Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers September 2012

In this issue

Manual medical review of therapy services

Provider types affected

This *MLN Matters*® article is intended for occupational therapists, speech language therapists, physical therapists, physicians, other practitioners, in certain provider settings submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and A/B Medicare administrative contractors (MACs)) for therapy services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

All requests for therapy services above $3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance. This includes services in these settings: Part B skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies (outpatient rehabilitation facilities (ORFs), private practices, home health agencies (TOB 34x), and hospital outpatient departments.

Caution – what you need to know

You must send a request for approval to the MAC or legacy contractor, i.e., FI, RHHI, or carrier, in advance of providing service. There are no automatic exceptions. Your MAC or legacy contractor will provide a fax number and mailing address where requests for pre-claim review can be submitted.

Go – what you need to do

Please read the *Background* and the *Additional information* sections for details. Make sure that your billing staffs are aware of these changes.

Background

The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act, and have been extended by legislation several times.

Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy cap on claims that are over the 2012 cap amounts -- $1,880 for occupational therapy services and $1,880 for the combined services for physical therapy and speech-language pathology. Use of the KX modifier indicates that the services are reasonable and necessary and that there is documentation of medical necessity in the patient's medical record.

(continued on Page 19)

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.

Publication staff:
Terri Drury
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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.

2013 annual update for the HPSA bonus payments

Provider types affected

This *MLN Matters*® article is intended for physicians, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries (FIs), carriers, or Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries in health professional shortage areas (HPSAs).

Provider action needed

Change request (CR) 7883, from which this article is taken, alerts you that the annual HPSA bonus payment file for 2013 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your Medicare contractor and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2013, through December 31, 2013. These files will be posted on or about December 1, 2012. You should review *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html* each year to determine whether you need to add the AQ modifier to their claim in order to receive the bonus payment, or to see if the ZIP code area in which you rendered services will automatically receive the HPSA bonus payment. Note that Medicare contractors will continue to accept the AQ modifier for partially designated HPSA claims. Please be sure that your staffs are aware of this update.

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated an annual update to the automated HPSA bonus payment file. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors each year. Contractors use this file for the automated bonus payment for claims with dates of service on or after January 1, 2013, through December 31, 2013. Contractors will continue to accept the AQ modifier for partially designated HPSA claims.

Additional information

The official instruction, CR 7883, issued to your FI, carrier, or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2526CP.pdf*.

You will find annual HPSA files (as they become available) and other important HPSA information at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html*.

If you have any questions, please contact your FI, 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*.

MLN Matters® Number: MM7883
Related Change Request (CR) #: CR 7883
Related CR Release Date: August 24, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2526CP
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.

Ambulatory Surgical Center

October 2012 update of the ambulatory surgical center payment system

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) 8032 which informs Medicare contractors about the changes to and billing instructions for various payment policies implemented in the October 2012 ambulatory surgical center (ASC) update. CR 8032 applies to Chapter 14, Section 10 of the *Medicare Claims Processing Manual*. Make sure that your billing staffs are aware of these changes.

Background

The key changes in CR 8032 are as follows:

Drugs and biologicals with payments based on average sales price (ASP) effective October 1, 2012

Payment for separately payable drugs and biologicals based on the ASPs are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, the Centers for Medicare & Medicaid Services (CMS) incorporates changes to the payment rates in the October 2012 release of the ASC DRUG file. The updated payment rates, effective October 1, 2012, will be included in the October 2012 update of the ASC payment system Addendum BB, which will be posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

New HCPCS codes for drugs and biologicals separately payable under the ASC payment system effective October 1, 2012.

Two drugs and biologicals have been granted ASC payment status effective October 1, 2012. These items, along with their descriptors and payment indicators, are identified in Table 1.

Table 1 – New separately payable drugs and biologicals effective October 1, 2012

HCPCS code	Long descriptor	Short descriptor	ASC PI
C9292	Injection, pertuzumab, 10 mg	Injection, pertuzumab	K2
C9293	Injection, , glucarpidase, 10 units	Injection, , glucarpidase	K2

Updated payment rates for certain drugs and biologicals HCPCS codes effective July 1, 2012, through September 30, 2012

The payment rates for three HCPCS codes were incorrect in the July 2012 ASC drug file. The corrected payment rates are listed in Table 2 and have been included in the revised July 2012 ASC drug file, effective for services furnished July 1, 2012, through implementation of the October 2012 update. Suppliers who have received an incorrect payment for dates of service from July 1, 2012, through September 30, 2012, may request contractor adjustment of the previously processed claims.

Table 2 – Updated payment rates for certain drugs and biologicals HCPCS codes effective July 1, 2012, through September 30, 2012

HCPCS code	Short descriptor	ASC PI	Corrected payment rate	
C9368	Grafix core	K2	$160.66	
C9369	Grafix prime	K2	$51.84	
Q2045	Human fibrinogen conc inj	K2	$0.89	

Additional information

The official instruction, CR 8032, 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/R2525CP.pdf*.

(continued on next page)

ASC *(continued)*

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*.

To review MM7854, the July 2012 Update to the ASC Payment System, you may go to *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7854.pdf*.

To review the Ambulatory Surgical Center Fee Schedule Fact Sheet you may go to *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508-09.pdf*.

MLN Matters® Number: MM8032
Related Change Request (CR) #: CR 8032
Related CR Release Date: August 24, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2525CP
Implementation Date: October 1, 2012

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.

Consolidated Billing

2013 annual update of HCPCS codes for SNF consolidated billing

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

Stop – impact to you

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in change request (CR) 8037 could impact your payments.

Caution – what you need to know

This article is based on CR 8037 which provides the 2013 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for skilled nursing facility consolidated billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

By the first week in December 2012:

- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (titled “2013 Carrier/A/B MAC Update”) will be posted at *http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*, and
- Providers who bill fiscal intermediaries or A/B MACs are advised that new Excel and PDF files (titled “2013 FI/A/B MAC Update”) will be posted to *http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*.

Go – what you need to do

It is important and necessary for you to read the “General Explanation of the Major Categories” PDF file located at the bottom of each year’s FI/A/B MAC update in order to understand the major categories, including additional exclusions not driven by HCPCS codes.

(continued on next page)

Consolidated *(continued)*

Background

Medicare's claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Section 110.4.1 (Annual Update Process) for carriers and A/B MACs, and Section 20.6 (SNF CB Annual Update Process for Fiscal Intermediaries) for FI and A/B MACs. You can find this manual at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf*.

Please note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional information

The official instruction, CR 8037 issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2542CP.pdf*.

If you have any questions, please contact your carrier, FI, A/B MAC, 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*.

MLN Matters® Number: MM8037
Related Change Request (CR) #: CR 8037
Related CR Release Date: September 7, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2542CP
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.

Information about a Medicare claim processing issue related to Part B services for skilled nursing facility patients

A Medicare Part B claims processing issue has been identified with the *2012 Annual Update of the Healthcare Common Procedure Code System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing*. Medicare Part B services may have been erroneously denied by Medicare's claims processing system. In other instances, the claims processing system may have paid and then identified a Medicare "overpayment" on these claims in error. The situation has been corrected as of July 30, 2012, but services meeting the following may have been impacted:

HCPCS for dates of service January 1, 2011, and after, claims processed January 3, 2011, through July 29, 2012:

- *21554* – until March 11, 2012
- *96522* – until July 29, 2012
- *96571* – until July 29, 2012

HCPCS for dates of service January 1, 2012, and after claims processed January 3, 2012, until July 29, 2012:

- *0079T*
- *0163T*
- *00790*
- *01630*
- *00792*
- *01632*
- *00794*
- *01634*
- *00796*
- *01636*

The Centers for Medicare & Medicaid Services (CMS) is working with its Medicare administrative contractors (MACs) to identify all claims that were denied in error as well as any overpayments that were identified erroneously and resulted in a demand letter so that appropriate payment adjustments can be made.

(continued on next page)

Issue *(continued)*

Your MAC will advise you through its website and listserv messages when it expects to complete this process so that you can anticipate when your claims (along with any notifications for payment recovery) will be adjusted. CMS thanks you for your patience and apologizes for any inconvenience.

Source: CMS PERL 201209-04

Durable Medical Equipment

Medicare demonstration allows for prior authorization for certain power mobility devices

Provider types affected

This *MLN Matters*® special edition article is intended for Medicare fee-for-service (FFS) suppliers who submit claims to the durable medical equipment Medicare administrative contractors (DME MACs) for power mobility devices (PMDs) in the demonstration states (California, Texas, Florida, Michigan, Illinois, North Carolina, and New York). Physicians and other practitioners who prescribe these devices for Medicare beneficiaries who reside in the demonstration states may also benefit from this article.

What you need to know

PMDs includes power wheelchairs and power-operated vehicles (POVs) that a beneficiary uses in their home (42 CFR 410.38(c)). Power wheelchairs are four-wheeled motorized vehicles that are steered by operating an electronic device or joystick to control direction and turning. POVs are three- or four-wheeled motorized scooters that are operated by a tiller. PMDs are classified as items of DME for Medicare coverage purposes.

Power-operated vehicles (POVs or scooters): Under the mobility assistive equipment (MAE) national coverage determination (NCD), POVs may be medically necessary for beneficiaries who cannot effectively perform mobility-related activities of daily living (MRADLs) in the home using a cane, walker, or manually operated wheelchair. In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment. These vehicles are appropriately used in the home environment to improve the ability of chronically-disabled persons to cope with normal domestic, vocational, and social activities.

Power (motorized) wheelchairs: Under the MAE NCD, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair. Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurological or muscular condition.

