Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers August 2012

In this issue

New health care standards to save up to $6 billion

Currently, when a health care provider bills a health plan, that plan may use a wide range of different identifiers that do not have a standard format. As a result, health care providers run into a number of time-consuming problems, such as misrouting of transactions, rejection of transactions due to insurance identification errors, and difficulty determining patient eligibility. The change announced August 24 will greatly simplify these processes.

The rule also makes final a one-year proposed delay – from October 1, 2013, to October 1, 2014 – in the compliance date for use of new codes that classify diseases and health problems. These code sets, known as the International Classification of Diseases, 10th Edition diagnosis and procedure codes, or ICD-10, will include codes for new procedures and diagnoses that improve the quality of information available for quality improvement and payment purposes.

The rule announced today is the fourth administrative simplification regulation issued by HHS under the health reform law:

- On July 8, 2011, HHS adopted operating rules for two electronic health care transactions to make it easier for health care providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health insurer. The rules will save up to $12 billion over ten years.
- On January 10, 2012, HHS adopted standards for the health care electronic funds transfers (EFT) and remittance advice transactions between health plans and health care providers. The standards will save up to $4.6 billion over ten years.
- On August 10, 2012, HHS published an IFC that adopted operating rules for the health care EFT and electronic remittance advice transaction. The operating rules will save up to $4.5 billion over ten years.

For more information

- *Fact sheet*
- Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets *Final Rule*

Full text of this excerpted *CMS press release* (issued August 24).

Source: CMS PERL 201208-11

Contents

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

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Articles included in the *Medicare B 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.

ICD-9-CM "E" code reported as the first diagnosis on CMS-1500

Provider types affected

Physicians, providers, and suppliers who submit Medicare claims to Medicare carriers, Medicare administrative contractors (A/B MACs), and/or durable medical equipment MACs (DME MACs) using the paper claim Form CMS-1500.

Provider action needed

This change request (CR) 7700 provides new instructions to return as unprocessable claims submitted on the Form CMS-1500 where an ICD-9-CM "E" Code (external causes of injury and poisoning) is reported as the first/ principal diagnosis on the claim.

Background

CR 7700 will bring the policy for handling form CMS-1500 claims into alignment with the policy for handling claims initially submitted in electronic format. The ICD-9-CM code set prohibits an "E" code from being reported as principal diagnosis (first-listed) on a claim. This guidance also applies to V00-Y99 (external causes of morbidity) equivalent ICD-10 CM diagnosis codes. Therefore, if an "E" code or V00-Y99 range ICD-10 CM diagnosis code is the first listed diagnosis code on the CMS-1500, the claim would not conform to the ICD-9-CM code set and electronic transmission of the electronic claim to a coordination of benefits agreement (COBA) trading partner would not be Health Insurance Portability and Accountability Act (HIPAA) compliant.

Claims initially submitted as electronic claims will, effective April 1, 2012, be rejected in accordance with an edit established by CMS CR 7596 when the principal (first) diagnosis code presented in the diagnosis code field is an "E" code or, effective with the implementation of ICD-10, when the principal (first) diagnosis is a code within the code range V00-Y99 of the ICD-10- CM code set. This procedure will prevent those non-HIPAA compliant claims from being adjudicated and then transmitted to the coordination of benefits contractor (COBC) for COBA crossover purposes. CR 7700 applies this reasoning to claims submitted on CMS-1500 on or after January 1, 2013.

Key points

Be aware of the following:

- For claims received via form CMS-1500 on or after April January 1, 2013, Medicare contractors will return as unprocessable claims for items or services where a diagnosis code is required and the diagnosis code reported in the number 1 field of Item 21 of the Form CMS-1500 is an ICD-9-CM "E" code (external causes of injury and poisoning) or, upon ICD-10 implementation, an ICD-10 CM code within the code range of V00-Y99
- Reprocessed/adjustment claims failing these edits will be denied
- Claims returned or denied as a result of these edits will show remittance advice remarks code message MA63 (Missing/incomplete/invalid principal diagnosis) and claim adjustment reason code 16 (Claim/service lacks information which is needed for adjudication)

Additional information

The official instruction, CR 7700, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2515CP.pdf*.

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

MLN Matters® Number: MM7700
Related Change Request (CR) #: 7700
Related CR Release Date: August 8, 2012
Effective Date: Claims received with an "E" code on or after January 1, 2013
Related CR Transmittal #: R2515CP
Implementation Date: April 1, 2013

Drugs and Biologicals

October 2012 quarterly ASP Medicare Part B drug pricing files and revisions to prior files

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Medicare will use the October 2012 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2012, with dates of service from October 1, 2012, through December 31, 2012.

Caution – what you need to know

Change request (CR) 7885, from which this article is taken, instructs your Medicare contractors to download and implement the October 2012 ASP Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised July 2012, April 2012, January 2012, and October 2011 files.

GO – what you need to do

Make sure that your billing staffs are aware of the release of these October 2012 ASP Medicare Part B drug files.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf*.)

The following table shows how the quarterly payment files will be applied:

Files	Effective for dates of service
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011

Additional information

You can find the official instruction, CR 7885, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2514CP.pdf*. If you have any questions, please contact your FI, carrier, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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ASP *(continued)*

MLN Matters® Number: MM7885
Related Change Request (CR) #: CR 7885
Related CR Release Date: August 3, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2514CP
Implementation Date: October 1, 2012

Laboratory/Pathology

Proper billing of *CPT*® code *88305*

Providers are incorrectly coding claims when billing for multiple specimens of *CPT*® code *88305*. Multiple specimens for the same date of service, billed on the same claim, should be submitted on one detail line by adjusting the "number billed field" to reflect the number of specimens. Billing these services on separate details is inappropriate.

Source: TDL 12376

Surgery

Liver transplantation for patients with malignancies

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for adult liver transplantation services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7908 which updates instructions regarding adult liver transplantation services for Medicare beneficiaries and revises relevant sections of the *Medicare Claims Processing Manual* and the Medica*re National Coverage Determinations (NCD) Manual*.

Caution – what you need to know

Effective for claims with dates of service June 21, 2012, and later, CR 7908 instructs that Medicare contractors may, at their discretion, cover adult liver transplantation for Medicare beneficiaries with 1) extrahepatic unresectable cholangiocarcinoma (CCA), 2) liver metastases due to a neuroendocrine tumor (NET), or 3) hemangioendotheliomo (HAE) when furnished in an approved liver transplant center. All other nationally non-covered malignancies continue to remain nationally non-covered.

Go – what you need to do

See the *Background* and *Additional information* sections for further details regarding these changes.

(continued on next page)

Liver *(continued)*

Background

Liver transplantation (in situ replacement of a recipient's liver with a donor liver) may be an accepted treatment for patients with end-stage liver disease due to a variety of causes. The procedure is used in selected patients as a treatment for malignancies including primary liver tumors (and certain metastatic tumors) which are typically rare but lethal and have very limited treatment options. It has also been used in the treatment of patients with extrahepatic perihilar malignancies. Despite potential short and long-term complications, transplantation may offer the only chance of cure for selected patients while providing meaningful palliation for some others.

Currently, Medicare covers liver transplantation for one malignancy, hepatocellular carcinoma (HCC), in certain circumstances. See the *Medicare NCD Manual* (Chapter 1, Part 4, Section 260.1 (Adult Liver Transplantation)) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf*.

It had been approximately 10 years since CMS reviewed liver transplantation for malignancies other than hierarchical condition categories (HCCs). Therefore, October 14, 2011, CMS opened this NCD reconsideration and solicited public comment.

On June 21, 2012, CMS issued a final NCD in the form of a non-decision stating that liver transplantation for patients with certain malignancies offers the potential for some clinical benefit in patients carefully selected on a case-by-case basis. These malignancies are:

1. Extrahepatic unresectable cholangiocarcinoma (CCA),
2. Liver metastases due to a neuroendocrine tumor (NET), and
3. Hemangioendothelioma (HAE).

The evidence base for these malignancies is sparse and especially limited in the Medicare population. In carefully selected patients, there appears to be a survival benefit from limited case series and reviews. Thus, CMS believes that local Medicare contractors are in a better position to consider the clinical characteristics of individual beneficiaries and the performance of transplant centers within their jurisdictions in the best interest of Medicare beneficiaries.

Therefore, CR 7908 instructs that Medicare contractors may determine coverage for adult liver transplantation (when furnished in a facility that meets CMS institutional criteria) for patients with CCA, NET, or HAE. All other nationally non-covered malignancies continue to remain nationally non-covered.

Additional information

The official instruction, CR 7908 issued to your carriers, FIs, and A/B MACs, regarding this change in two transmittals. The first transmittal, R146NCD, updates the *Medicare NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R146NCD.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2513CP.pdf*.

You can find more information about Medicare approval for organ transplant programs including links, applicable laws, regulations, compliance information, and a listing of currently approved programs at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Transplant.html*.

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

MLN Matters® Number: MM7908
Related Change Request (CR) #: CR 7908
Related CR Release Date: August 3, 2012
Effective Date: June 21, 2012
Related CR Transmittal #: R2513CP and R146NCD
Implementation Date: September 4, 2012

National coverage determination for transcatheter aortic valve replacement

Provider types affected

This *MLN Matters*® article is intended for physicians and hospitals who provide transcatheter aortic valve replacement (TAVR) services to Medicare beneficiaries.

Provider action needed

Stop - impact to you

Effective for claims with dates of service on and after May 1, 2012, Medicare carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (A/B MACs) will reimburse for TAVR under coverage with evidence development (CED).

Caution – what you need to know

Change request (CR) 7897, from which this article is taken, announces that on May 1, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a national coverage determination (NCD) covering TAVR under CED and CR 7897 details requirements that must be met when claims are submitted to Medicare for these services.

Go – what you need to do

You should make sure that your billing staffs are aware of this decision and its requirements which are summarized in the *Background* section.

Background

Transcatheter aortic valve replacement (TAVR) (also known as TAVI or transcatheter aortic valve implantation) is a new technology for use in treating certain patients with aortic stenosis. A bioprosthetic valve is inserted percutaneously using a catheter and implanted in the orifice of the native aortic valve.

CR 7879, from which this article is taken announces that on May 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) covering TAVR under CED and only when specific requirements are met.

