR 9246, consists of two transmittals:

1. *Transmittal R3374CP*, which updates the *Medicare Claims Processing Manual*; and
2. *Transmittal R185NCD*, which updates the *Medicare NCD Manual*.

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
June 24, 2016	The article was revised to add a link to a related article *MM9540*. That article provides a ICD-10 code that has been added for lung cancer screening with low dose computed tomography (LDCT).
November 16, 2015	Initial article post

MLN Matters® Number: MM9246 *Revised*
Related Change Request (CR) #: 9246
Related CR Release Date: October 15, 2015
Effective Date: February 5, 2015
Related CR Transmittal #: R3374CP and R185NCD
Implementation Date: January 4, 2016

Responding to additional documentation requests (ADRs)

First Coast Service Options (First Coast) frequently requires a clinical review of documentation to determine the medical necessity of services. It is the goal of First Coast to ensure that providers are properly reimbursed for medically reasonable and necessary services. When documentation is required, an ADR is mailed to the provider.

Prior to responding to the ADR, providers should:

- Verify patient and/or claim form billing information matches what is requested within the ADR letter
- Ensure legible and appropriate signatures are included in the documentation

Timeframe for submission of documentation:

- The Centers for Medicare & Medicaid Services (CMS) allows 45 calendar days to submit the documentation
  - The 45-day timeframe begins with the date of the ADR letter
  - Allow sufficient time for documentation to be mailed, received, and matched to the claim in question
  - Claims are set to automatically deny on day 46 when documentation has not been received

Methods of responding to ADR:

- By mail: See ADR letter for mailing address and instructions
- Secure Provider Online Tool (SPOT)
  - *Secure messaging*
- *Fax with cover sheet*
- *esMD*

First Coast must be able to clearly identify the author of the medical record:

- When the initial response to an ADR does not contain appropriate signatures, a second ADR will be sent requesting the signature log and/or attestation statement. See our *physician signature requirements for medical record documentation simulation* for examples of a signature log and attestation statement.
  - If the signature is missing, an attestation statement must be included to authenticate who authored or contributed to the record
  - If the signature is illegible, an attestation statement or signature log must be included to authenticate who authored or contributed to the record
  - Response to the request for an attestation or signature log must be received within 20 calendar days from the date of the second request, whether by phone contact or letter.

When documentation is submitted timely, CMS requires the contractor to make a claim determination within 30 calendar days.

Source: *Medicare Learning Network (MLN®) Matters*: *MM8583* and *MM6698*; *CMS Internet Only Manual (IOM), Publication 100-08, Chapter 3*

Learn the secrets to billing Medicare correctly

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

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

Avoid claim errors for current procedural terminology codes 98960, 98961 and 98962

First Coast Service Options (First Coast) has recently seen a large number of Part A outpatient claim errors for Current Procedural Terminology (CPT®) codes 98960, 98961, and 98962. Providers are reminded that professional services paid under the Medicare physician fee schedule (MPFS) for these codes are bundled or not valid for Medicare purposes.

The Centers for Medicare & Medicaid Services (CMS) published relative values units (RVU) as a courtesy, since many private payers use this methodology when establishing their payment rates.

The CPT® codes 98960, 98961, and 98962 are not separately billable services, and are either bundled into another service reported on the same day or are simply not covered. Do not report these codes to Medicare, unless required for secondary insurance.

- Verify the patient's records to ensure you are billing the correct CPT® code
- Submit the charges as non-covered when a denial is required for the secondary payer

CPT® code definitions:

- **98960** – Education & training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
- **98961** – 2-4 patients
- **98962** – 5-8 patients

Source: CMS *MLN Matters®* article *MM5528*

A physician's guide to Medicare's home health certification, including the face-to-face encounter

***Note**: This article was rescinded July 19, 2016, because the information was not current. See MLN Matters® articles SE1436 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf) and MM9119 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9119.pdf) for current information on home health certification requirements. This information was previously published in the May 2012 Medicare A Connection, pages 10-12.*

MLN Matters® Number: SE1219 *Rescinded*

Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2011
Related CR Transmittal #: N/A
Implementation Date: N/A

Home health face-to-face encounter - a new home health certification requirement

***Note**: This article was rescinded July 19, 2016, because the information was not current. See MLN Matters® articles SE1436 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf) and MM9119 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9119.pdf) for current information on home health certification requirements. This information was previously published in the February 2011 Medicare A Connection, pages 34-35.*

MLN Matters® Number: SE1038 *Rescinded*

Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2011
Related CR Transmittal #: N/A
Implementation Date: N/A

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

New LCDs

Chiropractic services – new Part A and Part B LCD

LCD ID number: L36617 (Florida, Puerto Rico/ U.S. Virgin Islands)

Medicare coverage of chiropractic service is specifically limited by statute with the requirements explicitly outlined in the Centers for Medicare & Medicaid Services (CMS) publications and manuals.

Medicare administrative contractors (MACs) have historically implemented chiropractic services local coverage determination (LCD) as an educational tool to further emphasize requirements for the diagnosis, treatment, documentation, and billing of chiropractic services. Given the implementation of ICD-10 diagnoses coding effective October 1, 2015, and the focus of CMS and its contractors on aligning education tools used to improve the documentation of services by a chiropractor described as means of manual manipulation of the spine to correct a subluxation of an individual, MAC JN has recently retired the Chiropractic services LCD and has developed a new LCD to address this service.

Additionally, the November 2015 comprehensive error rate testing (CERT) forecasting report for claims reviewed from the sampling period July 2013 to June 2014 showed chiropractic services in Florida as of August 12, 2015, were ranked third in the nation based on the projected error rate with an error rate of 66.2 percent (up from 44.0 percent the previous year). An excerpt from First Coast Service Options, Inc. (First Coast) medical review strategy indicated: Maintenance services billed as active treatment continues to be an issue for payment errors in chiropractic services; after the CMS implementation of an acute treatment modifier (AT) that allows providers to differentiate maintenance from active treatment on submitted claims.

Therefore, chiropractic services LCD has been created to addresses indications and limitations of coverage and/ or medical necessity, limitations, Current Procedural Terminology® (CPT®) codes, ICD-10 Codes that Support Medical Necessity, documentation guidelines, and utilization guidelines for this service.

Of note: The use of an ICD-10-CM code listed in the LCD as a primary diagnosis does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in the determination. The level of the subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculoskeletal condition necessitating the treatment should be listed as the secondary diagnosis. Secondary neuromuscular ICD 10 diagnosis codes should support the medical necessity of short, moderate, and long term treatment. All diagnosis codes must be coded to the highest level of specificity, and the primary diagnosis must be supported by x-ray or documented by physical examination. Chiropractic physicians submitting claims for beneficiaries receiving excessive services (chiropractic manipulative treatments) in a month (acute care) or over a year (chronic care) are likely to come under pre or post payment medical review.

Effective date

This LCD is effective for services rendered on or after September 12, 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*.

Retired LCDs

Amifostine (Ethyol®) – retired Part A and Part B LCD

LCD ID number: L33262 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD), it was determined that the amifostine (Ethyol®) LCD is no longer required and, therefore, was retired.

Effective date

This LCD retirement is effective for services rendered **on or after July 5, 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*.

Revisions to LCDs

Bone mineral density studies – revision to the Part A and Part B LCD

LCD ID number: L36356 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on the Centers for Medicare & Medicaid Services (CMS) *MLN Matters*® article SE1525, the local coverage determination (LCD) for bone mineral density studies was revised to remove ICD-10-CM diagnosis code M85.80 (Other specified disorders of bone density and structure, unspecified site) under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Current Procedural Terminology (CPT®) codes 77080 (Dual energy X-ray absorptiometry [DXA], bone density study, 1 or more sites; axial skeleton [eg, hips pelvis, spine]) and 77085 (Dual energy X-ray absorptiometry [DXA], bone density study, 1 or more sites; axial skeleton [eg, hips, pelvis, spine], including vertebral fracture assessment).