This article provides guidance on upcoming changes to billing requirements for PMDs. Please make sure your medical and billing staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing waste, fraud, and abuse in the Medicare fee-for-service program. CMS is conducting a three-year demonstration to ensure that Medicare only pays for PMDs that are medically necessary under existing coverage guidelines beginning with orders written on or after September 1, 2012. The demonstration will be conducted in seven states with high rates of Medicare fraud: California, Texas, Florida, Michigan, Illinois, North Carolina, and New York. These states accounted for 43 percent of the $606 million total Medicare PMD expenditures in 2010. This demonstration targets a claim type known to be susceptible to fraud and that have high rates of improper payments.

The demonstration will implement a prior authorization request process for PMDs for Medicare beneficiaries residing in the demonstration states. The prior authorization request can be completed by the ordering physician/practitioner or the DME supplier. The physician/practitioner or supplier who submits the request is referred to as the “submitter.” The DME MAC will review the prior authorization request.

The following HCPCS codes are subject to prior authorization process in the demonstration states:

- Group 1 power-operated vehicles (K0800-K0802 and K0812)
- All standard power wheelchairs (K0813 through K0829)

(continued on next page)

Demonstration *(continued)*

- All group 2 complex rehabilitative power wheelchairs (K0835 through K0843)
- All group 3 complex rehabilitative power wheelchairs without power options (K0848 through K0855)
- Pediatric power wheelchairs (K0890-K0891)
- Miscellaneous power wheelchairs (K0898)

The prior authorization process allows submitters to send a prior authorization request for a PMD before the supplier delivers the device to the beneficiary's home. All relevant documentation to support Medicare coverage of the PMD should be submitted to the appropriate DME MAC for an initial decision. The request package should include the face-to-face encounter documentation, the seven element order, the detailed product description and whatever additional documentation is necessary to show that coverage requirements have been met.

Physicians/practitioners can bill G9156 after he/she submits an initial prior authorization request to partially compensate physicians for the additional time spent in submitting the prior authorization request.

Please note, that the prior authorization demonstration does not create new documentation requirements for physician/practitioners or suppliers. It simply allows them to provide the information earlier in the claims process.

After receiving the prior authorization request, the DME MAC will conduct a medical review and communicate the coverage decision to the beneficiary, physician/practitioner and supplier within ten business days of receiving the request. Under rare, emergency circumstances, Medicare will complete this process within 48 hours. Claims with affirmative prior authorization requests will be paid so long as all other Medicare coverage and documentation requirements are met. Claims with a non-affirmative prior-authorization decision will not be paid by Medicare.

If a second prior-authorization request is resubmitted after a non-affirmative decision on an initial prior authorization request, DME MAC will conduct a medical review within 20 business days and communicate a coverage decision to the beneficiary, physician/practitioner and supplier. Tricare programs and private insurance use similar time frames for prior authorization of non-emergent services.

Suppliers may choose to submit claims without a prior authorization decision; however, the claim will still be subject to prepayment review. Beginning for orders written on or after December 1, 2012, CMS will assess a payment reduction for noncompliance with the prior authorization process. If the claim satisfies Medicare's coverage and documentation requirements, it will be paid with a 25 percent reduction in Medicare reimbursement. The 25 percent reduction will not be applied if the claim is submitted by a contract supplier under the Medicare DMEPOS competitive bidding program and the claim is for a PMD provided to a Medicare beneficiary residing in a competitive bidding area.

Extensive education and outreach to physicians, treating practitioners, suppliers, and Medicare beneficiaries on the requirements of the prior authorization process has been initiated by CMS and will continue after the implementation of the demonstration. Additional information and updates on the demonstration will be posted at *http://Go.cms.gov/PADemo*.

Utilizing the prior authorization request process will help CMS improve methods for identifying and prosecuting fraud and prevent improper payments. This will help ensure that Medicare only pays for PMD claims that are medically necessary under existing coverage guidelines. It will also provide valuable data for tackling the continued challenges the Medicare program faces.

Key points

CMS will initially conduct this three year demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on beneficiary address as reported to the Social Security Administration and recorded in Medicare's common working file (CWF). This demonstration will involve all four DME MACs. This demonstration will begin for orders written on or after September 1, 2012.

(continued on next page)

Demonstration *(continued)*

Competitive bidding would not affect participation in this demonstration. However, if a contract supplier submits a payable claim for a beneficiary with a permanent residence, according to the CWF, in a competitive bidding area, that supplier would receive the single payment amount under the competitive bid contract. In other words, the single payment amount rules for contract suppliers outlined in 42 CFR 414.408 are not affected by this demonstration.

This demonstration will help ensure that no Medicare payments are made for PMDs unless a beneficiary's medical condition warrants the equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers. It will also help protect beneficiaries from unexpected financial liability.

Additional information

The "Prior Authorization of Power Mobility Device" section of the CMS Web page is at *http://Go.cms.gov/PADemo*.

MLN Matters® special edition article SE1112, "Power Mobility Device Face-to-Face Examination Checklist," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf*.

The *Medicare Learning Network*® (*MLN*) fact sheet, "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf*.

Please visit *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html* for the latest *MLN* educational products designed to help Medicare FFS Providers understand – and avoid – common billing errors and other improper activities.

MLN Matters® Number: SE1231
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

Medicare Physician Fee Schedule Database

October 2012 update to the Medicare physician fee schedule database

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), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services that are paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 8017 which informs Medicare contractors that, in order to reflect appropriate payment policy in line with the calendar year (CY) 2012 MPFS final rule, the MPFSDB has been updated effective October 1, 2012, and new payment files have been created. CR 8017 instructs Medicare contractors to retrieve and implement the revised payment files when they are notified that these files are available for retrieval. Contractors will also give providers 30-day notice before implementing the changes identified in CR 8017. Changes will be retroactive to January 1, 2012, unless otherwise stated in CR 8017.

CR 8017 also points out that the Office of Clinical Standards and Quality (OCSQ-CMS) has updated their national coverage determination (NCD) concerning Healthcare Common Procedure Coding System (HCPCS) code *43775* (*Lap sleeve gastrectomy*). This HCPCS code was previously a non-covered Service (N), and CR 8017 now instructs that it will be carrier-priced (C).

(continued on next page)

MPFS *(continued)*

Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the U.S. Secretary of Health & Human Services (HHS) to establish ancillary policies necessary to implement relative values for the services of physicians. In order to reflect appropriate payment policy in line with the CY 2012 MPFS final rule, the MPFSDB has been updated effective October 1, 2012.

On December 23, 2011, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA; see *http://www.gpo.gov/fdsys/pkg/PLAW-112publ78/pdf/PLAW-112publ78.pdf*) became law and suspended the automatic negative update that would have taken effect with current law. The TPTCCA temporarily allowed for a zero percent update to the MPFS from January 1, 2012, until February 29, 2012. On February 22, 2012, the TPTCCA was signed into law and extended the zero percent update to the end of the CY to December 31, 2012.

The Centers for Medicare & Medicaid Services (CMS) updated these payment files in July through CR 7844. You can review the *MLN Matters*® article, MM7844, which corresponds to CR 7844 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7844.pdf*.

CR 8017 constitutes the October amendment to those payment files, and unless otherwise stated in CR 8017, changes will be retroactive to January 1, 2012.

MLN Matters® Number: MM8017
Related Change Request (CR) #: CR 8017
Related CR Release Date: August 24, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2530CP
Implementation Date: October 1, 2012

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.

Mental Health

Additional instructions related to screening and behavioral counseling interventions in primary care to reduce alcohol misuse (CR 7633)

Note: This article was revised on September 17, 2012, to reflect a revised change request (CR) 7791 issued on September 13. The CR transmittal number, release date, and the Web address for accessing the CR have been changed. All other information is the same. This information was previously published in the June 2012 *Medicare B Connection*, Pages 17-18.

Provider types affected

This *MLN Matters*® article is intended for physicians, providers and suppliers submitting claims to fiscal intermediaries (FI), carriers and A/B Medicare administrative contractors (A/B MAC) for screening and behavioral counseling services provided to Medicare beneficiaries.

What you need to know

If a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in Medicare's claims history within a prior 12-month period, CR 7791 requires contractors to deny these claims. Be sure to inform your staff of these changes.

Background

Pursuant to Section 1861(ddd) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) may add coverage of "additional preventive services" through the national coverage determination (NCD) process if all of the following criteria are met. They must be: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under

(continued on next page)

Alcohol *(continued)*

Part B of the Medicare program. CMS reviewed the USPSTF's "B" recommendation and supporting evidence for "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse" preventive services and determined that all three criteria were met.

According to the USPSTF (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems; and in the general adult population, risky or hazardous drinking is defined as >seven drinks per week or >three drinks per occasion for women, and >14 drinks per week or >four drinks per occasion for men. Harmful drinking describes those persons currently experiencing physical, social or psychological harm from alcohol use, but who do not meet criteria for dependence.

In the Medicare population, Saitz (2005) defined risky use as >seven standard drinks per week or >three drinks per occasion for women and persons >65 years of age, and >14 standard drinks per week or >four drinks per occasion for men ≤65 years of age. Importantly, Saitz included the caveat that such thresholds do not apply to pregnant women for whom the healthiest choice is generally abstinence. The 2005 "Clinician's Guide" from the National Institutes of Health National Institute on Alcohol Abuse and Alcoholism also stated that clinicians recommend lower limits or abstinence for patients taking medication that interacts with alcohol, or who engage in activities that require attention, skill, or coordination (e.g., driving), or who have a medical condition exacerbated by alcohol (e.g., gastritis).

CR 7791 adds further instructions for contractors if a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in claims history within a prior 12-month period. It requires contractors to deny such claims with the following specific messages:

- **Claim adjustment reason code (CARC) B15** – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remark code (RARC) M16** – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
- **Group code PR (patient responsibility)** assigning financial liability to the beneficiary, if a claim is received with a modifier indicating a signed Advanced Beneficiary Notice (ABN) is on file.
- **Group code CO (contractual obligation)** assigning financial liability to the provider, if a claim is received without a modifier indicating no signed ABN is on file.