CED coverage conditions with registry participation

CMS covers TAVR for the treatment of symptomatic aortic valve stenosis under CED with the following conditions:

1. It is furnished according to a Food and Drug Administration (FDA)-approved indication and when all of the following conditions are met:
   a) It is furnished with a complete aortic valve and implantation system that has received FDA premarket approval (PMA) for that system's FDA approved indication;
   b) Two cardiac surgeons have independently examined the patient face-to-face and evaluated the patient's suitability for open aortic valve replacement (AVR) surgery; and both surgeons have documented the rationale for their clinical judgment, and this rationale is available to the heart team;
   c) The patient (preoperatively and postoperatively) is under the care of a heart team: a cohesive, multi-disciplinary, team of medical professionals that embodies collaboration and dedication across medical specialties to offer optimal patient-centered care;
   d) It is furnished in a hospital with the appropriate infrastructure that includes (but is not limited to):
      - On-site heart valve surgery program;
      - Cardiac catheterization lab or hybrid operating room/catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering quality imaging;
      - Non-invasive imaging such as echocardiography, vascular ultrasound, computed tomography (CT) and magnetic resonance (MR);
      - Sufficient space, in a sterile environment, to accommodate necessary equipment for cases with and without complications;

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- Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures; and
- Appropriate volume requirements per the applicable qualifications (specifically, for hospitals without TAVR experience and for those with experience performing the procedure), which follow.

2. Required qualifications for the hospitals and heart teams performing the procedure.

Hospitals without TAVR experience must have the following qualifications to begin a TAVR program:

a) ≥ 50 total AVRs in the previous year prior to TAVR, including ≥ 10 high-risk patients;

b) ≥ Two physicians with cardiac surgery privileges; and

c) ≥ 1000 catheterizations per year, including ≥ 400 Percutaneous Coronary Interventions (PCIs) per year.

Heart Teams without TAVR experience must include the following to begin a TAVR program:

a) A cardiovascular surgeon with: 1) ≥ 100 career AVRs including 10 high-risk patients; or, 2) ≥ 25 AVRs in one year; or, 3) ≥ 50 AVRs in two years; and which include at least 20 AVRs in the last year prior to TAVR initiation; and,

b) An interventional cardiologist with: 1) Professional experience with 100 structural heart disease procedures lifetime; or, 2) 30 left-sided structural procedures per year of which 60 percent should be balloon aortic valvuloplasty (BAV). Atrial septal defect and patent foramen ovale closure are not considered left-sided procedures; as well as

c) Additional members of the heart team such as echocardiographers, imaging specialists, heart failure specialists, cardiac anesthesiologists, intensivists, nurses, and social workers; and,

d) Device-specific training as required by the manufacturer.

Hospital programs with TAVR experience must have the following qualifications:

a) Maintain ≥ two physicians with cardiac surgery privileges;

b) Perform ≥ 20 AVRs per year or ≥ 40 AVRs every two years; and

c) Perform ≥ 1000 catheterizations per year, including ≥ 400 percutaneous coronary interventions (PCIs) per year.

Heart teams with TAVR experience must have the following qualifications:

a) Include a cardiovascular surgeon and an interventional cardiologist whose combined experience maintains: 1) ≥ 20 TAVR procedures in the prior year, or 2) ≥ 40 TAVR procedures in the prior two years;

b) Include additional members of the heart team such as echocardiographers, imaging specialists, heart failure specialists, cardiac anesthesiologists, intensivists, nurses, and social workers; and

c) The interventional cardiologist(s) and cardiac surgeon(s) must jointly participate in the intra-operative technical aspects of TAVR.

In addition, the heart team and hospital must be participating in a prospective, national, audited registry. The complete list of requirements for a qualifying registry can be found in the NCD, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R145NCD.pdf*. To date, CMS has approved one registry, the transcatheter valve therapy registry operated by the Society of Thoracic Surgeons and the American College of Cardiology.

CED coverage conditions with clinical studies

For indications that are not approved by the FDA, CMS covers TAVR under CED when patients are enrolled in qualifying clinical studies. The clinical study requirements are available in the NCD, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R145NCD.pdf*.

Approved studies are listed at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html*.

Note: TAVR is not covered for patients in whom existing co-morbidities would preclude the expected benefit from correction of the aortic stenosis.

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Coding requirements – professional claims

For TAVR services furnished on or after May 1, 2012, you should bill with the appropriate temporary level III *Current Procedural Terminology* (*CPT*) code:

- *0256T: Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach*
- *0257T: Implantation of catheter-delivered prosthetic aortic heart valve; open thoracic approach (eg, transapical, transventricular)*
- *0258T: Transthoracic cardiac exposure (i.e. sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; without cardiopulmonary bypass*
- *0259T: Transthoracic cardiac exposure (i.e. sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass*

Beginning January 1, 2013, CMS anticipates permanent *CPT* level 1 codes will replace the above four codes for processing TAVR claims, and will issue instructions for the permanent *CPT* level 1 codes in a future CR.

You should be aware that, on or after May 1, 2012, your carrier or A/B MAC will only reimburse your professional claims for TAVR services (for *CPT* codes *0256T, 0257T, 0258T*, and *0259T*) when used with place of service (POS) code 21 (inpatient hospital). They will deny all other POS codes. Should they deny your claim because of an incorrect POS, they will use the following messages:

- Claim adjustment reason code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;"
- Remittance advice remark code (RARC) N428: "Not covered when performed in this place of service;" and
- Group code CO (contractual obligation).

Similarly, Medicare will only pay claim lines with these TAVR *CPT* codes when billed with modifier *62* (two surgeons/co-surgeons). They will return all others as unprocessable. Should they return such claims, they will use:

- CARC 4: "The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;"
- RARC N29: "Missing documentation/orders/notes/summary/report/chart;" and
- Group code CO (contractual obligation).

Medicare will only pay claim lines for these codes in a clinical trial when billed with modifier Q0 (zero). For TAVR services, use of modifier Q0 signifies CED participation (qualified registry or qualified clinical study).They will return such claims billed without modifier Q0 as unprocessable using:

- CARC 4: "The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present; "
- RACR N29: "Missing documentation/orders/notes/summary/report/chart," and
- Group code CO (contractual obligation).

Medicare will only pay claims for these codes in a clinical trial when billed with International Classification of Diseases, Ninth Revision Clinical Modification (ICD-9-CM) secondary diagnosis code V70.7 (routine general medical examination at a health care facility) (ICD-10 = Z00.6 -- encounter for examination for normal comparison and control in clinical research program). For TAVR services, use of V70.7 signifies CED participation (qualified registry or qualified clinical study).They will return claim lines billed without secondary diagnosis code V70.7 as unprocessable, using:

- CARC 16: "Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT);"
- RARC N29: "Missing documentation/orders/notes/summary/report/chart;" and
- Group code CO (contractual obligation).

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Coding requirements - inpatient hospital claims

Hospitals should bill for TAVR services on an 11x type of bill (TOB), effective for discharges on or after May 1, 2012. Your FI or A/B MAC will reimburse such claims containing ICD-9 procedure codes 35.05 (Endovascular replacement of aortic valve) or 35.06 (Transapical replacement of aortic valve) only when billed with secondary diagnosis code V70.7 (Examination of participant in clinical trial) and condition code 30 (qualifying clinical trial). For TAVR services, use of the latter two codes signifies CED participation (qualified registry or qualified clinical study).

Claims from hospitals without those latter two codes will be rejected using:

- CARC: 50: "These are non-covered services because this is not deemed a "medical necessity" by the payer;"
- RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD;" and
- Group code CO (contractual obligation).

The following are the ICD-10 procedure codes applicable for TAVR:

TAVR ICD-9 procedure codes	TAVR ICD-10 procedure codes
35.05	02RF37Z 02RF38Z 02RF3JZ 02RF3KZ
35.06	02RF37H 02RF38H 02RF3JH 02RF3KH

Additional information

CR 7897 was issued to your Medicare contractor in two transmittals. The first transmittal modifies the *Medicare National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R145NCD.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2512CP.pdf*.

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

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Effective Date: May 1, 2012
Related CR Transmittal #: R2512CP and R145NCD
Implementation Date: January 7, 2013

Therapuetic Services

Transcutaneous electrical nerve stimulation for chronic low back pain

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers that submit claims to Medicare contractors (carriers, regional home health intermediaries [RHHIs], and durable medical equipment Medicare administrative contractors [DME MACs]) for transcutaneous electrical nerve stimulation (TENS) services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7836 which informs providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) is revising the coverage for TENS for chronic low back pain (CLBP) effective for claims with dates of service on or after June 8, 2012. See the Key points section for specific coverage rules and review the lists of ICD- 9 and ICD-10 codes attached to the official instruction CR 7836.

Background

In 2010, the Therapeutic and Technology Assessment Subcommittee of the American Academy of Neurology (AAN) published a report finding TENS ineffective for CLBP. CMS internally initiated a new national coverage determination (NCD) after the AAN published report and reviewed all the available evidence on the use of TENS for the treatment of CLBP.

Medicare has four NCDs pertaining to various uses of TENS that were developed before the CMS adoption of an evidence based and publicly transparent paradigm for coverage decisions. Those four NCDs are:

- Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (10.2)
- Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1)
- Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13), and
- Transcutaneous Electrical Nerve Stimulators (TENS) (280.13). Please note, section 280.13 has been removed from the *NCD Manual* and incorporated into NCD 160.27

The evidentiary basis is unclear for historic coverage. TENS has been historically thought to relieve chronic pain but the current evidence base refutes this assertion when applied to TENS for CLBP. Since TENS falls within the durable medical equipment (DME) benefit, Medicare coverage results in purchase after a brief initial rental period, even if the patient soon develops a subsequent tolerance to the TENS effect.

Key points

Effective for claims with dates of service on or after June 8, 2012, CMS believes the evidence is inadequate to support coverage of TENS for CLBP as reasonable and necessary. Thus, effective for claims with dates of service on and after June 8, 2012, Medicare will only allow coverage of TENS for CLBP defined for this decision as pain for three months or longer and not a manifestation of a clearly defined and generally recognizable primary disease entity, when the patient is enrolled in an approved clinical study under coverage with evidence development (CED).

Note: CED coverage expires three years from the effective date of this CR, June 8, 2015.

Examples of clearly defined and recognizable primary disease entities: neurodegenerative (e.g. multiple sclerosis) disease, malignancy, or well-defined rheumatic disorders (except osteoarthritis).

Medicare contractors will accept and process line items that include an appropriate TENS HCPCS code, at least one ICD-9 diagnosis code for CLBP (see list of ICD-9 codes attached to CR 7836), and all of the following:

- Date of service on or after June 8, 2012
- Modifiers KX and Q0
- ICD-9 code V70.7 - Examination of participant in clinical trial (for institutional claims only)
- Condition code 30 - (for institutional claims only)
- An acceptable ICD-9 code, and
- An acceptable ICD-10 code upon implementation (see list of ICD-10 codes attached to CR 7836).

Medicare contractors will deny TENS line items on claims when billed with a TENS code and at least one of the ICD-9 or ICD-10 codes for CLBP (see attachments to transmittal R2511CP of CR 7836 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2511CP.pdf*), if the conditions of requirement listed above are not met. When Medicare denies such claims for not containing the requisite ICD-9 (or later ICD-10) code, your remittance advice will reflect the following messages:

- Group code CO
- Claim adjustment reason code B5 (Coverage/

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program guidelines were not met or were exceeded.), and

- Remittance advice remark code 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/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.