Effective date

This LCD revision is effective for claims processed **on or after June 2, 2016**, for services rendered **on or after October 1, 2015**, for Part A and for claims processed on or after **June 6, 2016**, for services rendered **on or after October 1, 2015**, for Part B. 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*.

Colorectal cancer screening – revision to the Part A and Part B LCD

LCD ID number: L36355 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for colorectal cancer screening was revised based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 9540 (NCD 210.3). ICD-10-CM diagnosis codes Z12.11 (Encounter for screening for malignant neoplasm of colon) and Z12.12 (Encounter for screening for malignant neoplasm of rectum) were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for CPT® code 81528.

Effective date

This LCD revision is effective for claims processed **on or after July 5, 2016**, for services rendered **on or after January 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, *click here*.

Genetic testing for Lynch syndrome – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for genetic testing for Lynch syndrome (L34912) was revised to add Current Procedural Terminology (CPT®) code 81435 to the "CPT/ HCPCS Codes" section of the LCD under Group 2 codes.

As stated in the LCD, providers must follow a stepped approach to meet the reasonable and necessary criteria. To progress to each subsequent step, refer to the indications detailed in the policy.

Effective date

This LCD revision is effective for services rendered **on or after June 28, 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, *click here*.

Hemophilia clotting factors – revision to the LCD

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

The local coverage determination (LCD) for hemophilia clotting factors was revised to include Idelvion® [coagulation factor IX (recombinant), albumin fusion protein indicated in children and adults with hemophilia B (congenital Factor IX deficiency)]. HCPCS codes C9399 and J7199 were added under the "CPT®/HCPCS Codes" section, and diagnosis code D67 was added to the "ICD-10 Codes that Support Medical Necessity" section. The "Sources of Information and Basis for Decision" section was also updated.

Effective date

This LCD revision is effective for claims processed **on or after July 11, 2016**, for dates of service rendered **on or after March 4, 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, *click here*.

Hyperbaric oxygen (HBO) therapy – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for hyperbaric oxygen (HBO) therapy (L36504) was revised to provide further clarification regarding coverage of HBO treatment for skin grafts, osteomyelitis treatment, including reference to change request (CR) 1138, emergency equipment in facilities and the utilization of healthcare common procedure coding system (HCPCS) G0277. The clarifications do not affect coverage.

In addition, based on CR 9540, the link to the Centers for Medicare & Medicaid Services (CMS) covered diagnoses codes has been changed.

Effective date

The effective date for the revision to provide further clarification regarding coverage of HBO treatment is for dates of service **on and after April 11, 2016**. The LCD revision based on CR 9540 is effective date claims processed **on or after July 5, 2016**, for dates of service **on and after October 1, 2015**. 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, *click here*.

Noncovered services – revision to the Part A and Part B LCD

LCD ID number: L33777 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was revised to remove Current Procedural Terminology (CPT®) code 0405T from the "CPT/HCPCS Codes" section of the LCD under the subtitle "Procedures for Part A and "Procedures for Part B" and add CPT® code 0405T to the "CPT/HCPCS Codes" section of the LCD under the subtitle "Procedures for Part B only" as the OPPS payment status indicator is a "B" (Not paid under OPPS).

Effective date

This LCD revision is effective for claims processed **on or after July 25, 2016**, for services rendered **on or after January 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, *click here*.

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.

Rituximab (Rituxan®) – revision to the Part A and Part B LCD

LCD ID number: L33746 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request the, "Indications and Limitations of Coverage and/ or Medical Necessity" section of the local coverage determination (LCD) for rituximab (Rituxan®) has been updated to add the off-labeled indication of neuromyelitis optica, a rare, relapsing and debilitating disease. Also, the "ICD-10 Codes that Support Medical Necessity" section of the LCD was updated to add ICD-10-CM diagnosis code G36.0. Additionally, the "Documentation Requirements" and "Sources of Information and Basis for Decision" sections of the LCD were updated.

Effective date

This LCD revision is effective for services rendered on or after July 28, 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*.

Psychiatric inpatient hospitalization – revision to the Part A LCD

LCD ID number: L33975 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 9522 external_pdf. gif (transmittal 98) (Clarification of Inpatient Psychiatric Facilities [IPF] Requirements for Certification, Recertification and Delayed/Lapsed Certification and Recertification), the local coverage determination (LCD) for psychiatric inpatient hospitalization was updated to add/revise language in the "Certification/Recertification – Inpatient Psychiatric Certification/ Recertification" section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after August 15, 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, *click here*.

Before you file an appeal...

Each month, thousands of medical providers send written inquiries to First Coast Service Options Inc. (First Coast) to check the status of an appealed claim. Unfortunately, many of these appeals and subsequent inquiries are submitted on claims that were ineligible for appeal.

Before you appeal a denied claim, check out *these resources*.

Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) was revised to add ICD-10-CM diagnosis code Z03.89 (Encounter for observation for other suspected diseases and conditions ruled out) for use with CPT® code 92134 in the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after July 22, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *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*.

Vitamin D; 25 hydroxy, includes fraction(s), if performed – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for vitamin D; 25 hydroxy, includes fraction(s), if performed was revised to add ICD-10-CM diagnosis codes M85.811, M85.812, M85.821, M85.822, M85.831, M85.832, M85.841, M85.842, M85.851, M85.852, M85.861, M85.862, M85.871, M85.872, M85.88, and M85.89 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for CPT® code 82306.

Effective date

This LCD revision is effective for claims processed **on or after June 30, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *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, *click here*.

Medicare A Connection subscription

Medicare A Connection is published monthly and is available online in both English and Spanish.

Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published in the current fiscal year.

To order an annual subscription, complete the *Medicare A Connection Subscription Form**, located here***.

Supplemental Security Income (SSI)/Medicare beneficiary data for fiscal year 2014 for IPPS hospitals, IRFs, and LTCHs

Provider types affected

This *MLN Matters*® article is intended for inpatient prospective payment system (IPPS) hospitals, inpatient rehabilitation facilities (IRFs), and long term care hospitals (LTCHs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9648 provides updated data for determining the disproportionate share adjustment for IPPS hospitals and the low-income patient (LIP) adjustment for IRFs as well as payments as applicable for LTCH discharges (for example, discharges paid the IPPS comparable amount under the short-stay outlier payment adjustment).

Background

The supplemental security income (SSI)/Medicare beneficiary data for hospitals are available electronically and contain the:

- Name of the hospital
- Centers for Medicare & Medicaid Services (CMS) certification number
- SSI days
- Total Medicare days, and
- The ratio of Medicare Part A patient days attributable to SSI recipients

The files are located on the CMS website addresses as follows:

- IPPS hospitals: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*
- IRFs: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html*
- LTCH: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html*

The data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during fiscal year (FY) 2014 (cost reporting periods beginning on or after October 1, 2013, and before October 1, 2014), except when explicitly directed otherwise by CMS.

CMS expects hospitals will express interest in revising the worksheet S-10 submitted with their FY 2014 cost reports. MACs are working on separate instructions to provide you with guidance for responding to and reviewing hospitals' worksheet S-10 data. MACs shall accept a hospital's request to amend its FY 2014 worksheet S-10, but hold off on settlement of FY 2014 cost reports until CMS issues further instructions

Additional information

The official instruction, CR 9648, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1681OTN.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: MM9648
Related Change Request (CR) #: CR 9648
Related CR Release Date: July 15, 2016
Effective Date: August 16, 2016
Related CR Transmittal #:R1681OTN
Implementation Date: August 16, 2016

Inpatient admission is prior to the Medicare Part A entitlement date

The Centers for Medicare & Medicaid Services (CMS) has provided guidance on reporting days of utilization for a beneficiary's inpatient stay. Days of utilization are charged based upon actual days of coverage, including grace and waiver days. The number of covered days used is maintained by CMS to track the beneficiary's eligible days in a benefit period.