Also, remember that Medicare will only pay for up to four G0443 services within a 12-month period. Claims for G0443 that exceed that four session limit in a 12-month period will be rejected. In addition, Medicare will continue to reject incoming claims when G0442 (PROF) and G0443 (PROF) are billed on the same day on types of bills 71x, 77x, and 85x with revenue codes 096x, 097x, and 098x.

Additional information

The official instruction, CR 7791, issued to your FI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2544CP.pdf*.

The *MLN Matters*® article MM7663, titled, "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse," may be viewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7633.pdf*.

If you have any questions, please contact your FI, 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*.

MLN Matters® Number: MM7791 *Revised*
Related Change Request (CR) #: 7791
Related CR Release Date: September 13, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2544CP
Implementation Date: October 1, 2012

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.

Radiology

Radiology and EKG interpretations furnished to emergency room patients

Through data analysis, First Coast Service Options (First Coast) has identified potential inappropriate billing of radiology and electrocardiogram interpretations, billed on the same dates of service by more than one provider in the emergency room setting (place of service 23).

The Medicare guidelines for radiology services from the *Medicare Claims Processing Manual*, Chapter 13 state:

> Carriers generally distinguish between an "interpretation and report" of an X-ray or an EKG procedure and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. This is because the review is already included in the emergency department evaluation and management (E/M) payment. For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available).
>
> Generally, carriers must pay for only one interpretation of an EKG or X-ray procedure furnished to an emergency room patient. They pay for a second interpretation (which may be identified through the use of modifier "-77") only under unusual circumstances (for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure.
>
> When carriers receive multiple claims for the same interpretation, they must generally pay for the first bill received. Carriers must pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient. Consideration is not given to physician specialty as the primary factor in deciding which interpretation and report to pay regardless of when the service is performed.

To address this issue First Coast plans to implement claim editing on both radiology and electrocardiogram interpretation services. First Coast will pay for the first claim received and deny the claim billed with the second interpretation for the same date of service, excluding claims billed with the modifier 77. Claims billed with modifier 77 may receive additional review, with a possible request for documentation to support the unusual circumstance.

If you disagree with the determination made by Medicare, you have the right to appeal the decision. Please follow the current appeals process as outlined in the CMS Internet-only manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 29 - Appeals of Claims Decisions.

Surgery

Extracorporeal photopheresis

Note: This article was revised September 10 and September 25, 2012, to reflect the revised change requests 7806 issued September 7 and September 24, 2012, respectively. The CR release date, transmittal number, and the Web address for accessing CR 7806 were revised. Also, the first bullet point following the table shows the ICD-10 code for V70.7. This information was previously published in the July 2012 *Medicare B Connection*, Pages 15-17.

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for providing extracorporeal photopheresis procedures for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation.

Provider action needed

Effective for claims with dates of service on and after April 30, 2012, Medicare will cover extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation, but only when provided under an approved clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. You should make sure that your billing staffs are aware of the expanded coverage provided in this NCD.

Background

Extracorporeal photopheresis is a second-line treatment for a variety of oncological and autoimmune disorders that is performed in the hospital inpatient, hospital outpatient, and critical access hospital (CAH) settings. In the procedure, some of a patient's removed white blood cells are exposed first to the drug 8-methoxypsoralen (8-MOP) and then to ultraviolet A (UVA) light. After UVA light exposure, the treated white blood cells are re-infused into the patient, stimulating their immune system in a series of cascading reactions. This activation of the immune system then impacts the illness being treated.

Currently, Medicare covers extracorporeal photopheresis for the following indications:

- Palliative treatment of skin manifestations of CTCL that has not responded to other therapy;
- Patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment; and
- Patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

On August 4, 2011, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request for a reconsideration to add coverage for extracorporeal photopheresis treatment for patients who have received lung allografts and then developed progressive BOS refractory to immunosuppressive drug treatment.

As a result of the reconsideration, effective for claims with dates of service on and after April 30, 2012, Medicare will begin to cover extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation; but only when provided under a clinical research study that meets specific requirements to assess its effect in the treatment of BOS following lung allograft transplantation.

NCD clinical research study requirements

This is a national coverage determination (NCD). In keeping with this NCD, any clinical research study that includes Medicare coverage of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation must be approved by meeting the requirements listed below. Additionally, consistent with section 1142 of the Social Security Act, AHRQ supports clinical research studies that CMS determines meet these standards and address the research questions.

(continued on next page)

Extracorporeal *(continued)*

An approved clinical research study:

1. Must address one or more aspects of the following question:

Prospectively, do Medicare beneficiaries who have received lung allografts, developed BOS refractory to standard immunosuppressive therapy, and received extracorporeal photopheresis, experience improved patient-centered health outcomes as indicated by:

   a) Improved forced expiratory volume in one second (FEV1);

   b) Improved survival after transplant; and/or

   c) Improved quality of life?

2. Must adhere to the following standards of scientific integrity and relevance to the Medicare population:

   a) Its principal purpose is to test whether extracorporeal photopheresis potentially improves the participants' health outcomes;

   b) It is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

   c) It does not unjustifiably duplicate existing studies;

   d) Its design is appropriate to answer the research question being asked in the study;

   e) It is sponsored by an organization or individual capable of successfully executing the proposed study;

   f) It is in compliance with all applicable federal regulations concerning the protection of human subjects found at 45 *Code of Federal Regulations* CFR Part 46. If a study is regulated by the Food and Drug Administration (FDA), it must also be in compliance with 21 CFR parts 50 and 56;

   g) All of its aspects are conducted according to appropriate standards of scientific integrity (see *http://www.icmje.org*);

   h) It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with evidence development (CED) coverage;

   i) It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR Section 312.81(a) and the patient has no other viable treatment options;

   j) It is registered on the ClinicalTrials.gov website (*http://clinicaltrials.gov*) by the principal sponsor/investigator prior to the enrollment of the first study subject;

   k) Its protocol specifies the method and timing of public release of all pre-specified outcomes to be measured including release of outcomes if outcomes are negative or study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors (*http://www.icmje.org*).

   l) It explicitly discusses subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of said populations on the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary

   m) Its study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability or Medicaid eligibility.

Note: Any clinical study in which there is coverage of extracorporeal photopheresis for this indication under this NCD must be approved by April 30, 2014 (two years from the effective date of this NCD). If there are no approved clinical studies by this date, this NCD will expire and coverage of extracorporeal photopheresis for BOS will revert to the coverage policy in effect prior to the issuance of its Final Decision Memorandum (DM) on April 30, 2012.

(continued on next page)

Extracorporeal *(continued)*

Billing requirements

Effective for claims with dates of service on and after April 30, 2012, your carrier, FI, or A/B MAC will accept and pay for hospital outpatient and physician claims containing Healthcare Common Procedure Coding System (HCPCS) procedure code *36522* along with one of the International Classification of Diseases (ICD-9-CM or ICD-10) diagnosis codes displayed in the following table.

ICD 9 CM	ICD 9 CM Description	ICD-10	ICD-10 Description
491.20	Obstructive chronic bronchitis without exacerbation	J44.9	Chronic obstructive pulmonary disease, unspecified
491.21	Obstructive chronic bronchitis with (acute) exacerbation	J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
491.9	Unspecified chronic bronchitis	J42	Unspecified chronic bronchitis
496	Chronic airway obstruction, not elsewhere classified	J44.9	Chronic obstructive pulmonary disease, unspecified
996.84	Complications of transplanted lung	T86.810	Lung transplant rejection
996.84	Complications of transplanted lung	T86.811	Lung transplant failure
996.84	Complications of transplanted lung	T86.812	Lung transplant infection (not recommended for ECP coverage)
996.84	Complications of transplanted lung	T86.818	Other complications of lung transplant
996.84	Complications of transplanted lung	T86.819	Unspecified complication of lung transplant
V70.7	Examination of participant in clinical trial	Z00.6	Encounter for examination for normal comparison and control in clinical research program (needed for CED)

Please note that your claims will only be paid when they also contain all of the following:

- Diagnosis code V70.7 (as secondary diagnosis) (ICD-10 Z00.6);
- Condition code 30 (institutional claims only);
- Clinical trial modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved research study); and
- Value code D4 with an 8-digit clinical trial number (optional)(FIs only).

Additionally, should your Medicare contractor return your claims as unprocessable because they are missing: 1) Diagnosis code V70.7 (as secondary diagnosis), 2) Condition code 30 (Institutional claims only), 3) Clinical trial modifier Q0 (Institutional claims only), and 4) Value code D4 with an 8-digit clinical trial number (optional) (FIs only); they will use the following messages:

- **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 MA 130** – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- **RARC M16** – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

Please keep in mind that your contractor will not retroactively adjust claims from April 30, 2012, processed prior to implementation of CR 7806. However, they may adjust claims that you bring to their attention.

Additional information

The official instruction, CR 7806, was issued in two transmittals. The first updates to the *Medicare National Coverage Determinations Manual* are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R143NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2551CP.pdf*.

(continued on next page)

Extracorporeal *(continued)*

MLN Matters® Number: MM7806 *Revised*
Related Change Request (CR) #: CR 7806
Related CR Release Date: September 24, 2012
Effective Date: April 30, 2012
Related CR Transmittal #: R143NCD and R2551CP
Implementation Date: October 1, 2012

Documenting medical necessity for major joint replacement

Provider types affected

This *MLN Matters*® special edition (SE) is intended for physicians who perform major joint replacement (hip and knee) surgery on Medicare beneficiaries. This article may also be of interest to hospitals, multi-specialty clinics, and accountable care organizations.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) is publishing this article as an educational guide to improve compliance with documentation requirements for major joint replacement surgery. The article presents suggestions for documenting medical necessity to avoid denial of Medicare fee-for-service (FFS) claims. The use of this guide is not mandatory and does not guarantee payment.