Medicare will pay for allowed TENS for CLBP based on the DME fee schedule.

All of the following conditions must be met for coverage of TENS for CLBP:

CLBP is defined as:

- An episode of low back pain that has persisted for three months or longer, and
- Is not the manifestation of a clearly defined and generally recognizable primary disease entity.

For example, there are cancers that, through metastatic spread to the spine or pelvis, may elicit pain in the lower back as a symptom. Certain systemic diseases, e.g. rheumatoid arthritis, multiple sclerosis etc, manifest many debilitating symptoms of which low back pain is not the primary focus. CMS believes that the appropriate management of these types of diseases is guided by a systematic strategy aimed at the underlying causes. While TENS may infrequently be used adjunctively in managing the symptoms of these diseases, it is clearly not the primary therapeutic approach.

The patient is enrolled in an approved clinical study that addresses one or more aspects of the following questions in a randomized, controlled design using validated and reliable instruments. This can include randomized crossover designs when the impact of prior TENS use is appropriately accounted for in the study protocol.

1. Does the use of TENS provide a clinically meaningful reduction in pain in Medicare beneficiaries with CLBP?
2. Does the use of TENS provide a clinically meaningful improvement of function in Medicare beneficiaries with CLBP?
3. Does the use of TENS provide a clinically meaningful reduction in other medical treatments or services used in the medical management of CLBP?

These studies must be designed so that the patients in the control and comparison groups receive the same concurrent treatments and either sham (placebo) TENS or active TENS intervention.

The study must also adhere to standards of scientific integrity and relevance to the Medicare population and those standards are part of Section 160.27. You may read the entire set of parameters in the official instruction attached to transmittal R144NCD of CR 7836. That transmittal is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R144NCD.pdf*.

Additional information

The official instruction, CR 7836, issued to your Medicare carrier, RHHI or DME MAC regarding this change via two transmittals. The first updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R144NCD.pdf*. The other transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2511CP.pdf*.

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

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Implementation Date: January 7, 2013

Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Use of KX modifier on cardiac rehabilitation and intensive cardiac rehabilitation procedures – clarification

With the implementation of change request 6850, the Centers for Medicare & Medicaid Services (CMS) included the use of the KX modifier on cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) procedures.

The KX modifier can be used on CR procedure codes (*93797, 93798*) and ICR procedure codes (G0422, G0423) for the same or different episode once the sessions have been exceeded. Providers are required to maintain medical documentation to support the use of the KX modifier.

General Coverage

Improper payments and inpatient prepayment medical review – update

As the Medicare administrative contractor (MAC) for jurisdiction 9 (J9), First Coast Service Options Inc. (FCSO) is committed to assisting the Centers for Medicare & Medicaid Services (CMS) in reaching the goal of reducing the national Medicare fee-for-service (FFS) paid claims error rate. Note: The Centers for Medicare & Medicaid Services (CMS) recently announced delay of the implementation of the recovery auditor (RAC) demonstration; however, that is a separate CMS initiative. FCSO's prepayment medical review schedule is described below.

MS-DRGs 153, 328, 357, 455, 473, and 517 are subject to prepayment medical review effective March 21, 2012 (in addition to MS-DRGs 226, 227, 242, 243, 244, 245, 247, 251, 253, 264, 287, 313, 392, 458, 460, 470, 490, 552, 641 that were already subject to prepayment review). MS-DRGs with a one-day length of stay (LOS) are subject to prepayment medical review effective April 11, 2012.

- *Click here* to view detail information for each MS-DRG in FCSO's staggered approach to implementing prepayment edits currently on its prepayment medical review MS-DRG strategy.

FCSO has identified certain hospitals who have sustained low error rates for certain DRGs. Beginning July 17, 2012, these hospitals will be excluded from prepayment editing for the specific DRGs for which a low rate is maintained.

Effective February 1, 2012, FCSO began performing data analysis in preparation for post-payment recoupment of the surgeon, assistant surgeon, or co-surgeon's Part B services.

FCSO will continue to provide outreach and education to hospitals, physician associations, and Part B providers associated with high payment error risk MS-DRG services.

The MAC J9 CERT payment error findings are included for claims sampled in the November 2010 and November 2011 report periods. Denial information is also provided for those services previously subject to FCSO medical review activities. FCSO will provide information regarding prepayment review error rates through future articles and other education and outreach forums. Notice will also be provided for future changes to prepayment review activities (e.g., increase in percentage of review). The percentage of prepayment review is based on the average of DRG receipts received in the Fiscal Intermediary Standard System (FISS).

This initiative is applicable to hospitals and physicians in Medicare administrative contractor (MAC) jurisdiction 9 (J9), excluding those in Puerto Rico and the U.S. Virgin Islands.

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? FCSO'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.

Claim status category and claim status codes update

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7905 which explains that the Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category and claim status codes approved by the National Code Maintenance Committee to report the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The code sets are available at *http://www.wpc-edi.com/content/view/180/223/*. The code lists include the date when a code was added, changed, or deleted. All code changes approved during the June 2012 committee meeting should have been posted on that site on or about July 1, 2012.

Background

HIPAA requires all health care benefit payers to use claim status category and claim status codes to report the status of submitted claim(s). Only codes approved by the National Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format are to be used. Proprietary codes may not be used in the X12 276/277 to report claim status.

The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The code sets are available at *http://www.wpc-edi.com/content/view/180/223/* (previously *http://www.wpc-edi.com/codes*). The code lists include specific details, including the date when a code was added, changed, or deleted. Your Medicare contractors must complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes by October 1, 2012.

Additional information

The official instruction, CR 7905, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2508CP.pdf*.

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

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Implementation Date: October 1, 2012

Addition of digital document repository to PECOS

Provider types affected

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

Provider action needed

Stop – impact to you

This article informs Medicare contractors about the changes and enhancements to the online version of the Provider Enrollment, Chain, and Ownership System (Internet-based PECOS). The changes allow physicians, other providers, and suppliers to digitally upload their PECOS supporting documents and submit them electronically with their enrollment application. A " Digital Document Repository (DDR) How to Guide" is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DigitalDocumentRepository-HowToGuide.pdf*.

Go – what you need to do

Make sure that your provider enrollment staff is aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Note: Providers/suppliers are not required to utilize the digital document repository (DDR) process and still have the option to mail their supporting documents to their MACs.

Background

CMS has updated Internet-based PECOS to allow all providers/suppliers the ability to submit electronic copies of supporting documentation to a DDR. Prior to this enhancement, providers/suppliers were required to mail copies of all supporting documentation to their MAC.

The DDR will be accessible by providers/suppliers via Internet-based PECOS during the application submission process. The DDR will apply to any documents required to be submitted as part of the Medicare enrollment application and requests from the MACs for additional documentation that may be essential to completely process the provider/supplier's enrollment application. Examples include, but are not limited to:

- Medical licenses/certifications
- Final adverse legal action documentation
- Internal Revenue Service (IRS) tax documents
- Accreditation documentation
- Voided check/account verification (for electronic funds transfer (EFT))
- National provider identifier (NPI) confirmation letters
- Pay.gov receipts
- Provider agreements, and
- CMS-460 Participation Agreement Forms.

Internet-based PECOS users will have the ability to upload all supporting documentation for any enrollment application that can be submitted via Internet-based PECOS, including new enrollment applications, Changes of Information (COI) applications, and revalidation applications. Uploaded documents must be in a PDF or TIFF file format, and be equal to or less than 10MB per file. Documents can only be uploaded for an application that has not yet been submitted for processing, or if the application has been returned for corrections. Once the application has been submitted for processing, the provider/supplier will not be able to attach any additional documents unless the application is denied, rejected, or returned for corrections by the MAC; or the application is approved and a new application is submitted (e.g., COI). Users who wish to submit an application for the sole purpose of updating documentation would submit a COI, and update the documents associated with the enrollment record. Users will also have the ability to classify documents that are uploaded based on the document type and to upload more than one document of a particular type (e.g., uploading of multiple documents with the type "W-2 for Managing Employee" for multiple W-2s for managing employees). Users will have the ability to add or delete previously submitted documents as part of a COI application submission and view/print any supporting documentation that was previously submitted and is currently associated with an enrollment record.

Additional information

To download the *Digital Document Repository (DDR) How to Guide* on how to use the new DDR functionality, please refer to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DigitalDocumentRepository-HowToGuide.pdf*.

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

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Posting the limiting charge after applying the e-Prescribing negative adjustment

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7877, which informs Medicare contractors about required changes to their websites and hard copy disclosure reports concerning the correct limiting charge (including the eRx negative adjustment limiting charge amount) for Medicare physician fee schedule (MPFS) services. Submission of a non-participating, non-assigned MPFS service with a charge in excess of the Medicare limiting charge amount constitutes a violation of the limiting charge. A provider who violates the limiting charge is subject to assessments of up to $10,000 per violation plus triple the amount of the charges in violation, and possible exclusion from the Medicare program. Therefore it is crucial that eligible professionals (EPs) are provided with the correct limiting charge they may bill for a MPFS service.

The purpose of this CR is to place the eRx negative adjustment limiting charge amount on contractor websites and hard copy disclosure reports. Make sure that your billing staffs are aware of these changes. See the Background and Additional information sections for further details regarding these changes.

Background

Beginning on January 1, 2012, EPs who are not successful electronic prescribers are subject to a negative payment adjustment. Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) (MIPPA) requires the Centers for Medicare & Medicaid Services (CMS) to apply this negative payment adjustment to any EP who is not a successful e-prescriber under the eRx incentive program.

Specifically, Section 1848(a)(5)(A) of the Act states that:

"If the eligible professional is not a successful electronic prescriber for the reporting period for the year (as determined under subsection (m)(3)(B)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph)."

The negative payment adjustment applies to all EPs, regardless of whether the EP elects to be "participating" or "non-participating" for purposes of Medicare payments. The 2012 payment adjustment applies to all of the EP's MPFS services and will result in the EP receiving 99 percent of the MPFS amount that would otherwise apply to such services during 2012. In other words, an EP receiving the negative payment adjustment would be paid 1 percent less than the MPFS amount for that service. In 2013, the negative payment adjustment increases to 1.5 percent, or payment of 98.5 percent of the MPFS amount for covered professional services furnished in 2013. In 2014, the negative payment adjustment is 2 percent, or payment of 98 percent of the MPFS amount for covered professional services furnished in 2014.

The hard copy disclosure report will explain the eRx reduced limiting charge by including a message as follows: "Limiting charge reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing (eRx) Incentive Program."