There are special billing guidelines to follow when the beneficiary becomes entitled to Part A benefits in the middle of an inpatient stay. Pre-entitlement days are not counted for utilization or for the hospital's inpatient prospective payment system (PPS) pricer. Furthermore, pre-entitlement days are not used for the cost report or for utilization in non-PPS hospitals, exempt units or skilled nursing facilities (SNFs). In this situation, the days are calculated based on the beneficiary's Medicare Part A entitlement date through discharge/transfer/death.

The hospital may not bill the beneficiary or other persons for days of care preceding entitlement, except for days in excess of the outlier threshold. The hospital may charge the beneficiary or other persons for applicable deductible and/or coinsurance amounts.

Listed below are the claim submission guidelines for inpatient hospital admit to discharge claims (no outlier):

- Type of bill (TOB) – Enter 111
- Admit date – Enter the actual date of admission
  - Do not enter the Medicare Part A entitlement date as the admit date
- Statement coverage period "From" date – Enter the Medicare Part A entitlement effective date
  - Do not enter the admit date as the coverage period "From" date
- Statement coverage period "Through" date – Enter the end date of the inpatient stay
- Utilization days – Enter the total number of days for the statement coverage period
  - Do not report any pre-entitlement days as covered or non-covered
  - Covered and non-covered days are reported utilizing value codes 80, 81, 82, and/or 83

    Value code 80 – Covered days

    Value code 81 – Non-covered days

    Value code 82 – Co-insurance days

    Value code 83 – Lifetime reserve days
- Diagnosis codes – enter all diagnosis codes from admission to discharge/transfer/death
- Accommodation days/units – Enter the appropriate number of units and charges as covered and/or non-covered for the statement coverage period
  - Do not report the pre-entitlement days as covered or non-covered room and board units or charges
  - Revenue codes – 010x – 016x are appropriate for billing room and board
  - Revenue code – 018x is appropriate for billing a leave of absence (non-covered days and charges)
- Remarks – Medicare Part A effective xx/xx/xx

Example:

The patient is admitted on April 25, 2016 and discharged on May 13, 2016. The patient's Medicare Part A entitlement effective date is May 1, 2016. The claim should be billed as follows:

- TOB – 111
- Admit date – April 25, 2016
- Statement coverage period "From" date – May 1, 2016
- Statement coverage period "Through" date – May 13, 2016
- Utilization days – 12 covered days
- Accommodation days/units – 12 covered units and covered charges
- Remarks – Medicare Part A effective May 1, 2016

Source: CMS internet-only manual, Publication 100-04, *Chapter 3*, Section 40;

Chapter 25; *MLN Matters*® article *SE1117*

Shared savings program accountable care organization qualifying stay edits

***Note**: This article was revised July 5, 2016, due to an updated change request (CR). That CR revised shared system maintainer (SSM) responsibility. The transmittal number, CR release date and link to the transmittal also changed. All other information remains the same. This information was previously published in the May 2016 Medicare A Connection, page 28.*

Provider types affected

This *MLN Matters*® article is intended for hospitals and skilled nursing facilities (SNFs) working with accountable care organizations (ACOs) participating in the Medicare shared savings program (SSP) and submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 9568 allows the processing of SNF claims without having to meet the three-day hospital stay requirement for certain designated SNFs that have a relationship with an ACO participating in the SSP. Make sure that your SNF is clear on whether or not it is eligible to participate in this initiative and that your billing staffs are aware of these changes.

Background

The Medicare SNF benefit is for beneficiaries who require a short-term intensive stay in a SNF, requiring skilled nursing and/or rehabilitation care. Pursuant to Section 1861(i) of the Social Security Act (the Act), beneficiaries must have a prior inpatient hospital stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF care. This has become known as the SNF three-day rule.

The Centers for Medicare & Medicaid Services (CMS) understands that, in certain circumstances, it could be medically appropriate for some patients to receive skilled nursing care and/or rehabilitation services provided in a SNF without prior hospitalization or with an inpatient hospital length of stay of less than three days.

Section 3022 of the Affordable Care Act amended Title XVIII of the Act by adding a new Section 1899 to establish the Medicare SSP. under Section 1899(f), the Secretary of Health and Human Services is permitted to waive "such requirements of . . . title XVIII of this Act as may be necessary to carry out the provisions of this section." As a result, CMS proposed and finalized through rulemaking (80 FR 32692 at *http://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf*) a waiver of the prior three-day inpatient hospitalization requirement in order to provide Medicare SNF coverage when certain beneficiaries assigned to SSP ACOs in track three are admitted to designated SNF affiliates either directly from an inpatient hospital stay or after fewer than three inpatient hospital days, starting in January 2017. The waiver will be available for SSP ACOs in track three that demonstrate the capacity and infrastructure to identify and manage patients who would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospital stay of fewer than three days, for services otherwise covered under the Medicare SNF benefit.

To identify the beneficiaries eligible to receive the SNF three-day waiver, CMS provides ACOs with a prospective beneficiary assignment list for the performance year. ACOs will receive the prospective assignment list close to the start of each performance year.

To identify the SNFs eligible to use the SNF three-day waiver, ACOs designate SNFs (as SNF affiliates) eligible to participate in the SNF three-day waiver with the ACO.

CMS will reimburse designated SNFs (specifically, SNF affiliates participating in track three SSP ACOs), for the Medicare SNF benefit without the required three-day in-patient hospitalization for beneficiaries that are prospectively assigned to the track three ACO.

Additional information

The official instruction, CR 9568, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1679OTN.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* on the CMS website under - How Does It Work.

You can learn more about the SSP by visiting our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html*. To learn more about the SNF three-day waiver, visit the SSP web page and click on "Statutes/Regulations/Guidance."

Document history

Date of change	Description
July 5, 2016	The article was revised due to an updated CR. That CR revised shared system maintainer (SSM) responsibility. The transmittal number, CR release date and link to the transmittal also changed.
May 11, 2016	Initial article release

MLN Matters® Number: MM9568 *Revised*
Related Change Request (CR) #: CR 9568
Related CR Release Date: July 1, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R1679OTN
Implementation Date: January 3, 2017

Allogeneic hematopoietic stem cell transplantation

***Note**: This article was revised July 5, 2016, due to an updated change request (CR). That CR added clarifying language and identified the appropriate FISS responsibility. The revision also included clarifying language for references to the "NCD Manual", under Summary of Changes. The transmittal number, CR release date and link to the transmittal also changed. All other information remains the same. This information was previously published in the May 2016 Medicare A Connection, pages 23-25.*

Provider types affected

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

Provider action needed

CR 9620, from which this article was developed, notifies providers that effective for claims with dates of service on and after January 27, 2016, for the use of allogeneic hematopoietic stem cell transplantation (HSCT) for treatment of multiple myeloma, myelofibrosis, and sickle cell disease is covered by Medicare, but only if provided in the context of a Medicare-approved clinical study meeting specific criteria under the coverage with evidence development (CED) paradigm.

CR 9620 also clarifies the ICD-9 and ICD-10 diagnosis codes for allogeneic HSCT for treatment of myelodysplastic syndromes (MDS) in the context of a Medicare-approved, prospective clinical study under CED. Specifically, for dates of service on or after August 4, 2010, through September 30, 2015, the ICD-9-CM diagnosis codes are 238.72, 238.73, 238.74, or 238.75 **and** clinical trial ICD-9-CM diagnosis code V70.7. For dates of service on or after October 1, 2015, the ICD-10-CM diagnosis codes are D46.A, D46.B, D46.C, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, or D46.Z AND clinical trial ICD-10-CM diagnosis code Z00.6. Make sure your billing staff is aware of these determinations.