Background

In 2010, the President announced the goals for cutting the Medicare FFS improper payment rate by half and reducing overall payment errors by $50 billion. Medicare has initiated a number of auditing projects with the intention of reaching those goals. Multiple auditing entities including the recovery audit contractors, comprehensive error rate testing (CERT) contractors, and Medicare administrative contractors (MACs) have demonstrated very high paid claim error rates among both hospital and professional claims associated with major joint replacement surgery.

Key points

Document medical necessity to avoid denial of claims

CMS recognizes that joint replacement surgery is reserved for patients whose symptoms have not responded to other treatments. To avoid denial of claims for major joint replacement surgery, the medical records should contain enough detailed information to support the determination that major joint replacement surgery was reasonable and necessary for the patient. Progress notes consisting of only conclusive statements should be avoided.

Consequently, the medical record must specifically document a complete description of the patients' historical and clinical findings. Examples of such information may include:

History

- Description of the pain (onset, duration, character, aggravating, and relieving factors)
- Limitation of activities of daily living (ADLs) – specify
- Safety issues (e.g., falls)
- Contraindications to non-surgical treatments
- Listing and description of failed non-surgical treatments such as:
  - Trial of medications (e.g., NSAIDs)
  - Weight loss
  - Physical therapy
  - Intra-articular injections
  - Braces, orthotics or assistive devices.

(continued on next page)

Replacement *(continued)*

Physical examination

- Deformity
- Range of motion
- Crepitus
- Effusions
- Tenderness
- Gait description (with/without mobility aides)

Investigations

- Results of applicable investigations (e.g., plain radiographs).

Clinical Judgment

- Reasons for deviating from a stepped-care approach

Examples of medical documentation

The following examples show portions of a medical record that either support or do not support the medical necessity of the joint replacement. Please note these examples do not describe all of necessary documentation required for a joint replacement surgery or all the clinical situations that require major joint surgery. These examples are solely for educational purposes.

Example of documentation demonstrating medical necessity for joint replacement surgery

A. The hospital record for the preoperative joint replacement surgical patient includes:

History

- Present illness from onset until the present
- Current symptoms and functional limitations
- Outcomes of nonsurgical treatments, such as:
  - Medications e.g., Anti-inflammatory medication, Analgesics
  - Intra-articular injections
  - Physical Therapy and/or home exercise plans
  - Assistive devices e.g., cane, walker, braces (specify type of brace), orthotics
- Comorbidities

Physical examination

- Joint examination with detailed objective findings.

Investigations

- Preoperative imaging studies.

The hospital record for the joint replacement surgical patient includes documentation of specific conditions. For example:

- Osteoarthritis (mild, moderate, severe)
- Inflammatory arthritis (e.g., rheumatoid arthritis, psoriatic arthritis)
- Failure of previous osteotomy
- Malignancy of distal femur, proximal tibia, knee joint, soft tissues
- Failure of previous unicompartmental knee replacement
- Avascular necrosis of knee
- Malignancy of the pelvis or proximal femur or soft tissues of the hip
- Avascular necrosis of the femoral head
- Fractures (e.g., distal femur, femoral neck, acetabulum)

(continued on next page)

Replacement *(continued)*

- Nonunion, malunion, or failure of previous hip fracture surgery, and
- Osteonecrosis.

B. The hospital record for the postoperative joint replacement surgical patient includes:

- Operative report for the procedure, including observed pathology
- Daily progress notes for inpatients, and
- Discharge plan and discharge orders.

Example of a medical record that may result in a DENIED claim

Mrs. Smith is a female, age 70, with chronic right knee pain. She states she is unable to walk without pain and pain meds do not work. Therefore, she needs a total right knee replacement.

Example of a medical record with more detail and support of medical necessity

History

Mrs. Smith is a 70-year-old female who is suffering from end-stage osteoarthritis (OA) of her right knee, worsening gradually over the past 10 years. Treatment has included NSAIDs which have not effectively relieved her pain/inflammation and which have recently begun to cause her gastric distress. She has also participated in an exercise program/physical therapy for the past three months without functional improvement. Sometimes the pain keeps her awake at night. She is using a cane and is no longer able to climb the five steps to her front door. Personal safety is compromised as she had falls x 3 in attempting the stairs to her home entrance. Her knee pain and stiffness limit her ability to perform ADLs. She cannot walk from her bedroom to her kitchen without stopping to rest.

Physical examination

Vital signs: 140/90, Heart rate 78, RR 18.

Physical exam: Bilateral varus knee deformity consistent with severe osteoarthritis. Right knee extension reduced to minus 15 degrees and flexion to less than 100 degrees. Unable to rise from chair unassisted. Full motion of the right hip, no calf tenderness or ankle edema. Antalgic gait noted.

Investigations

X-ray (7/2/11): right knee shows joint space narrowing along with marginal osteophytes.

Impression

Total knee arthroplasty (TKA) indicated

Plan/Orders

Discussed risks and benefits of total joint replacement with patient. Patient understands both. Admit to inpatient care for right TKA. Forward a copy of this note to include in patients chart along with a copy of the patient's x-ray reports.

Additional information

If you have any questions, please contact your carrier, fiscal intermediary, or 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*.

For additional information and educational materials related to provider compliance, visit *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html*.

MLN Matters® Number: SE1236
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Therapy Services

Therapy *(continued from page 1)*

MCTRJCA also established a requirement for manual medical review of claims over $3,700.

In mid-September 2012, CMS will mail a letter to beneficiaries who have received therapy services in Calendar Year (CY) 2012 over $1,700. The CMS letter will inform them of the $1,880 therapy cap, the exceptions process and that, if services over the cap do not qualify for the exception as medically necessary, that they will be responsible for the charges.

Request for Approval and Review Process

You must send a request for approval to the MAC or legacy contractor in advance of providing service. The MAC or legacy contractor will provide a mailing address and may provide a fax number where requests for pre-claim review can be submitted. Pre-claim reviews will not be reviewed any sooner than 15 days before the start of each Phase for providers within that phase.

The request must contain the following information:

- Beneficiary last name
- Beneficiary first name
- Beneficiary middle initial
- Beneficiary Medicare claim number (HICN)
- Beneficiary date of birth
- Beneficiary address and telephone number
- Name of provider certifying plan of care
- Address of provider certifying plan of care
- Telephone and fax number of provider certifying plan of care
- Provider number (national provider identifier (NPI)) of physician/non-physician practitioner (NPP) certifying plan of care
- Name of performing provider
- Address of performing provider
- Performing provider number (NPI)
- Telephone and fax number of performing provider
- Number of treatment days requested
- Expected date range of services
- Date of submission

A *cover/transmittal sheet* (see page 23) containing the following information and documentation must be sent:

- Cover sheet
- Justification
- Evaluation or reevaluation(s) for plan(s) of care
- Certification(s) of the plan(s) of care, where available
- Objectives and measurable goals and any other documentation requirements of the local coverage determinations (LCDs)
- Progress reports
- Treatment notes
- Any orders, if applicable, for the additional therapy services
- Any additional information requested by the Medicare contractor

You may request preapproval of up to 20 treatment days of services.

Helpful information

Click *here* to find out when which phase you're in; if you're not on the list, you're in Phase III.

Phase I begins October 1

Phase II begins November 1

Phase III begins December 1

Make the process easier by using our *interactive pre-approval form*. Simply fill it out online, print it , and fax (preferred) or mail it.

The contractor will make a decision and inform (by telephone, fax, or letter (if by letter, the letter must be postmarked by day 10)) the provider and beneficiary within 10 business days of receipt of all requested documentation. If the contractor cannot make a decision with 10 days, the therapy will be considered approved. The letter will indicate that the approval was made because of time constraints and not on the information provided to the contractor.

The contractors will use the coverage and payment policy requirements contained in the *Medicare Benefit Policy Manual*, Chapter 15, Section 220 (available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*) and any applicable local coverage decision policies when making decisions as to whether a service will be preapproved.

If the decision is non-affirmative, the letter communicating the decision will be detailed. If the request was non-approved, you may submit additional

(continued on next page)

Therapy *(continued)*

requests and provide additional information for consideration.

Contractors shall develop a methodology to identify pre-approval requests that have been submitted for pre-approval and match them to submitted claims for specific periods of time. Contractor shall inform the provider of the tracking mechanism being used for pre-approval requests (either approved or denied) and instructions on how to submit the claim. Contractors shall use the tracking mechanism to identify that the claims were preapproved or non-approved.

Pre-authorization itself is not a guarantee of payment. Retrospective reviews of claims receiving preapproval may still be performed. Any claims submitted without the pre-approval notice from providers in the respective phase will be subject to pre-payment review. If you or the beneficiary wishes to appeal a decision, you may provide the service. The MAC or legacy contractor will, upon receipt of the claim, deny the claim. Then you or the beneficiary may file an appeal.

CMS will notify beneficiaries when they reach the $1,700 level by September 1, 2012, by letter.

Phased implementation

Implementation will occur in three phases. The requirement for pre-approval of all therapy services shall apply to specifically identified providers on the effective date determined by CMS for the phase. CMS will publish the list of providers (by NPI number only) and the phase to which they are assigned. If CMS publishes a list and a provider is not on the list, then that provider shall be deemed to be in phase III. Contractors will post the list of NPI numbers CMS provides on their websites.

CMS will publish a list of providers and the respective phases in which they are placed. In addition, CMS shall send a mailing to every provider subject to the therapy manual medical review threshold notifying them of the respective phase they have been placed into. CMS is implementing this process in phases in order to ensure a smooth transition to the new process. Effective dates for the phases are:

- **Phase I**: October 1, 2012 – December 31, 2012
- **Phase II**: November 1, 2012 – December 31, 2012
- **Phase III**: December 1, 2012 – December 31, 2012

Claims suspended because of the cap will be automatically approved unless the provider is being reviewed in phase I, phase II, or phase III.

Contractors will notify providers by posting on their website when they have stopped doing the reviews.