Policy reminder

Non- participating EPs in the Medicare program may choose either to accept or not accept assignment on Medicare claims on a claim-by-claim basis. If EPs choose not to accept assignment, they may not charge the beneficiary more than the Medicare limiting charge for unassigned claims for Medicare services. The limiting charge is 115 percent of the MPFS amount. The beneficiary is not responsible for billed amounts in excess of the limiting charge for a covered service.

(continued on next page)

e-Prescribing *(continued)*

Non-participating, non-assigned EPs are paid 95 percent of the fee schedule amount. For example, if the MPFS amount is $100 and the beneficiary's Part B deductible has already been met, Medicare would pay the beneficiary $76 ($95 x 80 percent = $76) and the non-participating physician may collect $109.25 ($95 x 115 percent = $109.25) in total for the service. Therefore, the beneficiary would pay $33.25 ($109.25 - $76 = $33.25) out of his/her pocket for the service.

In cases where the EP is subject to the eRx negative adjustment, the limiting charge is adjusted to reflect the adjustment. For example, if the MPFS amount is $100, the beneficiary's Part B deductible has already been met, and the EP is subject to the eRx negative adjustment, Medicare would pay the beneficiary $75.24 ($94.05 x 80 percent = $75.24) and the non-participating physician may collect $108.16 ($94.05 x 115 percent = $108.1575) in total for the service. Therefore, the beneficiary would pay $32.92 ($108.16-$75.24=$32.92) out of his/her pocket for the service.

Non-participating, non-assigned EPs may choose to collect the entire amount up front from the beneficiary at the time of service.

Examples

Non-participating, non-assigned claim no eRx adjustment

Original fee schedule amount: $100
5 percent non-PAR status: $5 (100 x .05)
Adjustment total: $5.00
MPFS allowed amount: $100-$5.00= $95.00
Limiting charge allowed= $95.00 x 115 percent = $109.25

Non-participating, non-assigned claim with eRx adjustment

Original fee schedule amount: $100
5 percent non-PAR status: $5 (100 x .05)
1 percent eRx negative adjustment: $0.95 (95 x.01)
Adjustment total: $5.95
MPFS allowed amount: $100-$5.95= $94.05
Limiting charge allowed= $94.05 x 115 percent = $108.1575

Additional information

The official instruction, CR 7877, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1106OTN.pdf*.

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

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Registration opens for DMEPOS competitive bidding

Registration is now open to all suppliers interested in participating in the round 1 recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

In order to submit a bid for the round 1 recompete, you must first register in the Individuals Authorized Access to the Centers for Medicare & Medicaid Services (CMS) Computer Services (IACS) online application. Once you have registered in IACS, you will receive a user ID and password to access the online DMEPOS Bidding System (DBidS). You must register even if you registered during a previous round of competition (round 1 rebid, round 2, or the national mail-order competition). Only suppliers who have a user ID and password will be able to access DBidS; suppliers that do not register will not be able to bid.

If you are a supplier interested in bidding, register now – don't wait. Designate one individual listed as an authorized official (AO) on your organization's CMS-855S enrollment form in the Provider Enrollment, Chain and Ownership System (PECOS) to act as your AO for registration purposes. The AO must be the first person in the organization to register in IACS. After an AO successfully registers, other individuals listed as authorized officials on the CMS-855S in PECOS may register as backup authorized officials (BAOs). The AO must approve a BAO's request to register. For the AO and BAOs to register successfully, the name and Social Security number entered in IACS must match exactly with what is recorded on the CMS-855S and on file in PECOS. Individuals not listed as authorized officials on the CMS-855S in PECOS may register to serve as end users (EUs). The AO or a BAO must approve an EU's request to register. Bidders are prohibited from sharing user IDs and passwords.

CMS strongly urged all AOs to register no later than September 7 to ensure that BAOs and EUs have time to register before bidding begins. CMS recommends that BAOs register no later than September 28 so that they will be able to assist AOs with approving EU registration.

Registration will close on Friday, October 19 at 9:00 p.m. ET – no AOs, BAOs, or EUs can register after registration closes.

To register, go to the competitive bidding implementation contractor (CBIC) website, *www.dmecompetitivebid.com*, click on "Round 1 Recompete," and then click on "REGISTRATION IS OPEN" next to the registration clock. Before you register, CMS strongly recommends that you review the *IACS Reference Guide* with step-by-step instructions and the *Getting Started Registration Checklist*.

If you have any questions about the registration process, please contact the CBIC Customer Service Center at 877-577-5331 between 9:00 a.m. and 9:00 p.m. ET, Monday through Friday.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for "Email Updates" on the home page of the CBIC website. For information about the Round 1 Recompete, please refer to the bidder education materials on the CBIC website located under Round 1 Recompete > Bidding Suppliers.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201208-09

Timeline for DMEPOS competitive bidding round 1 recompete: begins bidder education program

Bidding timeline

The Centers for Medicare & Medicaid Services CMS has announced the bidding timeline for the round 1 recompete of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program. To view the timeline, visit the competitive bidding implementation contractor (CBIC) website at *www.dmecompetitivebid.com*.

Bidder education program

CMS has also launched a comprehensive bidder education program. This program is designed to ensure that DMEPOS suppliers interested in bidding receive the information and assistance they need to submit complete bids in a timely manner. The CBIC is the official information source for bidders and the focal point for bidder education. The CBIC website features a comprehensive array of important information for suppliers, including bidding rules, user guides, policy fact sheets, checklists, and bidding information charts. The education program will also include webcasts that will cover all the essential topics suppliers will need to know in order to bid. These webcasts will be posted on the CBIC website and will be available 24 hours a day/seven days a week. When a webcast is posted, the CBIC will announce its availability through a CBIC email update announcement. To sign up to receive webcast announcements and other key registration and bidding information, visit the CBIC website and subscribe to email updates.

In addition to viewing the information on the CBIC website, DMEPOS suppliers are encouraged to call the CBIC toll-free help desk, 877-577-5331, with their questions and concerns.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201208-08

Clarification of Medicare conditional payment policy and billing procedures for liability, no-fault, and workers' compensation MSP claims

Note: This article was revised on August 3, 2012, to reflect the revised change request (CR) 7355 issued on August 3. In the article, the CR release date, transmittal number, effective and implementation dates, and the Web address for accessing CR 7355 were revised. In addition, a reference to remittance advice remark code M32 was deleted. This information was previously published in the May 2012 *Medicare B Connection*, Pages 41-45.

Provider types affected

This *MLN Matters*® article is intended for physicians, hospitals, home health agencies, and other providers who bill Medicare carriers, fiscal intermediaries (FIs) or Medicare administrative contractors (A/B/MACs); and suppliers who bill durable medical equipment MACs (DME MACs) for Medicare beneficiary liability insurance (including self-insurance), no-fault insurance, and worker's compensation (WC) Medicare second payer (MSP) claims.

Provider action needed

This article provides clarifications in the procedures for processing liability insurance (including self-insurance), no-fault insurance and WC Medicare secondary payer (MSP) claims. Not following the procedures identified in this article may impact your reimbursement. CR 7355, from which this article is taken, clarifies the procedures you are to follow when billing Medicare for liability insurance (including self-insurance), no-fault insurance, or WC claims, when the liability insurance (including self-insurance), no-fault insurance, or WC carrier does not make prompt payment. It also includes definitions of the promptly payment rules and how contractors will identify conditional payment requests on MSP claims received from you. You should make sure that your billing staffs are aware of these Medicare instructions.

Background

CR 7355, from which this article is taken: 1) Clarifies the procedures to follow when submitting liability insurance (including self-insurance), no-fault insurance and WC claims when the liability insurer (including self-insurance), no-fault insurer and WC carrier does not make prompt payment or cannot reasonably be expected to make prompt payment; 2) Defines the promptly payment rules; and 3) Instructs you how to submit liability insurance (including self-insurance), no-fault insurance and WC claims to your Medicare contractors when requesting

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Clarification *(continued)*

Medicare conditional payments on these types of MSP claims.

The term Group Health Plan (GHP) as related to this *MLN*® article means health insurance coverage that is provided by an employer to a Medicare beneficiary based on a beneficiary's own, or family member's, current employment status. The term Non-GHP means coverage provided by a liability insurer (including self-insurance), no-fault insurer and WC carrier where the insurer covers for services related to the applicable accident or injury.

Key points

Conditional Medicare payment procedures

Medicare may not make payment on a MSP claim where payment has been made or can reasonably be expected to be made by GHPs, a WC law or plan, liability insurance (including self-insurance), or no-fault insurance.

Medicare can make conditional payments for both Part A and Part B WC, or no-fault, or liability insurance (including self-insurance) claims if payment has not been made or cannot be reasonably expected to be made by the WC, or no-fault, or liability insurance claims (including self-insurance) and the promptly period has expired. Note: If there is a primary GHP, Medicare may not pay conditionally on the liability, no-fault, or WC claim if the claim is not billed to the GHP first. The GHP insurer must be billed first and the primary payer payment information must appear on the claim submitted to Medicare.

These payments are made "on condition" that the trust fund will be reimbursed if it is demonstrated that WC, no-fault, or liability insurance is (or was) responsible for making primary payment (as demonstrated by a judgment; a payment conditioned upon the recipient's compromise, waiver, or release [whether or not there is a determination or admission of liability for payment for items or services included in a claim against the primary payer or the primary payer's insured]; or by other means).

"Promptly" definition

No-fault insurance and WC "promptly" definition

For no-fault insurance and WC, promptly means payment within 120 days after receipt of the claim (for specific items and services) by the no-fault insurance or WC carrier. In the absence of evidence to the contrary, the date of service for specific items and service must be treated as the claim date when determining the promptly period. Further with respect to inpatient services, in the absence of evidence to the contrary, the date of discharge must be treated as the date of service when determining the promptly period.

Liability insurance "promptly" definition

For liability insurance (including self-insurance), promptly means payment within 120 days after the earlier of the following:

- The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement; or
- The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

The *Medicare Secondary Payer (MSP) Manual* (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c01.pdf*), Chapter 1 (Background and Overview), Section 20 (Definitions), provides the definition of promptly (with respect to liability, no-fault, and WC) which all Medicare contractors must follow.

Note: For the liability situation, the MSP auxiliary record is usually posted to the Medicare's common working file (CWF) after the beneficiary files a claim against the alleged tortfeasor (the one who committed the tort [civil wrong]) and the associated liability insurance (including self-insurance). In the absence of evidence to the contrary, the date the general liability claim is filed against the liability insurance (including self-insurance) is no later than the date that the record was posted on Medicare's CWF. Therefore, for the purposes of determining the promptly period, Medicare contractors consider the date the liability record was created on Medicare's CWF to be the date the general liability claim was filed.

How to request a conditional payment

The following summarizes the technical procedures that Part A, and Part B and supplier contractors will use to identify providers' conditional payment requests on MSP claims.