Background

HSCT is a process that includes mobilization, harvesting, and transplant of stem cells and the administration of high-dose chemotherapy and/or radiotherapy prior to the actual transplant. During the process stem cells are harvested from either the patient (autologous) or a donor (allogeneic) and subsequently administered by intravenous infusion to the patient.

Multiple myeloma is a neoplastic plasma-cell disorder. Myelofibrosis is a stem cell-derived hematologic disorder. Sickle cell disease is a group of inherited red blood cell disorders created by the presence of abnormal hemoglobin genes. On April 30, 2015, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request from the American Society for Blood and Marrow Transplantation (ASBMT) to reconsider its policy and expand coverage of allogeneic HSCT for sickle cell disease, myelofibrosis, multiple myeloma, and rare diseases.

Myelodysplastic syndrome (MDS) refers to a group of diverse blood disorders in which the bone marrow does not produce enough healthy, functioning blood cells. On August 4, 2010, CMS issued a final decision stating that allogeneic HSCT for MDS is covered by Medicare only if provided pursuant to a Medicare-approved clinical study under CED.

CR 7137 (see the article, MM7137 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7137.pdf*) provides specific ICD-9 related coding and claim processing requirements regarding this particular coverage decision, and CRs 8197 and 8691 (see MM8197 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8197.pdf* and MM8691 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.pdf*) provide ICD-10 related coding requirements. On November 30, 2015, CMS accepted a formal request from the National Marrow Donor Program (NMDP) to clarify the list of ICD-9-CM and ICD-10-CM diagnosis codes covered for allogeneic HSCT for the treatment of MDS in the context of a Medicare-approved clinical study under CED.

On January 27, 2016, CMS issued a final decision to expand national coverage of items and services necessary for research in an approved clinical study via coverage with evidence development (CED) under Section 1862(a)(1)(E) of the Social Security Act (the Act) for allogeneic HSCT for the following indications:

- Multiple myeloma
- Myelofibrosis
- Sickle cell disease

ICD-10-PCS procedure code of 30230G1, 30230Y1, 30233G1, 30233Y1, 30240G1, 30240Y1, 30243G1, 30243Y1, 30250G1,30250Y1, 30253G1, 30253Y1, 30260G1, 30260Y1, 30263G1, **or** 30263Y1 AND

- The clinical trial ICD-10-CM code of Z00.6 **and**
- Condition code 30, denoting qualifying clinical trial **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an 8-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
  - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
  - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
  - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Outpatient claims

For claims submitted on type of bill 13x or 85x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

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- An HSCT CPT® code of 38240 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**
- Condition code 30, denoting qualifying clinical trial **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit *https://clinicaltrials.gov/* identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
  - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
  - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
  - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Method II critical access hospital (CAH) claims

For claims submitted on type of bill 85x with revenue codes 96x, 97x, or 98x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**
- Condition code 30, denoting qualifying clinical trial **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
  - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
  - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
  - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Professional claims

For professional claims submitted on type of bill 85x with revenue codes 96x, 97x, or 98x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**
- The Q0 modifier **and**
- A place of service code of 19, 21, or 22 along with the appropriate ICD-10-CM diagnosis code of:
  - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
  - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
  - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

For all of the above claims types submitted without the requisite coding, MACs will deny the claims using the following messages:

- **Claim adjustment reason code (CARC) 50** – These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks code (RARC) N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code** - Patient responsibility (PR) if an advance beneficiary notice (ABN)/hospital notice on non-coverage (HINN), otherwise contractual obligation (CO)

For claims with dates of service prior to the implementation date of CR 9620, MACs shall perform necessary adjustments only when the provider brings such claims to the attention of their MAC.

Additional information

The official instruction, CR 9620, consists of two transmittals. The first updates the *Medicare Claims Processing Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3556CP.pdf*. The second transmittal updates the *Medicare NCD Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R193NCD.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

Date of change	Description
July 5, 2016	The article was revised due to an updated change request (CR). That CR revised shared system maintainer (SSM) responsibility. The transmittal number, CR release date and link to the transmittal also changed.

See **HSCT**, next page

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

***Note**: This article was revised July 7, 2016, to add a notice showing that Medicare is suspending enforcement of three new edits that were to begin on July 1, 2016, including the edit that enforces weekly billing requirements for partial hospitalization program (PHP). This information was previously published in the April 2016 Medicare A Connection, page 15.*

Provider types affected

This *MLN Matters*® special edition article is intended for outpatient prospective payment system (OPPS) providers submitting PHP claims to Medicare A/B Medicare sdministrative contractors (MACs) for PHP 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, and Section 70.3 which 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 (3) 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.

These edits were scheduled to begin on July 1, 2016. CMS is suspending all three edits at this time, including the one that enforces weekly billing requirements for PHPs. CMS reminds PHPs that the 20 hours per week minimum PHP service requirement remains in effect, as described in regulation at 42 CFR 410.43(c).

See **PHP**, next page

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May 9, 2016	Initial article release

MLN Matters® Number: MM9620 *Revised*
Related Change Request (CR) #: CR 9620
Related CR Release Date: July 1, 2016
Effective Date: January 27, 2016

Related CR Transmittal #: R193NCD and R3556CP
Implementation Date: October 3, 2016

PHP

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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 weekly	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.

October 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	Deny 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 weekly	RTP claim

As a reminder, for claims received on or after July 1, 2016, PHP providers are instructed to submit "weekly" claims for type of bill 13x with condition code 41 and type of bill 76x. Interim billing requirements still apply.

Additional information

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

Chapter 6 of the *Medicare Benefit Policy Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf*.

Document history

July 7, 2016 – Article revised to announce suspension of three new edits that were to be effective on July 1, 2016.

March 31, 2016 – Initial issuance

MLN Matters® Number: SE1607 *Revised*
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

Before you file an appeal...

Each month, thousands of medical providers send written inquiries to First Coast Service Options Inc. (First Coast) to check the status of an appealed claim. Unfortunately, many of these appeals and subsequent inquiries are submitted on claims that were ineligible for appeal.

Before you appeal a denied claim, check out *these resources*.

Remittance advice remark and claim adjustment reason code and MREP and PC Print update

Provider types affected

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

Provider action needed

Change request (CR) 9695 informs MACs about the changes that update the remittance advice remark code (RARC) and claim adjustment reason code (CARC) lists, and CR 9695 calls for an update to the Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes. If you use the MREP and/or PC Print software, be sure to obtain the latest version that is released on or before October 3, 2016.

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, are required in the remittance advice and coordination of benefits transactions.

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

CR 9695 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare's standard system maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in CR 9695, MACs must implement on the date specified on the WPC website at *http://wpc-edi.com/Reference/*.

A discrepancy between the dates may arise as the WPC website is only updated three times a year and may not match the CMS release schedule.

Additional information

The official instruction, CR 9695, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3562CP.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: MM9695
Related Change Request (CR) #: CR 9695
Related CR Release Date: July 15, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3562CP
Implementation Date: October 3, 2016

Uniform use of claim CARC, RARC, and CAGC rule

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9696 which instructs MACs and Medicare's shared system maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of claim adjustment reason codes (CARC), remittance advice remark codes (RARC), and claim adjustment group code (CAGC) rule publication. These system updates reflect the committee on operating rules for information exchange (CORE) code combination list for June 2016. Make sure that your billing staff is aware of these changes. In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE electronic funds transfer (EFT) and electronic remittance advice (ERA) operating rule set that was implemented on January 1, 2014, under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions by mandating the adoption of a set of operating rules for each of the HIPAA transactions.

CAQH CORE lists the June 2016 version on the *code combination list* website. This update includes CARC and RARC updates as posted at the *Washington Publication Company (WPC) website* on or about March 1, 2016. This will also include updates based on Market Based Review (MBR) that the CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare as the industry needs them.

Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios. With the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 9696, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3558CP.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. The WPC website is at *http://www.wpc-edi.com/reference/*. The CAQH CORE code combination list is available at *http://www.caqh.org/CORECodeCombinations.php*.