Out of sequence claims – post-pay review not required

Medicare has a 12-month claim filing limitation. Therefore, claims may be received and processed in a sequence different than that of the services provided. When this occurs, a contractor is not required to conduct post-payment review on claims that would have been subjected to the $3,700 manual medical review threshold had the claims been received and processed in the order provided.

For example, a beneficiary was in a SNF and exhausted their SNF benefit days under Part A. The beneficiary continued to receive therapy services under Part B totaling $3,600 (all dates of service before October 1, 2012). The beneficiary was then discharged from the SNF and received therapy services from an independently practicing PT totaling $1,800. The independent PT billed in November 2012 for services provided after October 1, 2012. The MAC received the claims and processed them. After these claims were processed the MAC received the SNF Part B claims totaling $3,600 and processed them. Had these claims been received in advance of the independent PT services, the independent PT would have been required to have the services approved in advance. In circumstances such as this example, the contractor is not required to perform post-payment review on the $1,800 provided by the independent therapist.

Additional information

The official instruction, CR 8036, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1124OTN.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*.

MLN Matters® Number: MM8036
Related Change Request (CR) #: CR 8036
Related CR Release Date: September 25, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R1124OTN
Implementation Date: October 1, 2012

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.

Medicare Part B outpatient therapy cap and exceptions process extended through December 31, 2012

The Middle Class Tax Relief and Job Creation Act of 2012 (H.R.3630) was signed into law on February 22, 2012; extending the Medicare Part B outpatient therapy cap exceptions process through December 31, 2012.

The statutory Medicare Part B outpatient therapy cap for occupational therapy (OT) is $1,880 for 2012, and the combined cap for physical therapy (PT) and speech-language pathology services (SLP) is also $1,880 for 2012. This is the annual per-beneficiary therapy cap amount determined for each calendar year. Similar to the therapy cap, Congress established a threshold of $3,700 for PT and SLP services combined and another threshold of $3,700 for OT services. All therapy services rendered above $3,700 are subject to manual medical review, and certain providers will be required to submit a request for an exception.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Private practices
- Part B skilled nursing facilities
- Home health agencies (TOB 34x)
- Outpatient rehabilitation facilities (ORFs)
- Rehabilitation agencies (comprehensive outpatient rehabilitation facilities [CORFs])
- Hospital outpatient departments (HOPDs) – beginning October 1, 2012, until December 31, 2012

The law requires an exceptions process to the therapy cap that allows providers to receive payment from Medicare for medically necessary therapy services above the therapy cap amount. Beginning on October 1, 2012, some therapy providers will be required to submit requests for exceptions (pre-approval for up to 20 therapy treatment days for beneficiaries at or above the $3,700 threshold). The $3,700 figure is the defined threshold which triggers the requirement for an exception request. This requirement will not be imposed on all therapy providers at one time, it will be phased in, and therapy providers will be assigned to one of three groups or phases. The requirement to submit an exception request will be imposed on the dates listed below depending on which of the three groups or phases to which providers have been assigned.

- Phase I – October 1 to December 31, 2012
- Phase II – November 1 to December 31, 2012
- Phase III – December 1 to December 31, 2012

If you are a provider of physical therapy, speech-language pathology services, or occupational therapy services, you may receive a letter titled “Notification of Request for Exception Requirements for Therapy,” indicating your assigned phase.

You can find your assigned phase *here*. If you do not find your NPI number on the list, then you are in Phase III.

If you have questions, please contact your local Medicare administrative contractor’s (MAC’s) customer service department. You can find your local MAC on the *provider compliance interactive map*.

For more information on the Medicare Part B outpatient therapy cap and exceptions process visit the *Medical Review and Education website*.

Source: CMS PERL 201209-01

Prepayment review for therapy services

Effective October 1, 2012, the Centers for Medicare & Medicaid Services (CMS) has implemented a $3,700 therapy threshold.

Pre-approval process

Providers may avoid automatic pre-payment review by requesting preapproval of the services before they are rendered. Providers may request up to 20 treatment days per discipline. A decision letter will be provided to both the beneficiary and the provider for each request. The decision to allow or deny services will be made using all available information and based on Section 220 of the *Medicare Benefit Policy Manual* as well as First Coast's *Therapy and Rehabilitation Services* local coverage determinations. Contractors will have up to ten business days to make a decision on each pre-approval request. The ten days begin when the request has been received at the contractor. If the request is not processed within ten days, the request is considered automatically approved. If this occurs First Coast will send a decision letter advising of this instance.

Requests may not be submitted more than 15 days prior to the beginning of each phase

First Coast will establish provider- and beneficiary-specific editing based on each of the phases to closely monitor this process. All requests will be tracked via an internal database. All claims submitted for dates of services October 1, 2012, through December 31, 2012, without a pre-approval request will result in a request for supporting documentation for clinical review. All requests for preapproval must include a copy of the *Request for pre-approval of therapy services above the $3700 threshold* coversheet (see page 23). The coversheet must be completed in its entirety. **Requests may not be submitted more than 15 days prior to the beginning of each phase**. Although you have the option of faxing or mailing the request, **we strongly recommend faxing**. The decision letter will advise if the pre-approval request is approved or denied: The decision letter will include the number of treatment days allowed, or if denied, a detailed explanation. The letter will be returned via the same method it was received.

Note: If the pre-approval request is denied and an initial evaluation was performed, Medicare will allow the evaluation (i.e. *CPT* codes *92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003,* and *97004*).

Additional information

Additional information regarding the new $3700 therapy threshold is available at:

- The "Medical Review and Education" Web page at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/TherapyCap.html*
- Change request 8036, transmittal 1124 dated August 31, 2012, at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1124OTN.pdf*

First Coast local coverage determinations

The local coverage determinations (LCDs) listed below may be found using *First Coast's LCD lookup*.

- Therapy and Rehabilitation Services LCD
  - L28992 (Florida Part A), L29024 (Puerto Rico, U.S. Virgin Islands Part A)
  - L29289 (Florida Part B) L29399 (Puerto Rico, U.S. Virgin Islands Part B)
- THERSVCS LCD
  - L32807 (Florida Part B)

Limitation information

Therapy cap limitation information is obtained via the applicable eligibility system (HETS for Part B, ELGA for Part A). Additional information on each screen is below:

- **HIPAA Eligibility Transaction System (HETS)** – the *HIPAA Eligibility Transaction System (HETS) User Interface (UI) User Guide* at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS-UI-User-Guide.pdf#page=31*.
- **CWF PART A Eligibility System (ELGA)** – the *Medicare Part A Direct Data Entry (DDE) Training Manual* at *http://medicare.fcso.com/Direct_data_entry/139884.pdf#page=32*.

Source: Publication 100-04, transmittal 1124, CR 8036

(continued on next page)

Prepayment *(continued)*

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

Request for pre-approval of therapy services above the $3700 threshold

Providers are expected to submit the following types of documentation for therapy services:

1. Evaluation and certified plan of care
2. Certification/re-certification
3. Clinician-signed progress reports
4. Treatment encounter notes
5. Justification (explanation of medical necessity)

If all required documentation is not attached, a decision will be made based on the information received. All subsequent requests based on a prior denial of pre-approval must contain new or additional information. Documentation must be provided that is sufficient to support medical necessity for the additional treatment days, which shall be in accordance with the *Medicare Benefit Policy Manual* (Pub 100-02, Chapter 15, Section 220) and the First Coast Service Options Inc. (First Coast) local coverage determination (LCD) for rehabilitation therapy services. Please do not contact the customer service call center for a status of your request. A decision will be faxed or mailed within 10 business days of receipt of your request.

Request is for: (check only one; submit a separate request for each type of therapy)

◯ Physical therapy ◯ Occupational therapy ◯ Speech language pathology

Date of request: From: To:

Beneficiary name First: MI: HIC number:

Last: Suffix (Jr, Sr, III, etc.):

Beneficiary address: DOB:

Number of treatments being requested for this request (not to exceed 20)

Primary diagnosis code (list only one)

Secondary/additional diagnosis codes 1. 2.

Is this the first request for this patient ? ◯ Yes ◯ No

Facility/entity or provider group name: PTAN:

Performing provider name: Performing provider NPI/PTAN:

Name and telephone number of the person to contact regarding this request:

Fax number or mailing address for return decision:

You may fax to: (preferred)

Medicare Part **A**

◯ Florida: 904-361-0542

◯ PR/UVSI: 904-361-0786

Medicare Part **B**

◯ Florida: 904-361-0582

◯ PR/UVSI: 904-361-0821

OR mail to:

First Coast Service Options Inc.
532 Riverside Ave., 19T
Jacksonville, FL 32202-4914

CMS CENTERS for MEDICARE & MEDICAID SERVICES

www.fcso.com

First Coast Service Options Inc.

Therapy services billed by physicians

Florida only

In an effort to protect the Medicare Trust Fund and ensure proper payments, the Centers for Medicare & Medicaid Services (CMS) implemented the Comprehensive Error Rate Testing (CERT) program. CERT measures the accuracy of Medicare fee-for-service (FFS) payments. CERT contractors generate a number of measurements and statistics that reflect how effectively providers submit their claims and how Medicare contractors review and pay those claims.

First Coast Service Options Inc. (First Coast) analysis of CERT errors identified a trend of increased claim payment errors in the November 2011 CERT report when therapy services are billed by a physician 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.

Currently therapy services billed by both podiatry and general practice specialties are subject to prepayment review. In an effort to prevent improper claim payments for therapy services billed by physicians, prepayment review activities has now been expanded to include the family practice specialty. **A prepayment medical review edit was implemented on August 28, 2012.** This prepayment edit requires submission of medical records to support physical therapy services billed by family practice practitioners.

Medicare requirements for therapy services

Therapy services shall be payable when the medical record and the information on the claim form consistently and accurately report covered therapy services. Documentation must be legible, relevant, and sufficient to justify the services billed.