Part A conditional payment requests

Providers of Part A services can request conditional non-GHP payments from Part A contractors on the hardcopy Form CMS-1450, if you have permission from Medicare to bill hardcopy claims, or the 837 institutional electronic

(continued on next page)

Clarification *(continued)*

claim, using the appropriate insurance value code (i.e., value code 14, 15 or 47) and zero as the value amount. Again, you must bill the non-GHP insurer, and the GHP insurer, if the beneficiary belongs to an employer group health plan, first before billing Medicare.

For hardcopy (CMS-1450) claims, Providers must identify the other payer's identity on line A of Form Locator (FL) 50, the identifying information about the insured is shown on line A of FL 58-65, and the address of the insured is shown in FL38 or Remarks (FL 80). All primary payer amounts and appropriate codes must appear on your claim submitted to Medicare.

For 837 institutional claims, providers must provide the primary payer's zero value code paid amount and occurrence code in the 2300 HI. (The appropriate occurrence code (2300 HI), coupled with the zeroed paid amount and MSP value code (2300 HI), must be used in billing situations where you attempted to bill a primary payer in non-GHP (i.e., liability, no-fault and workers' compensation) situations, but the primary payer did not make a payment in the promptly period). **Note**: Beginning July 1, 2012, Medicare contractors will no longer be accepting 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 1 displays the required information of the electronic claim in which a Part A provider is **requesting conditional payments.**

Table 1

Data requirements for conditional payment for Part A electronic claims

Type of insurance	CAS	Part A value code (2300 HI)	Value amount (2300 HI)	Occurrence code (2300 HI)	Condition code (2300 HI)
No-fault/ liability	2320 - valid information why NGHP or GHP did not make payment	14 or 47	$0	01-Auto accident & date 02- No-fault insurance involved & date 24 – Date insurance denied	
WC	2320 - valid information why NGHP or GHP did not make payment	15	$0	04-Accident/ tort liability & date 24 – Date insurance denied	02- Condition is employment related

Part B conditional payment requests (Table 2)

Since the electronic Part B claim (837 4010 professional claim) does not contain value codes or condition codes, the physician or supplier must complete the: 1) 2320AMT02 = $0 if the entire claim is a non-GHP claim and conditional payment is being requested for the entire claim; or 2) 2430 SVD02 for line level conditional payment requests if the claim also contains other service line activity not related to the accident or injury, so that the contractor can determine if conditional payment should be granted for Part B services related to the accident or injury.

For version 4010, Physicians and other suppliers may include CP- Medicare conditionally primary, AP-auto insurance policy, or OT-other in the 2320 SBR05 field. The 2320 SBR09 may contain the claim filing indicator code of AM - automobile medical, LI-liability, LM-liability medical or WC-workers' compensation health claim. Any one of these claim filing indicators are acceptable for the non-GHP MSP claim types.

The 2300 DTP identifies the date of the accident with appropriate value. The "accident related causes code" is found in 2300 CLM 11-1 through CLM 11-3. **Note**: Beginning July 1, 2012, Medicare contractors will no longer accept 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

(continued on next page)

Clarification *(continued)*

Table 2 displays the required information for a MSP 4010 professional in which a physician/supplier is **requesting conditional payments.**

Table 2

Data requirements for conditional payments for MSP 4010 professional claims

Type of insurance	CAS	Insurance type code (2320 SBR05)	Claim filing indicator (2320 SBR09)	Paid amount (2320 AMT or 2430 SVD02)	Insurance type code (2000B SBR05)	Date of accident
No-fault/ liability	2320 or 2430 valid information why NGHP or GHP did not make payment	AP or CP	AM, LI, or LM	$0.00	14	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA, AP or OA
WC	2320 or 2430 valid information why NGHP or GHP did not make payment	OT	WC	$0.00	15	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Please note that for 837 5010 Professional claims, the insurance codes changed and the acceptable information for Medicare conditional payment request is modified as displayed in Table 3.

Table 3

Data requirements for conditional payment for 837 5010 professional claims

Type of insurance	CAS	Insurance type code 2320 SBR05 from previous payer(s)	Claim filing indicator (2320 SBR09)	Paid amount (2320 AMT or 2430 SVD02)	Condition code (2300 HI)	Date of accident
No-fault/ liability	2320 or 2430 – valid information why NGHP or GHP did not make payment	14/47	AM or LM	$0.00		2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 – valid information why NGHP or GHP did not make payment	15	WC	$0.00	02- Condition is employment related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Note: Medicare beneficiaries are not required to file a claim with a liability insurer or required to cooperate with a provider in filing such a claim, but they are required to cooperate in the filing of no-fault claims. If the beneficiary refuses to cooperate in filing of no-fault claims Medicare does not pay.

Situations where a conditional payment can be made for no-fault and WC claims

Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

(continued on next page)

Clarification *(continued)*

- There is information on the claim or information on Medicare's CWF that indicates the no-fault insurance or WC is involved for that specific item or service;
- There is/was no open GHP record on the Medicare CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the no-fault insurer or WC entity first; and
- There is information on the claim that indicates the no-fault insurer or WC entity did not pay the claim during the promptly period.

Situations where a conditional payment can be made for liability (including self-insurance) claims

Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates liability insurance (including self-insurance) is involved for that specific item or service;
- There is/was no open GHP record on the Medicare's CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the liability insurer (including the self-insurer) first, and
- There is information on the claim that indicates the liability insurer (including the self-insurer) did not make payment on the claim during the promptly period.

Conditional primary Medicare benefits paid when a GHP is a primary payer to Medicare

Conditional primary Medicare benefits may be paid if the beneficiary has GHP coverage primary to Medicare and the following conditions are NOT present:

- It is alleged that the GHP is secondary to Medicare;
- The GHP limits its payment when the individual is entitled to Medicare;
- The services are covered by the GHP for younger employees and spouses but not for employees and spouses age 65 or over;
- If the GHP asserts it is secondary to the liability (including self-insurance), no-fault or workers' compensation insurer.

Situations where conditional payment is denied

Liability, no-fault, or WC claims denied

1. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - You did not send the claim to the employer GHP first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, or WC entity, but the insurer entity did not pay the claim.
2. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - The employer GHP denied the claim because the GHP asserted that the liability insurer (including the self-insurer), no-fault insurer or WC entity should pay first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, insurer or WC entity, but the insurer entity did not pay the claim.

Denial codes

To indicate that claims were denied by Medicare because the claim was not submitted to the appropriate primary GHP for payment, Medicare contractors will use the following codes on the remittance advice sent to you:

- Claim adjustment reason code 22 – "This care may be covered by another payer per coordination of benefits" and

(continued on next page)

Clarification *(continued)*

- Remittance advice remark code MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible."

Additional information

You can find official instruction, CR 7355, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R87MSP.pdf*.

You will find the following revised Chapters of the *Medicare Secondary Payer Manual*, as an attachment to that CR:

Chapter 1 (Background and Overview)

- Section 10.7 (Conditional Primary Medicare Benefits),
- Section 10.7.1 (When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare), and
- Section 10.7.2 (When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare).

Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements)

- Section 30.2.1.1 (No-Fault Insurance Does Not Pay), and
- Section 30.2.2 (Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation).

Chapter 5 (Contractor Prepayment Processing Requirements)

- Section 40.6 (Conditional Primary Medicare Benefits),
- Section 40.6.1 (Conditional Medicare Payment), and
- Section 40.6.2 (When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable).

MLN Matters® Number: MM7355 *Revised*
Related Change Request (CR) #: 7355
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Effective Date: January 1, 2013
Related CR Transmittal #: R87MSP
Implementation Date: January 7, 2013

'Medicare Quality Reporting Incentive Programs Manual' update

Provider types affected

This *MLN Matters*® article is intended for physicians, practitioners, and therapists who participate, or wish to participate, in the Medicare Physician Quality Reporting System and/or the e-Prescribing incentive program.

What you need to know

Change request (CR) 7879 updates the *Medicare Quality Reporting Incentive Programs Manual* to incorporate and consolidate information (from various other sources) about the Physician Quality Reporting System and the Electronic Prescribing (eRx) Incentive Program. CR 7879 does not establish any new requirements for the Physician Quality Reporting System, but simply includes relevant information in the manual that was contained in previous CRs and in annual Medicare physician fee schedule legislation.

Background

CR 7879, from which this article is taken, incorporates information contained in existing CRs and Medicare physician fee schedule (MPFS) legislation into the *Medicare Quality Reporting Incentive Programs Manual*, Chapters 1 (The Physician Quality Reporting System) and 2 (The Electronic Prescribing (eRx) Incentive Program).

As a refresher, relevant parts of the manual revisions made by CR 7879 are summarized as a refresher as follows:

Physician Quality Reporting System

The Physician Quality Reporting System (previously known as the Physician Quality Reporting Initiative or PQRI) is a voluntary reporting program that provides a combination of incentive payments and payment adjustments to identified individual eligible

(continued on next page)

Update *(continued)*

professionals, and group practices, who satisfactorily report data on quality measures for covered professional services.

The Affordable Care Act makes further changes to the Physician Quality Reporting System, including the following:

1. Authorizing incentive payments until 2014;
2. Requiring payment adjustments beginning in 2015 for eligible professionals who do not satisfactorily report data on quality measures during the applicable reporting period for the year;
3. Requiring timely feedback to participating eligible professionals;
4. Requiring the establishment of an informal review process through which eligible professionals may seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures for purposes of qualifying for a Physician Quality Reporting System incentive payment; and
5. Making an additional incentive payment available for those eligible professionals who satisfactorily report data on quality measures for a year and having that data submitted on their behalf through a Maintenance of Certification Program and participate in a Maintenance of Certification Program practice assessment more frequently than is required to qualify for or maintain board certification status.

In addition, beginning in 2010, group practices that have reassigned their billing rights to the TIN. can qualify to earn a Physician Quality Reporting System incentive payment based on the determination that the group practice (as a whole) satisfactorily reports Physician Quality Reporting System quality measures data.

In 2012, the definition of group practice reporting option (GPRO) was extended to include group practices comprised of a TIN with at least 25 or more eligible professionals. Therefore, effective beginning January 1, 2012, "group practice" is defined as a TIN with at least 25 eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN.

In order to participate in the GPRO, group practices are required to complete a self-nomination process, the specific requirements of which can be found in the Group Practice Reporting Option section of the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System located at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html*.

How much is the payment?

A participating individual eligible professional or group practice who satisfactorily reports data on Physician Quality Reporting System quality measures may earn an incentive payment equal to the applicable quality percent of the Secretary of the Department of Health and Human Services' (HHS) estimate of allowed part B charges for covered professional services furnished by the eligible professional or group practice during a specified reporting period.