MLN Matters® Number: MM9696
Related Change Request (CR) #: CR 9696
Related CR Release Date: July 1, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3558CP
Implementation Date: October 3, 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.

Correction of remark code information

Provider types affected

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

What you need to know

Change request (CR) 9641 updates the *Medicare Claims Processing Manual*" Chapter 30, to make corrections to remittance advice codes and general punctuation and grammar corrections. All remittance advice messaging must follow a prescribed set of rules. Specifically, claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) may only be used in specified combinations laid out by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE), the designated Standards Development Organization (SDO). The CARC and RARC code sets are available via the Washington Publishing Company (WPC) at *http://www.wpc-edi.com/Reference*.

Additional information

The official instruction, CR 9641, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3560CP.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: MM9641
Related Change Request (CR) #: CR 9641
Related CR Release Date: July 15, 2016
Effective Date: October 17, 2016
Related CR Transmittal #: R3560CP
Implementation Date: October 17, 2016

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

First Coast Service Options Inc. (First Coast) would like to remind providers that only an authorized official or a delegated official, as listed on the CMS 855, can sign the Electronic Data Interchange (EDI) enrollment form, Direct Data Entry (DDE) Access Request form and other EDI forms.

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

As of March 1, 2016, any DDE Request for Access form or any other EDI forms not signed by an authorized or delegated official will be rejected. A new form will be required.

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

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

- **Mail**: First Coast Medicare EDI, P.O. Box 44071, Jacksonville, FL 32231-4071
- **Fax**: (904) 361-0470
- **Email**: *MedicareEDI@fcso.com*

Starting September 1, 2016, any EDI form submitted on an outdated form will be rejected. The current DDE Request for Access form was updated on July 6, 2016, and the EDI Enrollment form was revised July 15, 2016. All forms received after 2:00 p.m. ET will have the date of receipt of the next business day. Please allow 10 business days before contacting Medicare EDI for a status of an application.

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

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

Skilled nursing facility prospective payment system pricer update 2017

Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries paid under the skilled nursing facility (SNF) prospective payment system (PPS).

Provider action needed

Change request (CR) 9712 announces the availability of the payment rates used under the PPS for SNFs for fiscal year (FY) 2017, as required by statute. Make sure that your billing staffs are aware of these changes.

Background

Annual updates to the PPS rates are required by *Section 1888(e)* of the Social Security Act as amended by the Medicare, Medicaid, and the State Children's Health Insurance Plan (SCHIP) Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

Each July, the Centers for Medicare & Medicaid Services (CMS) publishes the *SNF payment rates* for the upcoming fiscal year (that is, October 1, 2016, through September 30, 2017) in the *Federal Register*.

The update methodology is identical to that used in the previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds 0.5 percentage point. The statute mandates an update to the Federal rates using the latest SNF full market basket adjusted for productivity. The payment rates will be effective October 1, 2016.

Additional information

The official instruction, CR 9712, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3555CP.pdf*.

The CNF payment rates for FY2017 are available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html*.

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: MM9712
Related Change Request (CR) #: CR 9712
Related CR Release Date: July 1, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3555CP
Implementation Date: October 3, 2016

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- *Diabetes Prevention Program*

See the full text of this excerpted *CMS press release* (issued July 7).

Hospital and ASC: Proposed OPPS Changes for CY 2017

On July 6, CMS proposed updated payment rates and policy changes in the hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system. Several of the proposed policy changes would improve the quality of care Medicare patients receive by better supporting their physicians and other health care providers. These proposals are based on feedback from stakeholders, including beneficiary and patient advocates, as well as health care providers, including hospitals, ambulatory surgical centers and the physician community.

Proposed changes include:

- Addressing physicians' concerns regarding pain management
- Focusing payments on patients rather than setting
- Improving patient care through technology
- Emphasizing health outcomes that matter to the patient

CMS estimates that the updates in the proposed rule would increase OPPS payments by 1.6 percent and ASC payments by 1.2 percent in 2017.

For more information:

- *Proposed Rule (CMS-1656-P)*: Comments due no later than 5 pm September 6, 2016
- *Fact Sheet*

See the full text of this excerpted *CMS press release* (issued July 6).

July 2016 update of the hospital outpatient prospective payment system

***Note**: This article was revised June 29, 2016, due to an updated change request (CR). The CR changed the APC number for the HCPCS code Q5102 from 1761 to 1847 in table 5. Also, business requirement 9658.3 in the CR had incorrect termination date for C9743, C9458, and C9459. The correct termination date should be June 30, 2016, instead of June 30, 2015. The transmittal number and CR release date and link to the transmittal was also changed. All other information remains the same. This information was previously published in the May 2016 Medicare A Connection, pages 31-35.*

Provider types affected

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

Provider action needed

CR 9658 describes changes to, and billing instructions for, various payment policies implemented in the July 2016 OPPS update. It identifies the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions that are reflected in the July 2016 integrated outpatient code editor (I/OCE) and OPPS Pricer. Make sure that your billing staffs are aware of these changes.

Key points of CR 9658

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

Billing instructions for IMRT planning

The revised intensity modulated radiation therapy (IMRT) planning billing instructions (in the paragraph, below), that were also included in the April 2016 update of the hospital OPPS (CR 9549), replace the instructions discussed in the 2016 OPPS final rule at 80 FR 70401-70402 and in the January 2016 update of the hospital outpatient prospective payment system (OPPS) (CR 9486). The effective date of these instructions is January 1, 2016.

These instruction state that payment for the services identified by CPT® codes 77014, 77280, 77285, 77290, 77295, 77306 through 77321, 77331, and 77370 are included in the APC payment for CPT® code 77301 (IMRT planning). You should not report these codes in addition to CPT® code 77301, when provided prior to, or as part of, the development of the IMRT plan.

The *MLN Matters*® articles related to CRs 9549 and 9486 are available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9549.pdf*, and *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9486.pdf*, respectively.

Upper eyelid blepharoplasty and blepharoptosis repair

The Centers for Medicare & Medicaid Services (CMS) payment policy does not allow separate payment for a blepharoplasty procedure (CPT® codes 15822, 15823) in addition to a blepharoptosis procedure (CPT® codes 67901-67908) on the ipsilateral upper eyelid. Any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery is considered a part of the blepharoptosis surgery.

A blepharoplasty cannot be billed to Medicare and the beneficiary cannot be separately charged for a cosmetic procedure regardless of the amount of upper eyelid skin that is removed on a patient receiving a blepharoptosis repair because removal of (any amount) of upper eyelid skin is part of the blepharoptosis repair. In addition, the following are not permitted:

- Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery
- Charging the beneficiary an additional amount for a cosmetic blepharoplasty when a blepharoptosis repair is performed
- Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repaiis performed
- Performing a blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the blepharoplasty or charging the beneficiary for a cosmetic surgery
- Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)
- Billing for two procedures when two surgeons divide the work of a blepharoplasty performed with a blepharoptosis repair
- Using modifier 59 to unbundle the blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities
- Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery
- Using an advance beneficiary notice of noncoverage for a service that would be bundled into another service if billed to Medicare
- In the rare event that a blepharoplasty is performed on one eye and a blepharoptosis repair is performed on the other eye, the services must each be billed with

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the appropriate RT or LT modifier.

Revised status indicators (SIs) for pathology CPT® codes

The SI for CPT® code 85396 (Clotting assay whole blood) will change from SI=Q4 (Conditionally packaged laboratory tests) to SI=N (Paid under OPPS; payment is packaged into payment for other services) in the July 2016 update.

The SI for CPT® code 88141 (Cytopath c/v interpret) will change from SI=Q4 to SI=N in the July 2016 update.

The SI for CPT® code 88174 (Cytopath c/v auto in fluid) will change from SI=N to SI=Q4 in the July 2016 update.

The SI for CPT® code 88175 (Cytopath c/v auto fluid redo) will change from SI=N to SI=Q4 in the July 2016 update.