The patient receiving outpatient therapy services must be under the care of a physician/nonphysician practitioner (NPP). NPP signifies a physician assistant, clinical nurse specialist or nurse practitioner, who may, if state and local law permit it, and when appropriate rules are followed, provide, certify, or supervise therapy services.

Therapy services **must** relate directly and specifically to a written treatment plan. The plan (also known as a plan of care or plan of treatment) **must** be established before treatment is started. The plan is established when it is developed (e.g., written or dictated). The signature and professional identity of the person who established the plan, and the date it was established **must** be recorded within the plan.

Various entities may request documentation to support services billed to the Medicare program (e.g., Medicare administrative contractor [MAC], CERT, recovery audit contractor [RAC], zone program integrity contractors [ZPIC], or the office of inspector general [OIG]). The following documentation **must** be submitted in response to a request for documentation, unless the requesting contractor specifies otherwise.

- Evaluation and plan of care (POC) (may be one or two documents). Include the initial evaluation and any reevaluations relevant to the episode being reviewed; certification (physician/NPP approval of the plan), and recertification when records are requested after the certification/recertification is due;
- Progress reports (including discharge notes, if applicable) when records are requested after the reports are due;
- Treatment notes for each treatment day (may also serve as progress reports when required information is included in the notes). Daily treatment notes must indicate the individual modalities performed that day. Minutes must be documented for each modality that represents a time-based code and the total time in treatment must be documented; and
- A justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands the reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation. If the patient is expected to exceed the therapy cap, the record must clearly indicate the medical necessity for the patient to receive covered services above the cap.

Note: Excessive use of modifier KX (Requirements specified in the medical policy have been met) may indicate abusive billing.

Therapy services have their own benefit under Section 1861 of the Social Security Act (the Act) and shall be covered when provided according to the standards and conditions of the benefit described in Medicare manuals. Statute 1862 (a) (20) of the Act requires that payment be made for a therapy service billed by a physician/NPP only if the service meets the standards and conditions – other than licensing – that would apply to a therapist.

(continued on next page)

CERT *(continued)*

Medicare is authorized to pay **only** for services provided by those trained specifically in physical therapy, occupational therapy, or speech-language pathology. That means that the services of athletic trainers, massage therapists, recreational therapists, kinesiotherapists, low vision specialists, or any other profession may not be billed as covered therapy services.

In addition, there is no coverage for services provided "incident to" the service of a therapist. Although physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the benefit for therapy services and not by the benefit for services "incident to" a physician/NPP. The services furnished by PTAs and OTAs are not incident to the therapist's services. A physical therapist must supervise PTAs and an occupational therapist must supervise OTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for PTAs in all settings except private practice (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed.

The service of a PTA and OTA shall not be billed as services "incident to" a physician/NPP's service, because they do not meet the qualifications of a therapist. Only services provided by a licensed therapist or an individual who has completed an accredited PT or OT curriculum and are qualified for licensure may provide services "incident to" the physician/NPP.

Providers are encouraged to review the complete requirements for billing rehabilitation services found on First Coast's "Therapy and Rehabilitation Services" local coverage determination (LCD) *L29289* (Florida) as well as the requirements found in the Internet-only manual (IOM), *Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 220-230*.

Additional information

Visit First Coast's Medicare provider website *rehabilitation services* page for the latest news on therapy services. To learn about upcoming educational events related to therapy services visit the *events calendar* more information.

General Coverage

Ordering and certifying documentation – maintenance requirements

Provider types affected

This *MLN Matters*® article is intended for physicians, non-physician practitioners, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers and home health agencies (HHAs) submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article, based on change request (CR) 7890, informs you of instructions to Medicare contractors regarding the implementation of ordering and certifying documentation and maintenance requirements found in 42 Code of Federal Regulations (CFR) 424.516(f).

Caution – what you need to know

A provider or supplier that furnishes covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for seven years from the date of service, and
- Provide access to that documentation upon the request of the Centers for Medicare & Medicaid Services (CMS) or a Medicare contractor.

A physician who orders/certifies home health services and a physician or, when permitted, other eligible professional, who orders items of DMEPOS or clinical laboratory or imaging services is required to:

- Maintain the documentation for seven years from the date of service, and

(continued on next page)

Documentation *(continued)*

- Provide access to that documentation upon the request of CMS or a Medicare contractor.

If the provider, supplier, physician or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke the party's Medicare billing privileges under 42 CFR 424.535(a)(10).

Go – what you need to do

Review the description of documentation to be maintained in the *Background* section below. Make sure that your billing staffs are aware of these requirements for documentation.

Background

Under 42 CFR 424.516(f)(1), a provider or supplier that furnishes covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services is required to (1) maintain documentation (see next paragraph) for seven years from the date of service, and (2) provide access to that documentation upon the request of CMS or a Medicare contractor.

The documentation to be maintained includes written and electronic documents (including the national provider identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician or, when permitted, other eligible professional who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

In addition, under 424.516(f)(2), a physician who orders/certifies home health services and the physician or, when permitted, other eligible professional, who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain the documentation described in the previous paragraph for seven years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request.

If the provider, supplier, physician, or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke the party's Medicare billing privileges under 42 CFR 424.535(a)(10).

The CMS policy states that, absent a CMS directive to the contrary, the Medicare contractor will request the documentation described above if it has reason to believe that the provider, supplier, physician or eligible professional (hereinafter collectively referred to as "provider") is not maintaining the documentation in accordance with Section 424.516(f)(1) or (2).

Examples of when a request might be appropriate include, but are not limited to, the following:

- The contractor has detected an unusually high number of denied claims involving the provider, or the Fraud Prevention System has otherwise generated an alert with respect to the provider.
- The provider has been the subject of a recent zone program integrity contractor referral.
- The provider maintains an elevated surety bond amount.

If a provider fails to respond to a letter request for documentation within 30 days of the Medicare contractor's request, the contractor may revoke the provider's Medicare billing privileges and impose a one-year re-enrollment bar.

Additional information

The official instruction, CR 7890 issued to your carrier, FI, or A/B MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R431PI.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*.

MLN Matters® Number: MM7890
Related Change Request (CR) #: CR 7890
Related CR Release Date: August 31, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R431PI
Implementation Date: October 1, 2012

Improper payments and inpatient prepayment medical review – update

Note: This article was revised September 9, 2012, adding the process that began August 31, 2012, for Part B only. This information was previously published in the August 2012 *Medicare B Connection*, Page 13.

As the Medicare administrative contractor (MAC) for jurisdiction 9 (J9), First Coast Service Options Inc. (First Coast) 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. First Coast'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 First Coast's staggered approach to implementing prepayment edits currently on its prepayment medical review MS-DRG strategy.

First Coast 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, First Coast began performing data analysis in preparation for post-payment recoupment of the surgeon, assistant surgeon, or co-surgeon's Part B services. Beginning August 31, 2012, First Coast began issuing notification letters advising Part B surgeons of the intent to recoup Part B payment. This is not an overpayment demand letter. The Part B surgeons will receive in a future correspondence the overpayment demand letter, which includes guidance regarding appeal rights.

- *Click here* for more information regarding the notification letter.

First Coast 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 First Coast medical review activities. First Coast 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.

Find out first: Subscribe to First Coast *eNews*

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

PWK is here

PWK allows for documentation to be submitted with an initial claim

Effective October 1, 2012, First Coast Service Options Inc. (First Coast) implemented the PWK (paperwork) segment of the X12N version 5010. This allows for voluntary submission of supporting documentation with a 5010 version electronic claim.

PWK is a segment within the 2300/2400 Loop of the 837 professional and institutional electronic transactions that provides the link between electronic claims and additional documentation. PWK will allow providers to submit electronic claims that require additional documentation and, through the dedicated PWK process, have the documentation imaged to be available during the claims adjudication. Eliminating the need for costly development and allowing providers and Medicare contractors to utilize efficient, cost-effective electronic data interchange or EDI technology will create a significant cost savings.

Although PWK ultimately allows electronic submission of additional documentation, the October implementation only allows for submission of additional documentation via mail and fax (PWK 02 segment, BM [by mail] and FX [by fax] qualifier, respectively).

First Coast made available a fax/mail coversheet that providers or trading partners shall use to submit the unsolicited additional documentation. The First Coast fax/mail coversheet is an interactive form posted to our website. Providers or trading partners will complete required data elements and then be able to print a hardcopy of the form to mail or fax with their documentation. Modifications to the fax/mail coversheet will not be permitted. Separate forms will be provided for Part A and B for Florida, Puerto Rico, and the U.S. Virgin Islands. First Coast will also provide secure faxination numbers for those providers or trading partners who elect to fax the additional documentation.

PWK Fax/mail coversheets

First Coast is requiring the following section of the form to be completed with valid information to ensure the paperwork documentation is appended to the pending claim in our system: ACN (Attachment Control Number (submitted in the PWK06 segment)), DCN (document control number [Part A]), ICN (internal control number [Part B]), the beneficiary's health insurance claim number (HICN)/Medicare number, Billing provider's name and NPI (national provider identifier).

First Coast will return PWK coversheets with missing or inaccurate data. The coversheet will be returned based on how it was received (fax or mail).

Note: First Coast will not return any paperwork documentation that accompanies a rejected PWK coversheet; nor will the documentation be used for adjudication of the claim.

PWK documentation may not be submitted prior to submission of a claim. Submitters must send all relevant PWK data at the same time for the same claim. Thus, if the claim was submitted with multiple PWK iterations, all PWK data for the claim must be submitted together under one coversheet.

If the PWK segment is completed and additional documentation is needed for adjudication, First Coast will allow seven calendar "waiting" days (from the claim date of receipt) for the paperwork documentation to be faxed or ten calendar waiting days to be mailed. The seven and ten day waiting periods apply to claims for both Part A and Part B.