The applicable quality percentages for years 2007-2014 are displayed in the following table:

Reporting year	Incentive payment
2007 and 2008	1.5 percent
2009 and 2010	2.0 percent
2011	1.0 percent
2012-2014	0.5 percent

In addition, from 2011 through 2014, participating eligible physicians may qualify to earn an additional Maintenance of Certification Program incentive (the applicable quality percent for each year is 0.5 percent). To earn this additional incentive payment, each year, the physician must:

1. Satisfactorily submit data on quality measures (i.e. meet the criteria for satisfactory reporting to earn a Physician Quality Reporting System reporting incentive) for the 12-month reporting that applies for the year;
2. Have such data submitted on their behalf through a Maintenance of Certification Program that meets the criteria for registry (as specified by CMS) or an alternative form and manner that the Secretary determines is appropriate;
3. Participate in a Maintenance of Certification Program more frequently than is required to qualify for or maintain board certification status; and
4. Successfully complete a qualified Maintenance of Certification Program practice assessment more frequently than is required to qualify for or maintain Board certification status.

What is measured?

For 2012, CMS retained all of the 2011 Physician Quality Reporting System measures groups; and added 8 new measures groups, for a total of 22 measures groups. In addition, 15 specific conditions contained in these measures groups are also reportable as individual measures.

You can find the complete list of the individual Physician Quality Reporting System quality measures for a specific program year, along with the associated detailed measure specifications and respective reporting requirements, at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html*. Additionally, measures group specifications for the current or upcoming program year can be found on the "Measures Codes" page of the same website.

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Update *(continued)*

Electronic Prescribing (eRx) Incentive Program

Section 132 of the Medicare Improvements for Patients and Providers Act (MIPPA) also required the Secretary to establish a new incentive program for individual eligible professionals who are successful electronic prescribers as defined by MIPPA beginning on January 1, 2009, and for group practices under the Group Practice Reporting Option (GPRO) beginning in 2010.

The eRx Incentive Program encourages significant expansion of the use of eRx by authorizing a combination of financial incentives and payment differentials, which is separate from, and in addition to, any incentive payment that eligible professionals may earn through the Physician Quality Reporting System program.

Who can participate?

For purposes of the eRx incentive program, the definition of "individual eligible professional" is identical to that for the Physician Quality Reporting System. All Medicare-enrolled professionals in these categories are eligible to participate in the eRx incentive program regardless of whether you have signed a Medicare participation agreement to accept assignment on all claims. Further, unless you want to participate in the eRx incentive program under the GPRO, you do not have to participate in the Physician Quality Reporting System to participate in the eRx incentive program, or vice-versa.

Finally, you should be aware that there are circumstances in which an individual professional is eligible to participate in the eRx program, but is not subject to the payment adjustment; for example, the eligible professional is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of the reporting period, or does not have prescribing privileges for the reporting period.

As in the Physician Quality Reporting System, group practices who participate in the eRx GPRO are eligible to qualify for an eRx incentive payment based on the determination that the group practice, as a whole, is a successful electronic prescriber.

The current definition of group practice for the eRx incentive program mirrors the 2012 definition of group practice for the 2012 Physician Quality Reporting System. As described above, a group practice is defined as a TIN with at least 25 or more individual eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN. The definition also includes those groups participating in certain Medicare-approved demonstrations projects or various other CMS programs, under which Physician Quality Reporting System requirements and the associated incentives have been incorporated, such as groups participating in the Medicare Shared Savings Program.

Unlike an individual eligible provider, however, in order for a group practice to participate in the eRx Incentive Program through the GPRO, group practices must have self-nominated and been selected by CMS to participate. Please note also, that once a group practice TIN is selected to participate in the GPRO for a particular program year, this is the only method of eRx Incentive Program participation available to the group and all individual NPIs who bill Medicare under the group's TIN for that program year. In other words, an individual eligible professional who is a member of a group practice selected to participate in the eRx GPRO for a particular program year is not eligible to separately earn an eRx incentive payment as an individual eligible professional for the same TIN/NPI combination for that year.

You should also keep in mind that, beginning in 2012, group practices will also be assessed for applicability of the payment adjustment. Although the determination of whether a GPRO is a successful electronic prescriber will be analyzed at the TIN level, if a group practice elects to participate in the eRx GPRO for a particular program year and fails to meeting the reporting thresholds for reporting its eRx activities (i.e., fails to become a successful electronic prescriber); each eligible professional who belongs to the group practice will be subject to the payment adjustment, regardless of whether or not the eligible professional, as an individual, successfully reports.

How much is the payment?

An individual eligible professional may qualify to earn an incentive payment or receive a payment adjustment equal to a percentage of the total estimated Medicare Part B-allowed charges for covered professional services furnished by the eligible professional during the respective reporting period. The incentive payments for successful electronic prescribers for each authorized year are displayed in the following table.

Reporting year	Incentive payment
2009	2.0 percent
2010	2.0 percent
2011	1.0 percent
2012 and 2013	1.0 percent

In addition to the eRx incentive payment, beginning in 2012 a PFS payment adjustment applies to those who are not successful electronic prescribers for the payment adjustment reporting period. The payment adjustments for eligible professionals who are not successful electronic prescribers for each authorized year are displayed in the following table.

Reporting year	Incentive payment
2012	1.0 percent
2013	1.5 percent
2014	2.0 percent

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Update *(continued)*

An eRx payment is a lump sum payment based upon allowed charges for all covered professional services (paid under or based upon the Medicare PFS only), not just those charges associated with eRx events. It is calculated at the individual eligible professional level using individual NPI data, and (beginning in 2010) for group practices participating in the eRx GPRO, at the group practice level using TIN data. CMS uses the TIN as the billing unit so that individual incentive payments for groups that bill under one TIN are aggregated and paid to the TIN holder of record (regardless of whether the incentive payment was earned by an individual eligible professional or a group practice). Because some individuals may be associated with more than one practice, and CMS makes an incentive payment for each unique TIN/NPI combination, an eligible professional who qualifies for the eRx incentive payment under more than one TIN could receive a separate eRx incentive payment associated with each TIN.

You should be aware that there is a limitation with regard to the application of the incentive and the payment adjustment. The incentive and payment adjustment do not apply to eligible professionals (and group practices participating in the eRx GPRO) if the Medicare allowed charges for all covered professional services for the codes to which the eRx quality measure applies are less than 10 percent of the total allowed charges under Medicare Part B for all such covered professional services furnished by the eligible professional (or group practice), during the reporting period. Also, please note that an eligible professional may not receive incentive payments under both the Medicare eRx incentive program and Medicare EHR incentive program; however they may receive an incentive under the Medicare EHR incentive program and a payment adjustment under the Medicare eRx incentive program

What is measured?

The measure for the eRx incentive program is the number of unique visits amassed during the reporting period in which an electronic prescription was generated. The 2012 reporting period for eRx incentive program incentive payments is January 1, 2012, to December 31, 2012. Normally, there are two reporting periods for eRx incentive program payment adjustments: 1) The 12-month calendar year two years prior to the applicable payment adjustment; and 2) A six-month reporting period occurring during the first six months of the calendar year prior to the applicable payment adjustment. For the 2012 payment adjustment, there is only one reporting period: the six-month reporting occurring during the first six months of 2011.

Additional information

You can find more information about the Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program by going to CR 7879, located at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R10QRI.pdf*. You will find the updated chapters of the "Medicare Quality Reporting Incentive Programs Manual" as an attachment to that CR.

To learn more about how to start reporting quality measures for the Physician Quality Reporting System, see the "How to Get Started" section of the Physician Quality Reporting System website, available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html*.

You might also want to read:

MLN Matters article MM6935 "The Physician Quality Reporting Initiative (PQRI) and E-Prescribing (eRx) Medicare Quality Reporting Incentive Programs Manual" which you can find at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6935.pdf*,

MLN Matters article MM6514, "Coding and Reporting Principles for the Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing (E-Prescribing) Incentive Programs," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6514.pdf*, and

MLN Matters special edition article SE1206, "2012 Electronic Prescribing (eRx) Incentive Program: Future Payment Adjustments," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1206.pdf*.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7879
Related Change Request (CR) #: CR 7879
Related CR Release Date: August 3, 2010
Effective Date: October 29, 2012
Related CR Transmittal #: R10QRI
Implementation Date: October 29, 2012

New physician specialty code for centralized flu

Provider types affected

This *MLN Matters*® article is intended for non-physician practitioners submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors (MACs)) for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) established a new non-physician practitioner specialty code for centralized flu effective January 1, 2013. The new non-physician practitioner specialty code for centralized flu is C1 and is only applicable to the CMS-855B enrollment application. Make sure that your billing staffs are aware of this change for 2013.

Background

Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855B) or Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) when they enroll in the Medicare program. However, non-physician practitioners are assigned a Medicare specialty code when they enroll. The specialty code becomes associated with the claims submitted by that physician or non-physician practitioner. Specialty codes are used by CMS for programmatic and claim processing purposes and the new code for centralized flu, C1, will be added to PECOS and recognized as the non-physician practitioner code for centralized flu.

Additional information

The official instruction, CR 7884, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2516CP.pdf*.

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

To review details for Mass Immunizers and Roster Billing you may go to *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mass_Immunize_Roster_Bill_factsheet_ICN907275.pdf*.

To review the CMS QUICK REFERENCE INFORMATION: Medicare Immunization Billing (Seasonal Influenza Virus, Pneumococcal, and Hepatitis B) you may go to *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf*.

A downloadable brochure titled Preventive Immunizations is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/adult_immunization.pdf*.