These codes, their descriptors, and status indicators are listed in table 1.

Table 1 – Pathology CPT® codes with revised SIs

CPT® code	Long descriptor	SI
85396	Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment), including use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day	N
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician	N
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	Q4
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision	Q4

Reporting for certain outpatient department services that are similar to therapy services) ("Non-therapy outpatient department services") that are adjunctive to comprehensive APC procedures

Effective for claims received on or after July 1, 2016, with dates of service on or after January 1, 2015, non-therapy outpatient department services (that are similar to therapy services) that are adjunctive to a comprehensive APC procedure (status indicator (SI) = J1 procedure) (see 80 FR 70326 at *https://www.federalregister.gov/articles/2015/11/13/2015-27943/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment*) or the specific combination of services assigned to the observation comprehensive APC 8011 (SI = J2), should not be reported with therapy CPT® codes. This includes services described at 1833(a)(8), namely outpatient physical therapy, outpatient speech-language pathology and outpatient occupational therapy furnished either by therapists or non-therapists and included on the same claim as a comprehensive APC procedure. Non-therapy outpatient department services that are adjunctive to J1 or J2 procedures should be reported without a CPT® code and instead should be reported with revenue code 0940 (other therapeutic services). The SI for this revenue code will be changed from SI=B to SI=N, indicating that the payment for these services will be packaged into the C-APC payment.

Category III CPT® codes effective July 1, 2016

The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT®) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2016 update, CMS is implementing in the OPPS nine Category III CPT® codes that the AMA released in January 2016 for implementation on July 1, 2016. The SIs and APCs for these codes are shown in Table 2. Payment rates for these services are available in Addendum B of the July 2016 OPPS Update that is posted at *https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/HospitalOutpatientpps/Addendum-A-and-Addendum-B-Updates.html*.

Please note that HCPCS code C9743 (Also listed in Table 2) will be deleted June 30, 2016, since it will be replaced with Category III CPT® code 0438T effective July 1, 2016. CPT® code 0438T will be assigned to the same SI and APC assignment as its predecessor HCPCS code C9743 effective July 1, 2016.

Table 2 - Category III CPT® codes effective July 1, 2016

CPT® code	Long descriptor	Add date	Term date	July 2016	July 2016 OPPS APC
0437T	Implantation of non-biologic or synthetic implant (eg,		N	N/A	
0438T	Transperineal placement of	7/1/16		T	5374
0439T	Myocardial contrast perfusion	7/1/16		N	N/A
0440T	Ablation,	7/1/16		J1	5361
0441T	Ablation,	7/1/16		J1	5361
0442T	Ablation,	7/1/16		J1	5361

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CPT® code	Long descriptor	Add date	Term date	July 2016	July 2016 OPPS APC
0443T	Real time spectral analysis of prostate tissue by fluorescence spectroscopy	7/1/16		T	5373
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral	7/1/16		N	N/A
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral	7/1/16		N	N/A
C9743	Injection/ implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies)			T	5374

Drugs, biologicals, and radiopharmaceuticals

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

For 2016, payment for both nonpass-through, and pass-through, drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs of these items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis, as later quarter ASP submissions become available. Updated payment rates effective July 1, 2016, and drug price restatements are available in the July 2016 update of the OPPS Addendum A and Addendum B at *https://www.cms.gov/HospitalOutpatientPPS/*.

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

Some drugs and biologicals paid based on the ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*.

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

c. Drugs and biologicals with OPPS pass-through status effective July 1, 2016

Five drugs and biologicals have been granted OPPS pass-through status, effective July 1, 2016. These items, along with their descriptors and APC assignments, are identified in Table 3.

Table 3 – Drugs and biologicals with OPPS pass-through status effective July 1, 2016

Code	Long descriptor	SI	APC
C9476	Injection, daratumumab, 10 mg	G	9476
C9477	Injection, elotuzumab, 1 mg	G	9477
C9478	Injection, sebelipase alfa, 1 mg	G	9478
C9479*	Instillation, ciprofloxacin otic suspension, 6 mg	G	9479
C9480	Injection, trabectedin, 0.1 mg	G	9480

*Note on reporting C9479: Each vial of C9479 contains 60 mg, or 10 doses. If one single use vial is used for both patient's ears with the remainder of the drug in the vial unused, then two units of C9479 should be reported as administered to the patient; any discarded amount should be reported with the JW modifier according to the *Medicare Claims Processing Manual*, Chapter 17 - Drugs and Biologicals, Section 40 - Discarded Drugs and Biologicals.

d. New drug HCPCS code

Effective July 1, 2016, one new HCPCS code has been created for reporting drugs and biologicals in the hospital

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outpatient setting, where there have not previously been specific codes available. This new code is listed in Table 4 (on page 35).

e. Biosimilar biological product payment and required modifiers

As a reminder, OPPS claims for separately paid biosimilar biological products are required to include a modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers.

On April 5, 2016, the second biosimilar biological product, Inflectra®, was approved by the FDA. Table 5 lists biosimilar HCPCS codes and required modifiers (on page 35).

f. Reassignment of skin substitute product from the low cost group to the high cost group One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. This product is listed in Table 6 .

Table 6 – Reassignment of skin Substitute product from the low cost group to the high cost group effective July 1, 2016

HCPCS code	Short descriptor	Status indicator	Low/high cost status
Q4164	Helicoll, per square cm	N	High

g. Other changes to 2016 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

Effective July 1, 2016, HCPCS code Q9982, flutemetamol f18 diagnostic, will replace HCPCS code C9459, Flutemetamol f18. The SI will remain G, "pass-through drugs and biologicals."

Effective July 1, 2016, HCPCS code Q9983, florbetaben f18 diagnostic, will replace HCPCS code C9458, Florbetaben f18. The SI will remain G, "Pass-Through Drugs and Biologicals."

Table 7 describes the HCPCS codes changes and effective dates (on page 35).

h. Changes to OPPS pricer logic

Effective July 1, 2016, there will be four diagnostic radiopharmaceuticals (two with new Q-codes replacing the previously used C-codes (as described above in the immediately preceding section g.)) and one contrast agent receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical or contrast agent payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical or contrast agent with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical or contrast agent expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals and contrast agents are the "policy-packaged" portions of the 2016 APC payments for nuclear medicine procedures and are on the CMS website.

Addition of C1713 and C1817 to the list of devices allowed for the device intensive procedure edit

CMS will be adding C1713 (Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)) and C1817 (Septal defect implant system, intracardiac) to the list of devices allowed for the device intensive procedure edit in the July 2016 release, and will make it retroactive to January 2016.

Coverage determinations

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

Please note that your MACs will adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of July 2016 OPPS Pricer.

Additional information

The official instruction, CR 9658, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3552CP.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

Date of change	Description
June 29, 2016	The article was revised due to an updated CR. The CR changed the APC number for the HCPCS code Q5102 from 1761 to 1847 in table 5, Attachment A (page 7 above). Also, business requirement 9658.3 in the CR had incorrect termination date for C9743, C9458, and C9459. The correct termination date should be June 30, 2016, instead of June 30, 2015. The transmittal number and CR release date and link to the transmittal was also changed.
May 18, 2016	Initial post

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MLN Matters® Number: MM9658 *Revised*
Related Change Request (CR) #: CR 9658
Related CR Release Date: June 28, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3552CP
Implementation Date: July 5, 2016

Table 4 – New drug HCPCS codes effective July 1, 2016

HCPCS code	Short descriptor	Long descriptor	SI	APC
Q9981	rolapitant, oral, 1mg	Rolapitant, oral, 1 mg	K	1761

Table 5 – Biosimilar biological product payment and required modifiers

HCPCS code	Short descriptor	Long descriptor	SI	APC	Code effective date	Modifier	Modifier effective date
Q5101	Inj filgrastim g-csf biosim	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	G	1822	3/6/15	ZA-Novartis/ Sandoz	1/1/16
Q5102	Inj., infliximab biosimilar	Injection, Infliximab, Biosimilar, 10 mg	K	1847	4/5/16	ZB – Pfizer/ Hospira	4/1/16

Table 7 – Other changes to 2016 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals effective July 1, 201

HCPCS code	Short descriptor	Long descriptor	Status indicator	APC	Added date	Termination date
C9459	Flutemetamol f18	Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries	G	9459	1/1/16	6/30/16
Q9982	flutemetamol f18 diagnostic	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	G	9459	7/1/16	
C9458	Florbetaben f18	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	G	9458	1/1/16	6/30/16
Q9983	Florbetaben f18 diagnostic	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	G	9458	7/1/16	

Take action to combat the flu

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

July update for 2016 DMEPOS fee schedule

Provider types affected

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

Provider action needed

Change request (CR) 9642 advises providers of fee schedule amounts for codes in effect on January 1, 2016, and July 1, 2016, for all other changes. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 (*https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*).