If the PWK data is not received within the waiting timeframe and additional documentation is needed, a development request will be sent. If documentation is received after the timeframe has elapsed, the


FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

Medicare Part A fax/mail cover sheet

Complete all fields and fax or mail the form to the applicable address/number provided at the bottom of the page.
Complete ONE Medicare Fax/Mail Cover Sheet for each electronic claim for which documentation is being submitted.
This form should not be submitted prior to filing the claim. Please use ALL CAPS for your entries.
Note: this form may not be altered.

ACN: (Exactly as entered in the PWK loop on the claim) | DCN:
Beneficiary last name: | First name: | HICN:
Date(s) of service From: | To: | Total Claim Billed Amount:
Billing provider's name: | Contact and phone number:
NPI:
State where services were provided: | Total number of documentation pages (including cover sheet):
Please provide a complete return mailing address if documentation is being mailed:


FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

Medicare Part B fax/mail cover sheet

Complete all fields and fax or mail the form to the applicable address/number provided at the bottom of the page.
Complete ONE Medicare Fax/Mail Cover Sheet for each electronic claim for which documentation is being submitted.
This form should not be submitted prior to filing the claim. Please use ALL CAPS for your entries.
Note: this form may not be altered.

ACN: (Exactly as entered in the PWK loop on the claim) | ICN:
Beneficiary last name: | First name: | HICN:
Date(s) of service From: | To: | Total Claim Billed Amount:
Billing provider's name: | Contact and phone number:
NPI:
State where services were provided: | Total number of documentation pages (including cover sheet):
Please provide a complete return mailing address if documentation is being mailed:

(continued on next page)

PWK *(continued)*

coversheet will be returned and the documentation will not be used for adjudication of the claim. Thus, the paperwork will need to then accompany our request for additional documentation to prevent possible claim denials.

Claims submitted with a PWK segment, that would not otherwise suspend for review and/or require additional development, will process routinely and will not be held for the seven or ten day waiting period.

Faxination numbers

First Coast will provide designated faxination lines to expedite receipt of the PWK coversheets/attachments, depending on the provider's line of business and location (Part A or Part B; Florida, Puerto Rico, or the U.S. Virgin Islands.

Each fax/mail coversheet will include the appropriate First Coast return mailing address and faxination number, based on the provider's selection.

5010 Companion Guide

Additional information on the PWK segment is available in the X12 version 5010 837I and 837P companion guides.

- Part A: *837 Institutional Claim Transaction Specific Information*
- Part B: *837 Professional Claim Transaction Specific Information*

Source: Pub 100-08, Transmittal 396, Change Request 7330

CARC, RARC, MREP, and PC Print 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.

Provider action needed

This article is based on change request (CR) 8029 which instructs Medicare contractors and shared system maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) that have been added since the last recurring code update. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) maintainers to update PC Print and Medicare Remit Easy Print (MREP) software. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA; see *http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf*), instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or global policy information that generally applies to the adjudication process are required in remittance advice (RA) and coordination of benefits (COB) transactions. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice (RA), there are two code sets – CARC and RARC – that must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate group code must be reported as well. Additionally, CARC and RARC must be used for transaction 837 COB.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare contractors stop using codes that have been deactivated **on or before** the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual "Stop Date" posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule.

(continued on next page)

CARC *(continued)*

Note that a deactivated code used in derivative messages must be accepted, even after the code is deactivated, if the deactivated code was used before the deactivation date by a payer or payers who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR 8029, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times a year and may not match the CMS release schedule.

CR 8029 lists only the changes that have been approved since the last code update provided by CR 7775 (Transmittal 2442 issued April 6, 2012; see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2442CP.pdf*).

CR 8029 does not provide a complete list of CARCs and RARCs, and the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website which is updated three times a year (around March 1, July 1, and November 1).

The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule.

The WPC website (see *http://www.wpc-edi.com/Reference*) has four listings available of codes by status for both CARC and RARC.

1. **Show All**: All codes including current, to be deactivated and deactivated codes are included in this listing.
2. **Current**: Only currently valid codes are included in this listing.
3. **To Be Deactivated**: Only codes to be deactivated at a future date are included in this listing.
4. **Deactivated**: Only codes with prior deactivation effective dates are included in this listing.

Note 1: In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

Note 2: CR 8029 lists only the changes approved since the last recurring code update CR once. If any change becomes effective at a future date, Medicare contractors must make sure that they update on the quarterly release date that matches the effective date as posted on the WPC website. If the effective date per the WPC website does not match any quarterly release date, Medicare contractors may update earlier than the effective date per WPC website for any deactivation, and later than the effective date per WPC website for any modification or new code.

CARCs

A national code maintenance committee maintains the health care CARCs, and a new code may not be added and the indicated wording may not be modified without the approval of this committee. These codes were developed for use by all U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare.

This code set is updated three times a year, and the updated list is published three times a year after the committee meets before the ANSI ASC X12 trimester meeting in January/February, June, and September/October.

The full list of CARCs can be found and downloaded from *http://wpc-edi.com/Reference* and to find out more about CARCs, see the *Medicare Claims Processing Manual* (Chapter 22, Sections 60.1 and 130.2 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf*.

New CARCs were approved by the code committee, and the following changes were made in the CARC database since the last code update provided by CR 7775. These changes must be implemented, if appropriate for Medicare, by October 1, 2012.

(continued on next page)

CARC *(continued)*

New CARCs

Code	Code narrative	Effective date
240	The diagnosis is inconsistent with the patient's birth weight. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/3/2012
241	Low Income Subsidy (LIS) Co-payment Amount.	6/3/2012
242	Services not provided by network/primary care providers.	6/3/2012
243	Services not authorized by network/primary care providers.	6/3/2012

Modified CARCs

Code	Code narrative	Effective date
133	The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. Use Group Code OA.	6/3/2012

Deactivated CARCs

Code	Code narrative	Effective date
38	Services not provided or authorized by designated (network/primary care) providers.	1/1/2013

Remittance advice remark codes

Remittance advice remark codes (RARCs) are maintained by CMS and may be used by any health plan when they apply. Medicare contractors must report appropriate remark code(s) that apply in both electronic and paper remittance advice, and COB claims. RARCs are used in a remittance advice to further explain an adjustment in conjunction with an appropriate CARC or relay general information about the adjudication process.

The remark code list is updated three times a year, and the list as posted at the WPC website and gets updated at the same time when the reason code list is updated. Both code lists are updated on or around March 1, July 1, and November 1. Medicare contractors must use the currently valid remark codes as included in the recurring update notification and/or any other CMS instruction. Medicare contractors also must get the full list of RARCs by downloading the list from the WPC website after each update. Contractor and shared system changes must be made, as necessary, as part of a routine release to reflect changes such as retirement of previously used codes or introduction of newly created codes that may impact Medicare.

The list of RARCs can be found at *http://www.wpc-edi.com/codes*.

For more information about remark codes

You can find out more about CARCs in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 22, Section 60.2, and 130.3 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf*.

These following changes were made in the RARC database since the last code update provided by CR 7775. The full RARC list must be downloaded from the WPC website at *http://wpc-edi.com/Reference*.

New RARCs

Code	Code narrative	Effective date
N554	Missing/Incomplete/Invalid Family Planning Indicator	7/1/2012
N555	Missing medication list.	7/1/2012
N556	Incomplete/invalid medication list.	7/1/2012
N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.	7/1/2012
N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.	7/1/2012

(continued on next page)

CARC *(continued)*

Code	Code narrative	Effective date
N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the ordering physician is located.	7/1/2012

Modified RARCs

Code	Modified code narrative	Effective date
N69	PPS (Prospective Payment System) code changed by claims processing system.	7/1/2012
N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.	7/1/2012

Deactivated RARCs

None

Medicare contractors must report only currently valid codes in both the RA and COB Claim transactions, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see the "Business Requirements" segment of CR 8029 for explanation of conditions). SSMs and Medicare contractors must make the necessary changes on a regular basis as per this recurring code update CR and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation has not been initiated by Medicare.

Additional information

The official instruction, CR 8029, issued to your contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2521CP.pdf*.

If you have any questions, please contact your 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: MM8029
Related Change Request (CR) #: CR 8029
Related CR Release Date: August 17, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2521CP
Implementation Date: October 1, 2012

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.

Healthcare provider taxonomy code updates effective October 2012

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare contractors (carriers and Part B Medicare administrative contractors (B MACs)) for services to Medicare beneficiaries.

What you need to know

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) website at *http://www.wpc-edi.com/codes*.

Change request (CR) 8021 implements the NUCC HPTC code set that is effective on October 1, 2012. The changes for October consist of the addition of two new HPTCs, both under the "Individual or Groups (of Individuals") section, for "Dental Provider" types:

- 125J00000X Dental Therapist classification
- 125K00000X Advanced Practice Dental Therapist classification

There are no other changes to the October 2012 code set.

Medicare does not use HPTCs to adjudicate its claims. It would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC code set.

Additional information

The official instruction, CR 8021 issued to your carrier or B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2534CP.pdf*.

If you have any questions, please contact your carrier or 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*.

MLN Matters® Number: MM8021
Related Change Request (CR) #: CR 8021
Related CR Release Date: August 31, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2534CP
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.

Electronic data interchange communication requirements

To electronically interface directly with First Coast Service Options, Inc. for the purpose of either transmitting electronic media claims (EMC) or retrieving electronic data, i.e., electronic remittance advices and acknowledgements of EMC submissions, you must meet the following communication requirements:

- Capability to connect to our electronic data interchange (EDI) gateway over an analog telephone line, which excludes Internet and digital phone line connections. If a consistent loss of connection to our EDI gateway is experienced, it is recommended that you contact your telephone carrier to confirm your current phone line configuration and the options available to you.
- Software on your computer that supports the creation of communication command files and the transfer of EDI data.