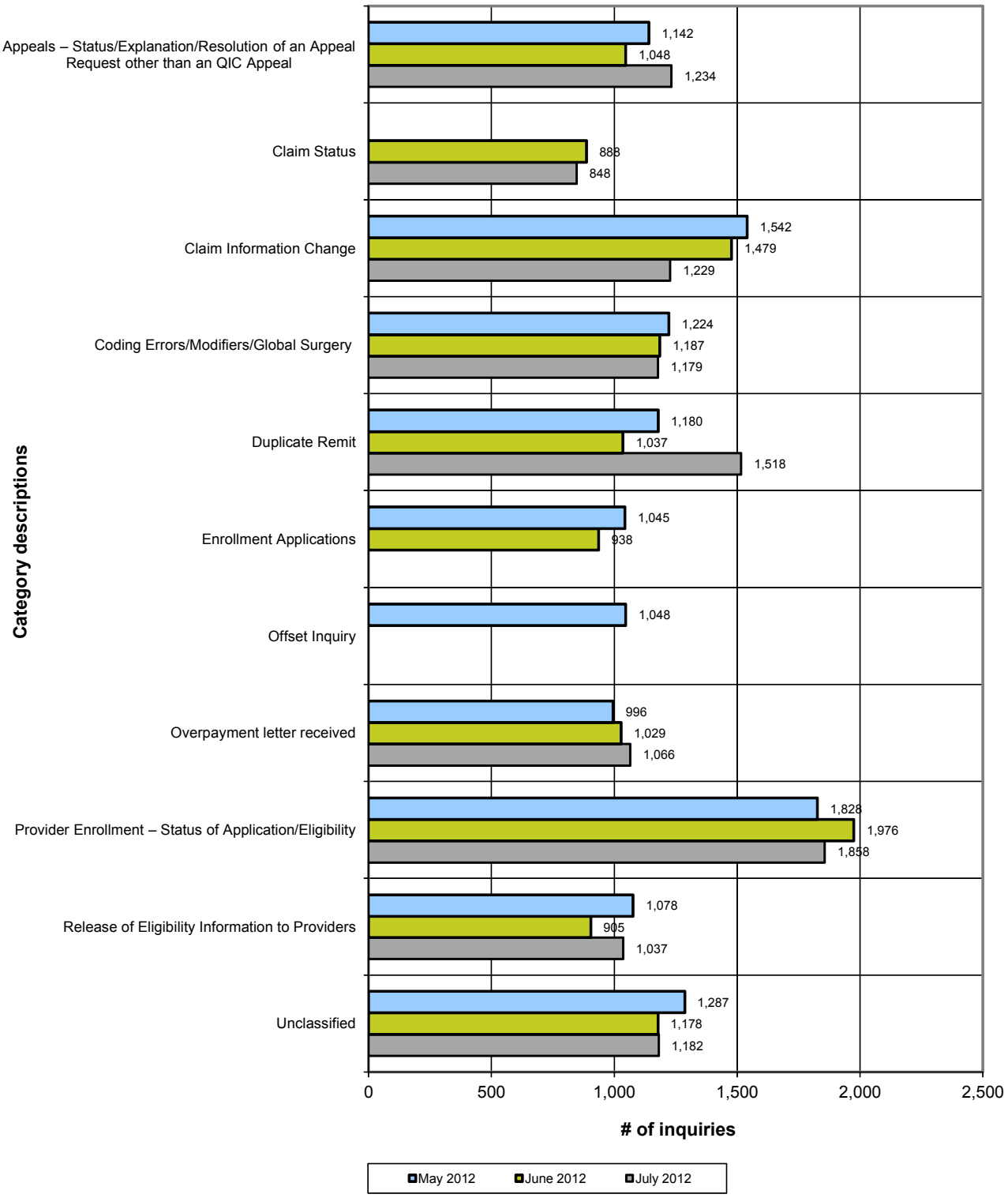
MLN Matters® Number: MM7884
Related Change Request (CR)# 7884
Related CR Release Date: August 10, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2516CP
Implementation Date: January 7, 2013

Top inquiries, denials, and return unprocessable claims

The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during May-July 2012.

For tips and resources to help providers avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Part B top inquiries for May-July 2012



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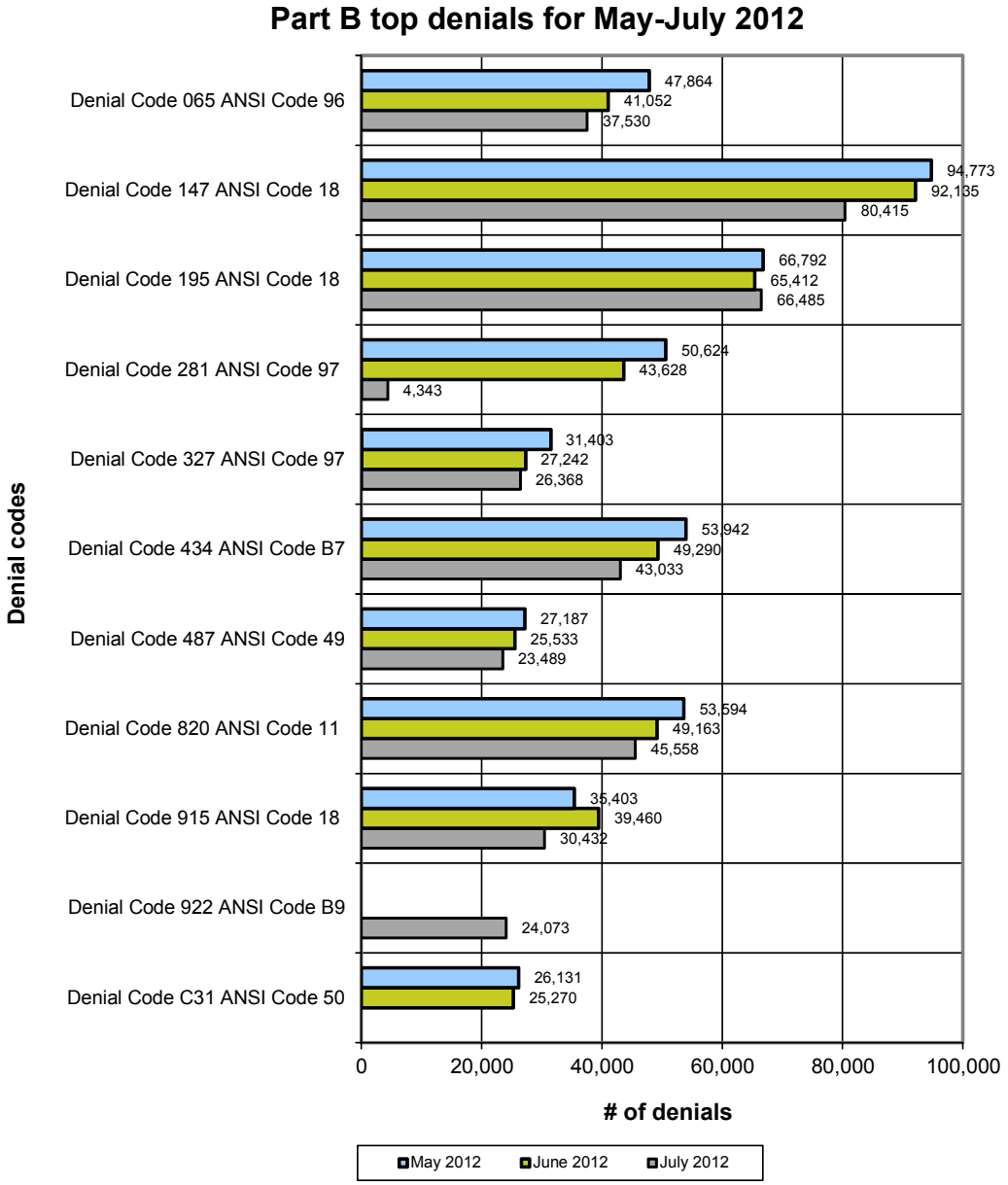


What to do when your claim is denied

Before contacting customer service, check claim status though the IVR. The IVR will release necessary details around claim denials.

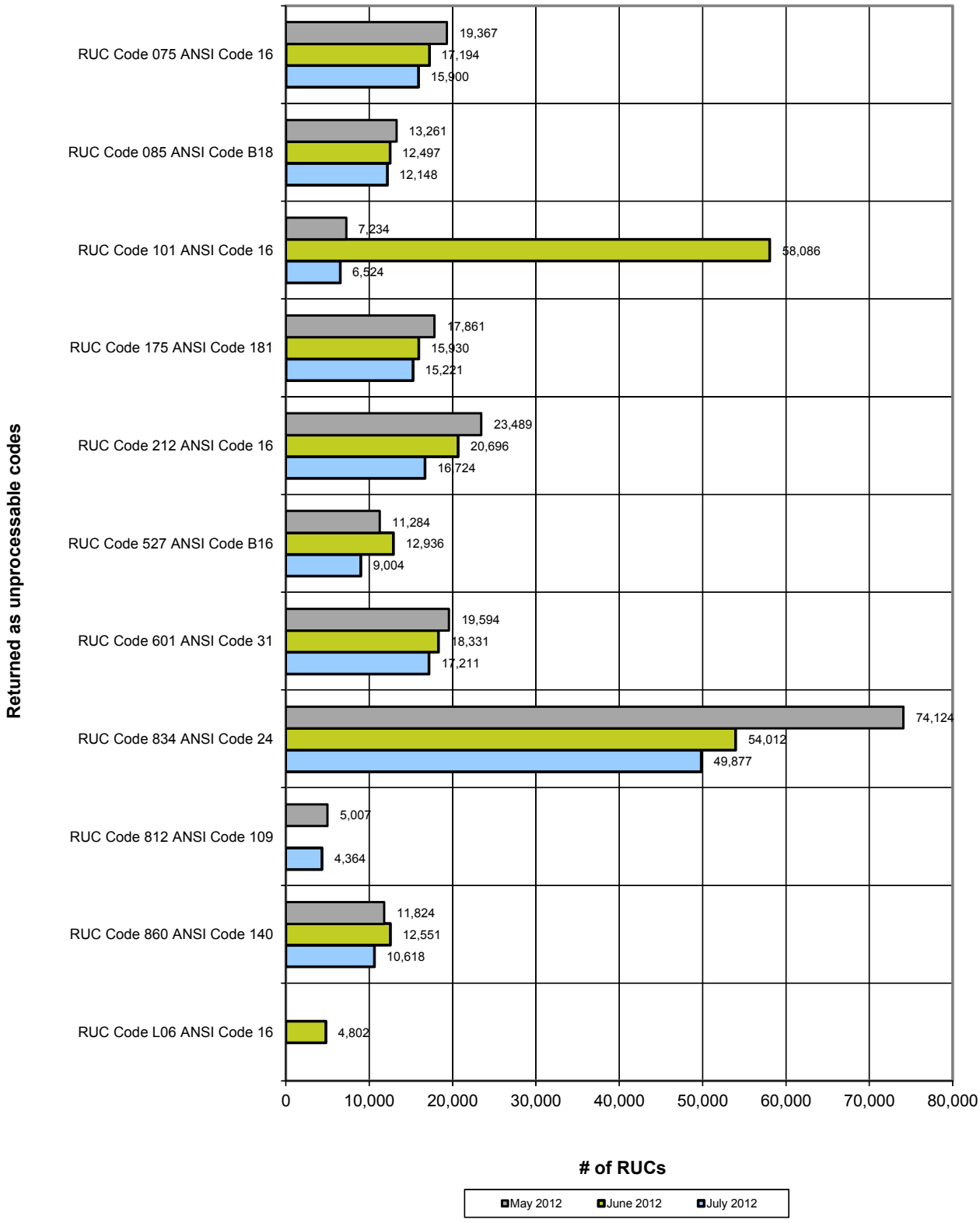
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

Refer to the *Claim completion FAQs*, *Billing issues FAQs*, and *Unprocessable FAQs* on the FCSO Medicare provider website for additional information on why claims may deny and how to correct this.

You may also refer to the *Top Part B claim denials* and *RUCs* tip sheets for tips and resources on correcting and avoiding certain claim denials.