Payment on a fee schedule basis is required by the Social Security Act (the Act) for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR lenses (IOLs) inserted in a physician's office. The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas for the items, based on information from competitive bidding programs (CBPs) for DME. The CBP product categories, HCPCS codes and single payment amounts (SPAs) included in each Round of the CBP are available on the competitive bidding implementation contractor (CBIC) website (*http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*). The changes for the 2016 are detailed in MM9431.

Adjusted fee schedule amounts

The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. The adjustments to the fee schedule amounts have been phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount. As part of this update, for claims with dates of service on or after July 1, 2016, the July quarterly update files include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts. Information from CBPs that take effect on July 1, 2016 is factored into the adjusted fee schedule amounts effective on July 1, 2016, in accordance with the regulations at 42 CFR 414.210(g)(8).

Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated in accordance with 42 CFR 414.210(g)(8) when information from the CBPs is updated. Pursuant to 42 CFR §414.210(g)(4), for items where the single payment amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2016 for this update) and for each subsequent year such as 2017 and 2018.

There are three general methodologies used in adjusting the fee schedule amounts:

1. **Adjusted fee schedule amounts for areas within the contiguous United States**

The average of SPAs from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs (RSPAs) are also subject to a national ceiling (110 percent of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90 percent of the average of the RSPAs for all contiguous states plus the District of Columbia). The methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (those included in more than 10 competitive bidding areas (CBAs)).

Also, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. Regulations at 42 CFR 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP code within an MSA that is excluded from a CBA established for that MSA.

2. **Adjusted fee schedule amounts for areas outside the contiguous United States**

Areas outside the contiguous United States (areas such as Alaska, Guam, Hawaii) receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

3. **Adjusted fee schedule amounts for items Included in 10 or fewer CBAs**

DME items included in 10 or fewer CBAs receive

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adjusted fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs. This methodology applies to all areas, non-contiguous and contiguous.

In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file is updated to include rural payment amounts for certain HCPCS codes where the adjustment methodology is based on average regional SPAs. Also, on the PEN file, the national fee schedule amounts for enteral nutrition transitions to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology remains unchanged.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts based on information from the CBPs. ZIP codes for non-contiguous areas are not included in the DMEPOS rural ZIP code file. The DMEPOS rural ZIP code file is updated on a quarterly basis as necessary.

Key points of CR 9642

Public use files (PUFs)

In October 2015, CMS posted sample 2016 DMEPOS and PEN Medicare payment PUFs that were modified to accommodate the adjusted fee schedule amounts effective January 1, 2016. At that time, CMS communicated that different PUF file formats would be used for the January 2016 Excel file update as opposed to the July 2016 update and all subsequent fee schedule updates. CMS has recently determined that it is necessary to retain separate rural fee fields for each state and not transition, beginning July 1, 2016, to one field titled “Contiguous United States rural fee” as previously communicated.

Therefore, beginning with the July 2016 update, the July DMEPOS and PEN Excel PUF record layouts will retain the separate rural fees for each state as implemented January 1, 2016. As discussed above, the phase in of adjusted fees are based on 100 percent of the adjusted fee schedule amounts effective July 1, 2016. The rural fee for the contiguous United States, which is equal to the national ceiling amount, applies to all rural areas within the contiguous United States. However, in any case where the application of the adjusted fee methodology results in an increase in the fee schedule amount that would otherwise apply, the rural adjustment for an area/state is not made. Non-contiguous areas are not subject to rural fees under the 2016 DMEPOS fee schedule methodology.

The 2016 DMEPOS and PEN fee schedules and the July 2016 DMEPOS rural ZIP code file PUFs will be available for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the data files at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched*.

KU modifier for complex rehabilitative power wheelchair accessories & seat and back cushions

Section 2 of the Patient Access and Medicare Protection Act (PAMPA) mandates that the adjustments to the 2016 fee schedule amounts for certain DME based on information from CBPs not be applied to wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs prior to January 1, 2017. Group 3 complex rehabilitative power wheelchair bases are currently described by codes K0848 through K0864 of the HCPCS.

As a result, the fees for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier ‘KU’ are included in the July 2016 DMEPOS fee schedule file and are effective for dates of service January 1, 2016, through December 31, 2016. The fee schedule amounts associated with the KU modifier represent the unadjusted fee schedule amounts (the 2015 fee schedule amount updated by the 2016 DMEPOS covered item update factor of -0.4 percent) for these wheelchair accessory codes.

The codes for wheelchair accessories and seat and back cushions affected by this change along with claims processing instructions are available in CR 9520 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3535CP.pdf*. In accordance with that article, if brought to their attention, MACs may adjust claims for the Group 3 complex rehabilitative power wheelchair accessories referenced in Attachment A of related CR 9520 for dates of service January 1, 2016, through June 30, 2016.

Discontinuation of KE modifier for items in initial round 1 CBP

As part of this update, the fees for certain items included in round 1 CBP, denoted with the HCPCS pricing modifier ‘KE’, are deleted from the DMEPOS fee schedule file. Program instructions on the implementation of these fees and the list of applicable HCPCS codes were issued via CR 6720, dated November 7, 2008 (see related article *MM6720*).

The KE fees were retained on the fee schedule file for dates of service January 1, 2016, through June 30, 2016, because of the phase-in of the adjusted fee schedule amounts, but are no longer needed.

Reclassification of certain DME included in CBPs

As part of this update, capped rental fees are established for payment of the following 14 HCPCS codes: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.

For dates of service on or after July 1, 2016, these HCPCS codes are reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the nine round 1 re-compete (round 1 2014) CBAs. These changes are made to align the payment with the regulatory definition of routinely purchased equipment. Articles *MM8822* and *MM8566* discuss these program instructions.

See **DME**, next page

DME

From previous page

When submitting claims, suppliers in areas outside of round 1 re-compete CBAs that furnish these 14 HCPCS codes on a capped rental basis use the capped rental modifiers KH, KI, and KJ as appropriate. Beginning January 1, 2017, payment for these codes in all geographic areas will be made on a capped rental basis.

Also, certain HCPCS codes for wheelchair options/accessories (E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955) that are furnished to be used as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864) can be paid under the associated lump sum purchase option set forth in article *MM8566*.

The supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished for initial or replacement. If the beneficiary declines the purchase option, the supplier must furnish the items on a capped rental basis and payment shall be made on a monthly rental basis in accordance with the capped rental payment rules.

Diabetic testing supplies (DTS)

The fee schedule amounts for non-mail order DTS without KL modifier for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4258 are not updated by the covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they were equal to the SPAs for mail order DTS established in implementing the national mail-order CBP under Section 1847 of the Act. The non-mail order payment amounts on the fee schedule file are updated each time the single payment amounts are updated. As part of the this update, the non-mail order payment amounts on the fee schedule file for the above codes will be updated, effective July 1, 2016, using the SPAs established under the national mail-order re-compete CBP.

As part of this update, the DTS mail order (with KL modifier) fee schedules for all states and territories are removed from the DMEPOS fee schedule file. The SPAs calculated under the national mail-order CBPs replace the mail order fee schedule amounts for diabetic testing supply codes listed above. The SPAs are available at *http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*.

The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with Section 42 *Code of Federal Regulations* (CFR) 414.210(g)(7), the fee schedule amounts for mail order DTS furnished in the Northern Mariana Islands are adjusted to equal 100 percent of the SPAs established under the national mail-order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the six-month transition phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which were based on 50 percent of the un-adjusted mail order fee schedule amounts and 50 percent of the adjusted mail order SPAs, were provided on the DMEPOS fee schedule file in the Hawaii column of the eight mail-order (KL) DTS codes listed above for dates of service January 1, 2016, through June 30, 2016.

Beginning July 1, 2016, the fully adjusted mail order fees (the SPAs) will apply for mail order DTS furnished in the Northern Mariana Islands. As part of this update, the Northern Mariana Island DTS transition mail-order payment amounts will no longer appear in the Hawaii column of the fee schedule file and the DTS mail order (KL) fee schedules for all states and territories are removed from the DMEPOS fee schedule file as of July 1, 2016.

Specific coding and pricing issues

As part of this update, fees are established for HCPCS codes A6450 and A6451 which were added to the HCPCS file in 2004. Claims for codes A6450 and A6451 with dates of service on or after January 1, 2016, that have already been processed may be adjusted to reflect the newly established fees if brought to your MAC's attention.

Additional information

The official instruction, CR 9642, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3551CP.pdf*.

42 CFR 414.202 is available at *https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol3/CFR-2011-title42-vol3-sec414-202*.

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: MM9642
Related Change Request (CR) #: CR 9642
Related CR Release Date: June 23, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3551CP
Implementation July 5, 2016

Upcoming provider outreach and educational events

Ask-the-contractor teleconference (ACT): NCCI General Coding Guidelines & Resources (A/B)

Date: Wednesday, August 24
Time: 10:00-11:30
Type of Event: Webcast
http://medicare.fcso.com/Events/0338499.asp

Medicare Part A changes and regulations

Date: Tuesday, September 20
Time: 10:00-11:30
Type of Event: Webcast
http://medicare.fcso.com/Events/0338439.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.

MLN Connects®

CMS MLN Connects® Provider eNews

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

MLN Connects® Provider eNews for June 30, 2016

MLN Connects® Provider eNews for June 30, 2016
View this edition as a PDF

In this edition:

News & Announcements

- ESRD and DMEPOS: Proposed Updates to CY 2017 Policies and Payment Rates
- Home Health Agencies: Proposed Payment Changes for CY 2017
- July 2016 DMEPOS Fee Schedules Available
- Moratoria Provider Services and Utilization Data Tool
- EHR Incentive Program: Hardship Exception Applications Due by July 1
- CMS to Release a CBR on Physician Assistant Use of Modifier 25 in July
- Updated Inpatient and Outpatient Data Available

Claims, Pricers & Codes

- 2017 ICD-10-CM and ICD-10-PCS Files Available

Upcoming Events

- Clinical Diagnostic Laboratory Test Payment System Final Rule Call — July 6
- DMEPOS Competitive Bidding Program Round 2 Recompete Webinars — July 7 and 12
- Quality Measures and the IMPACT Act Call — July 7
- SNF Quality Reporting Program Call — July 12
- Comparative Billing Report on Diabetic Testing Supplies Webinar — July 27

Medicare Learning Network® Publications & Multimedia

- Medicare Coverage of Diagnostic Testing for Zika Virus *MLN Matters*® Article — New
- Recovering Overpayments from Providers Who Share TINs *MLN Matters*® Article — New
- Implementation of Section 2 of the PAMPA *MLN Matters*® Article — New
- Physician Compare Call: Audio Recording and Transcript — New
- SBIRT Services Fact Sheet — Reminder
- Remittance Advice Resources and FAQs Fact Sheet — Reminder

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.

MLN Connects® Provider eNews for July 7, 2016

MLN Connects® Provider eNews for July 7, 2016
View this edition as a PDF

In this edition:

News & Announcements

- HHS Announces Physician Groups Selected for an Initiative Promoting Better Cancer Care
- Open Payments Program Posts 2015 Financial Data
- Hospice CAHPS® Exemption for Size Deadline: August 10
- Help Us Improve Access to DMEPOS
- Revised CMS-855R Application: Reassignment of Medicare Benefits
- July Quarterly Provider Update Available
- Rule Gives Providers/Employers Improved Access to Information for Better Patient Care

Claims, Pricers & Codes

- Modifications to HCPCS Code Set

Upcoming Events

- SNF Quality Reporting Program Call — July 12

Medicare Learning Network® Publications & Multimedia

- Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
- Subscribe to the Medicare Learning Network Educational Products and MLN Matters® Electronic Mailing Lists

MLN Connects® Provider eNews for July 14, 2016

MLN Connects® Provider eNews for July 14, 2016

View this edition as a PDF

In this edition:

Editor's Note:

This week's eNews includes a new section on Provider Compliance, highlighting common billing errors. Check out the first message in this series on chiropractic services and learn how to bill Medicare correctly the first time.

News & Announcements

- New Hospice Report Available July 17
- Clinical Laboratory Fee Schedule Resources
- HIPAA Administrative Simplification Enforcement and Testing Tool
- 2017 QRDA Hospital Quality Reporting Implementation Guide, Schematrons, and Sample File
- Upcoming Medicare Learning Network® Website Redesign

Provider Compliance

- Chiropractic Services: High Improper Payment Rate within Medicare FFS Part B

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call — August 2
- IRF Quality Reporting Program Provider Training — August 9 and 10
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10
- LTCH Quality Reporting Program Provider Training — August 11

Medicare Learning Network® Publications & Multimedia

- Medicare Billing Certificate Program for Part A Providers WBT — Revised
- Medicare Billing Certificate Programs for Part B Providers WBT — Revised
- Complying With Medicare Signature Requirements Fact Sheet – Revised
- DMEPOS Accreditation Fact Sheet — Revised
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet — Reminder

MLN Connects® Provider eNews for July 21, 2016

MLN Connects® Provider eNews for July 21, 2016
View this edition as a PDF

In this edition:

Editor's Note:

Our *Medicare Learning Network* (*MLN*®) website is updated to improve your access to education resources and make finding what you need easier. We hope you will take a look and share your thoughts with us. Learn more in this week's eNews.

News & Announcements

- Improved Medicare Learning Network® Website
- IRF Quality Reporting Program Data Submission Deadline: August 15
- LTCH Quality Reporting Program Data Submission Deadline: August 15
- Hospice Quality Reporting: Reconsideration Period Ends Soon
- SNF Readmission Measure: Top 10 Things You Should Know
- Enhanced Administrative Simplification Website

Provider Compliance

- CMS Provider Minute: CT Scans Video

Claims, Pricers & Codes

- Billing for Nursing Visits in Home Health Shortage Areas by an RHC or FQHC

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call — August 2

- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10

Medicare Learning Network® Publications & Multimedia

- Clinical Labs Call: Audio Recording and Transcript — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Medicare Podiatry Services: Information for FFS Health Care Professionals Fact Sheet — Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet — Revised
- How to Use the National Correct Coding Initiative Tools Booklet — Revised

Provider minute videos for Part A and Part B providers and DMEPOS suppliers

The *Medicare Learning Network*® has a series of the *Centers for Medicare & Medicaid (CMS) provider minute videos* on compliance for Part A and Part B providers and durable medical equipment, prosthetics, orthotic, and supplies (DMEPOS) suppliers. These videos have tips to help you properly submit claims with sufficient documentation in order to receive correct payment the first time.

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