Top *(continued)*

Part B top return as unprocessable claims for May-July 2012



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 9 (J9) 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 FCSO 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

Contents

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.

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? FCSO'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.

New LCDs

IMT: Implantable miniature telescope (IMT) – new LCD

LCD ID number: L32822 (Florida/Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for implantable miniature telescope (IMT) was developed after consideration of comments received from various experts in the field and in order to give access to care for those beneficiaries who otherwise may not have any other treatment options. Limited coverage will be allowed for patients with untreatable end-stage, age-related macular degeneration who meet all of the indications as outlined under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for the utilization of the IMT.

The LCD outlines indications and limitations of coverage and/or medical necessity, *CPT*®/HCPCS codes *0308T*/C1840, ICD-9-CM code 362.51 (Nonexudative senile macular degeneration) that supports medical necessity, documentation requirements, and utilization guidelines.

Effective date

This new LCD is effective for services rendered **on or after October 9, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

THERSVCSPHYSICIAN: Therapy services billed by physicians/nonphysician practitioners – new LCD

LCD ID number: L32807 (Florida/Puerto Rico/U.S. Virgin Islands)

Physical therapy and rehabilitative services are prescribed treatment plans generally provided to improve, restore, and/or compensate for loss of impaired physical function resulting from disease, injury, or surgical procedure. The goal of rehabilitative medicine is a return to the highest level of function realistically attainable and within the context of the disability through the use of therapeutic exercise, education, and mobilization. During its analysis of comprehensive error rate testing (CERT) data (in the November 2011 CERT report), First Coast Service Options Inc. (FCSO) identified a trend of increased claim payment errors when therapy services are billed by physicians in the state of Florida. Services billed by physician specialties represented 70 percent of the dollars incorrectly paid for therapy services with a 19.05 percent claim payment error rate (based on dollars). Additionally, past medical review experience has identified high claim error rates when therapy services are billed by physicians. The most common reasons for an error to be assigned are insufficient documentation, including failure to meet Medicare's documentation requirements specific to therapy services and failure to meet medical necessity.

This local coverage determination (LCD) has been developed to address specific issues identified through CERT and medical record review when therapy services are billed by physicians/non-physician practitioners. This LCD gives indication and limitations of coverage and/or medical necessity as well as documentation requirements for physical therapy services when billed by physicians or non-physician practitioners.

Please refer to the LCD titled "Therapy and rehabilitation services" for specific indications and limitations of individual therapy modalities.

Effective date

This new LCD is effective for services rendered **on or after October 09, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

33224: Biventricular pacing/cardiac resynchronization therapy – new LCD

LCD ID number: L32811 (Florida/Puerto Rico/U.S. Virgin Islands)

Certain inpatient medical severity-diagnosis related groups (MS-DRG's) for Medicare administrative contractor (MAC) jurisdiction 9 (J9) described as permanent pacemaker and cardiac defibrillator implants were identified by comprehensive error rate testing (CERT) as being high risk for payment error and are subject to prepayment review edits. These DRG's contain inpatient hospital procedure codes that describe biventricular pacing/cardiac resynchronization therapy (CRT-biventricular pacemaker) with or without an implantable cardioverter defibrillator (CRT-D). For consistency, the biventricular pacing/cardiac resynchronization therapy local coverage determination (LCD) was also developed for Part B. In the absence of a national coverage determination (NCD) or LCD, contractors use screening tools, as well as, clinical judgment when reviewing claims containing these DRG's. Currently, there is NCD 20.8 for cardiac pacemakers and NCD 20.4 for implantable automatic defibrillators. However, they do not specifically address coverage requirements for cardiac resynchronization therapy.

This new LCD has been developed to give indications and limitations of coverage and/or medical necessity, *CPT*® codes, ICD-9-CM diagnosis codes, documentation requirements, utilization guidelines, and coding guidelines for cardiac resynchronization therapy with or without an implantable cardioverter defibrillator.

Effective date

This new LCD is effective for services rendered **on or after October 9, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

35475: Dialysis (AV fistula and graft) vascular access maintenance – new LCD

LCD ID number: L32828 (Florida/Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) was developed based on a request from First Coast Service Options' Inc. (FCSOs) program safeguards communication group (PSCG). Data analysis and claims review identified occurrences of *CPT*® codes *35475* (*Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel*) and *35476* (*Transluminal balloon angioplasty, percutaneous; venous*) billed on the same date of service and this billing scenario appears to be trending up. The data reviewed also demonstrated that providers routinely billing *CPT*® codes *35475* and *35476* on the same date of service are bypassing the correct coding initiative (CCI) editing currently in place by appending the *59* modifier (Distinct procedural service). Therefore, *CPT*® codes *35475* (arterial) and *35476* (venous) performed on the same date of service will be developed for documentation (records requested for medical review) since this should be a rare occurrence.

This new LCD outlines the indications and limitations of coverage and/or medical necessity, *CPT*® codes that support medical necessity, documentation requirements, utilization guidelines, and a LCD "coding guidelines" attachment.

(continued on next page)

35475 *(continued)*

Effective date

This new LCD is effective for services rendered **on or after October 9, 2012**. FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

93224: Long-term wearable electrocardiographic monitoring (WEM) – new LCD

LCD ID number: L32818 (Florida/Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) was developed as a result of a recent post pay medical review, in which there was a 49.68 percent error rate for cardiovascular monitoring services (*CPT®* code *93271* [*External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis*]). Findings of the medical review indicated the documentation did not support the medical necessity for the testing.

Two current LCDs, external electrocardiographic recording (L29162/L29422) and patient demand single or multiple event recorder (L29253/L29379) are being revised and combined into one LCD with clarification of indications and utilization guidelines. The long-term wearable electrocardiographic monitoring (WEM) LCD addresses the previous *CPT®* codes listed in the external electrocardiographic recording and patient demand single or multiple event recorder LCDs and additional *CPT®* codes *93228, 93229, 0295T, 0296T, 0297T*, and *0298T* were added. The use of external electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage has not been demonstrated to be a standard of care. Therefore, category III *CPT®* codes *0295T, 0296T, 0297T*, and *0298T* will require documentation for review and individual consideration to determine medical necessity. This new LCD addresses the indications and limitations of coverage, documentation requirements, utilization guidelines, and ICD-9-CM diagnosis codes for electrocardiographic monitoring. The external electrocardiographic recording and patient demand single or multiple event recorder LCDs will be retired effective October 9, 2012, when the new LCD (93224 long- term wearable electrocardiographic monitoring [WEM]) becomes effective.

Effective date

This new LCD is effective for services rendered **on or after October 9, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

Revisions to LCDs

NCSVCS: Noncovered services – revision to the LCD

LCD ID number: L29288 (Florida)
LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised July 2, 2012. Since that time, the LCD was revised to remove HCPCS code C1840 from the "*CPT*/HCPCS Codes, Local Noncoverage Decisions-Devices" section of the LCD and to remove Category III *CPT*® code *0308T* from the "*CPT*/HCPCS Codes, Local Noncoverage Decisions-Procedures" section of the LCD. These codes were removed from the noncovered services LCD as they were added to the new LCD for implantable miniature telescope (IMT), L32822 (Florida/Puerto Rico/U.S. Virgin Islands).

Effective date

This LCD revision is effective for services rendered **on or after October 9, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

Educational Events

Upcoming provider outreach and educational events
September 2012

Introduction to the 5010 electronic paperwork segment – PWK

When: Wednesday, September 19
Time: 2:00-3:00 p.m.

Place of service (POS) for physician services

When: Wednesday, September 26
Time: 11:00 a.m.-noon

Note: Unless otherwise indicated, all FCSO 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 *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 FCSO 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 FCSO 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 our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. 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 FCSO Medicare training website and explore our catalog of online courses.

Educational Resources

CMS Medicare fee-for-service provider e-News

The Centers for Medicare & Medicaid Services (CMS) Medicare fee-for-service (FFS) provider e-News is an official *Medicare Learning Network*® (*MLN*)-branded product that contains a week's worth of news for Medicare FFS providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate. To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS is conducting a pilot from August 1-September 30, 2012. The following are links to the latest e-News:

- CMS e-News for Wednesday, August 1, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-01Enews.pdf*
- CMS e-News for Wednesday, August 8, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-08Enews.pdf*
- CMS e-News for Wednesday, August 15, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-15Enews.pdf*

Source: CMS PERL 201208-01, 201208-03, 201208-05

Mail directory

Claims submissions

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating providers
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare secondary payer
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD claims
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

Communication

Redetermination requests
Medicare Part B claims review
P.O. Box 2360
Jacksonville, FL 32231-0018

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of Information Act
Freedom of Information Act requests
Post office box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

Electronic media claims (EMC)

Claims, agreements and inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting charge issues:
Processing errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

Refund verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare claims for Railroad retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse
First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Phone numbers

Providers

Toll-Free
Customer Service:
1-866-454-9007

Interactive Voice Response (IVR):
1-877-847-4992

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Medicare websites

Provider

First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor
http://medicare.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

First Coast Service Options Inc.
P. O. Box 45098
Jacksonville, FL 32232-5098

Flu rosters

First Coast Service Options Inc.
P. O. Box 45031
Jacksonville, FL 32232-5031

Electronic data interchange (EDI)

First Coast Service Options Inc.
P. O. Box 44071
Jacksonville, FL 32231-4071

Part B debt recovery, MSP inquiries and overpayments, and cash management

First Coast Service Options Inc.
P.O. Box 45013
Jacksonville, FL 32232-5013

Provider enrollment

Where to mail provider/supplier applications
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Redeterminations

First Coast Service Options Inc.
P. O. Box 45024
Jacksonville, FL 32232-5091

Redetermination overpayment

First Coast Service Options Inc.
P. O. Box 45091
Jacksonville, FL 32232-5091

Freedom of Information Act requests (FOIA)

First Coast Service Options Inc.
P. O. Box 45073
Jacksonville, FL 32232-5073

Congressional inquiries

First Coast Service Options Inc.
Attn: Carla-Lolita Murphy
P. O. Box 2078
Jacksonville, FL 32231-0048

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Medicare claims for railroad retirees

Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse

First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Local coverage determinations

First Coast Service Options Inc.
P. O. Box 2078
Jacksonville, FL 32231-0048

Post pay medical review

First Coast Service Options Inc.
P. O. Box 44288
Jacksonville, FL 32231-4288

Overnight mail and/or other special courier services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Medicare websites

Provider
First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor
http://medicare.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries
Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

Email address:
AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO Account # (use appropriate account number). Do not fax your order; it must be mailed.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2012 through September 2013.	40300260	$33		
2012 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2012, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)

Medicare B Connection

First Coast Service Options Inc.
P.O. Box 2078 Jacksonville, FL. 32231-0048

Attention Billing Manager