If the above communication requirements cannot be met, then a potential solution is utilization of a billing service, a clearinghouse, or a network service vendor. A current listing of the companies that have successfully passed X12N 837 5010 testing is located at: *http://medicare.fcso.com/Getting_started/206578.asp*.

Claim status category and claim status codes update

Provider types affected

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

Provider action needed

This article, based on change request (CR) 8045, explains that claim status and claim status category codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277, Health Care Claim Acknowledgement ASC X12N 277 are updated three times per year at the national code maintenance committee meetings.

These codes explain the status of submitted claim(s). 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 codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* or *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*. Make sure that your billing staffs are aware of these updates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use. All code changes approved during the June 2012 committee meeting will be posted on or about July 1, 2012.

Additional Information

The official instruction, CR 8045, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2547CP.pdf*.

If you have any questions, please contact your FI, carrier, RHHI, A/B MAC, 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*.

MLN Matters® Number: MM8045
Related Change Request (CR) #: CR 8045
Related CR Release Date: September 14, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2547CP
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.

New file reload pages available

First Coast Service Options Inc (First Coast) is pleased to announce that you may now reload remittance advices and claim file acknowledgements to your mailbox through the *http://medicare.fcso.com/* website. These new reload tools can be accessed through the "Electronic Data Interchange" (EDI) menu, under "Reload Requests."

You will need to have a valid email address and your submitter number on hand to get started.

Acknowledgments

Claim file acknowledgments may be reloaded using the following information:

- Submitter number
- File transmission date
- Either number of claims or the total file value

Note: Only acknowledgments for files received on or after September 10, 2012, can be reloaded with this tool. For prior dates, please contact Medicare EDI at 888-670-0940 option -1 for assistance.

You will need to have a valid email address and your submitter number on hand to get started.

There is an option for the 999 Implementation acknowledgements and the 277 CA (claim acknowledgment). Each request must be submitted separately. If you are not one of First Coast's electronic data trading partners, please contact either your billing service or your clearinghouse to obtain your acknowledgments.

Remittances

- 835 remittance advices may be reloaded using the following information:
- Submitter number
- Check/control number
- Check date
- Remittance amount

Each request will return only one remittance advice but multiple requests may be submitted. If you are not one of First Coast's electronic data trading partners, please contact either your billing service or your clearinghouse to obtain your electronic remittance advice. Reload requests must be initiated by that billing service or clearing house, not the provider.

If your request is successful, an email will be returned to you confirming the reload. If your request is unsuccessful you will not be notified; you should wait one hour before contacting Medicare EDI at 888-670-0940 option -1 for assistance.

Go green to get your green faster

Save time, money, and the environment all at the same time by signing up for electronic funds transfer (EFT). With EFT, funds are transferred directly to your financial institution, which means quicker reimbursement for you. To start receiving EFT, simply complete and return the EFT Authorization Agreement form at *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS588.pdf*.

Provider Enrollment

Edits on the ordering/referring providers in Medicare Part B claims

Note: This *MLN Matters*® article was revised on September 17, 2012, to change the reference to certified clinical nurse specialist under *Background* to say clinical nurse specialist. Also, a reference to *MLN Matters*® article SE1221 was added to the *Additional information* section. All other information remains the same. This information was previously published in the August 2011 *Medicare B Connection,* Pages 31-35.

Provider types affected

This special edition *MLN Matters*® article is intended for physicians, non-physician practitioners (including interns, residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries, Part B providers and suppliers who submit claims to carriers, Part B Medicare administrative contractors (MACs), Part A regional home health intermediaries, fiscal intermediaries who still have a home health agency (HHA) workload and DME MACs for items or services that they furnished as the result of an order or a referral should be aware of this information.

Provider action needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare.. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Review the *Background* and *Additional information* sections and make sure that your billing staffs are aware of these updates.

What providers need to know

Phase 1: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim will not be paid. If the ordering/referring provider is reported on the claim, but does not have a current enrollment record in PECOS or is not of a specialty that is eligible to order and refer, the claim will be paid and the billing provider will receive an informational message in the remittance indicating that the claim failed the ordering/referring provider edits.

Phase 2: The Centers for Medicare & Medicaid Services (CMS) has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60-day notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer.

Enrollment applications must be processed in accordance with existing Medicare instructions. It is possible that it could take 45-60 days, sometimes longer, for Medicare enrollment contractors to process enrollment applications. All enrollment applications, including those submitted over the Web, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of Phase 2 of the ordering/referring provider edits.

Background

The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B, DME and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests
- Claims from imaging centers for ordered imaging procedures, and
- Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS.

(continued on next page)

Ordering *(continued)*

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry)
- Physician assistant
- Clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Interns, residents, and fellows
- Certified nurse midwife, and
- Clinical social worker.

Questions and answers relating to the edits

- **What will the edits do?**

The edits will determine if the ordering/referring provider (when required to be identified in Part B, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and it contains a valid national provider identifier (NPI) (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

- **Why did Medicare implement these edits?**

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

- **How and when will these edits be implemented?**

These edits are being implemented in two phases:

- **Phase 1:** Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message[1] in the Medicare remittance advice indicating that the claim failed the ordering/referring provider edits.[2].

  The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264 Missing/incomplete/invalid ordering physician provider name

N265 Missing/incomplete/invalid ordering physician primary identifier

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544 **Alert**: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272 Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

Note: If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

(continued on next page)

Ordering *(continued)*

- **Phase 2:** CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60-day notice prior to turning on these edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral. The denial edits are identified below:
- Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D Referring/Ordering Provider Not Allowed To Refer

255D Referring/Ordering Provider Mismatch

289D Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

Reason code	Situation
37236 – This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code
37237 – This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • The type of bill frequency code is '7' or 'F-P' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.[3]

CMS will give the provider community at least 60-day notice prior to turning on Phase 2 edits.

On January 28, 2010, CMS made available to the public, via the *Downloads* section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the report on a bi-weekly basis. At any given time, only one report (the most current) will be available for downloading. To learn more about the report, and to download it, go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*; click on "Ordering Referring Report" (on the left). Information about the report will be displayed.

1 The informational messages vary depending on the claims processing system.
2 DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.
3 NPIs were added only when the matching criteria verified the NPI.

(continued on next page)

Ordering *(continued)*

Effect of edits on providers

A. I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, **you – the ordering/referring provider—need to ensure that:**

1. **You have a current Medicare enrollment record.**

- If you are not sure you are enrolled in Medicare, you may: (1) check the Ordering Referring Report mentioned above, and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI; (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or (3) use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare). If you choose (3), please read the information on the Medicare provider/supplier enrollment Web page about Internet-based PECOS before you begin.
- **If you do not have an enrollment record in Medicare:**
  - You need to submit an enrollment application to Medicare in one of two ways:

a. Use Internet-based PECOS to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to either e-sign the certification statement or mail a printed, signed, and dated certification statement and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment Web page to learn more about the Web-based system before you attempt to use it. Go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the *Downloads* section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that Web page.

b. Submit an electronic application through the use of Internet-based PECOS or obtain a paper enrollment application, fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (*http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html*).

Note about physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every two years, and the NPI is required on the affidavit).

2. **You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.** When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

B. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the ordering/referring provider edits?

As the billing provider, you need to ensure that your Medicare claims for items or services that you furnished based on orders or referrals will pass the edits on the ordering/referring provider so that you will not receive informational messages in Phase 1 and so that your claims will be paid in Phase 2.

You need to use due diligence to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records (i.e., they have Medicare enrollment records that contain their NPIs) and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or

(continued on next page)

Ordering *(continued)*

services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article. Ensure you are correctly spelling the ordering/referring provider's name. If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the ordering/referring provider edits. Keep in mind that this Ordering Referring Report will be replaced bi-weekly to ensure it is current. It is possible, therefore, that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report. You may appeal a claim that did not initially pass the ordering/referring provider edits.

Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits. Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the ordering/referring provider's first name first, and last name second (e.g., John Smith). Ensure that the name and the NPI you enter for the ordering/referring provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral. Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer. If there are additional questions about the informational messages, billing providers should contact their local carrier, A/B MAC, or DME MAC.

Billing providers should be aware that claims that are denied because they failed the ordering/referring provider would expose the Medicare beneficiary to liability. Therefore, an advance beneficiary notice is not appropriate.

Additional guidance

1. **A note on terminology:** Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred or certified an item or service reported in that claim. The final rule uses technically-correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
2. **Orders or referrals by interns or residents**. The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that state-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if states provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with state law.
3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare.** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. **Orders or referrals by dentists**. Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional information

You may want to review the following *MLN Matters*® articles for important reminders on the requirements for ordering and referring physicians:

SE1201 – *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf*

SE1221 – *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1221.pdf*

(continued on next page)

Ordering *(continued)*

If you have questions, please contact your Medicare carrier, Part A/B MAC, or DME MAC, at their toll-free numbers, 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: SE1011 *Revised*
Related Change Request (CR) #: 6421, 6417, 6696, 6856
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R7810TN
Implementation Date: N/A

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.

Important reminder for providers and suppliers who provide services and items ordered or referred by other providers and suppliers

Note: This article was revised on September 19, 2012, to add the last bullet under *Background* regarding optometrists. The article also now contains a reference to *MLN Matters*® article SE1221 and all Web addresses have been updated. All other information remains the same. This information was previously published in the January 2012 *Medicare B Connection*, Pages 45-45.

Provider types affected

This *MLN Matters*® special edition article is intended for providers and suppliers (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries.

Provider action needed

Stop – impact to you

Medicare will only pay for items or services for Medicare beneficiaries that have been ordered by a physician or eligible professional who is enrolled in Medicare and their individual national provider identifier (NPI) has been provided on the claim. The ordering provider or supplier (physician or eligible professional) must also be enrolled with a specialty type that is eligible (per Medicare statute and regulation) to order and refer those particular items or services.

Caution – what you need to know

Make sure you follow Medicare directives when providing services ordered for the services outlined below.

Go – what you need to do

You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide.

Background

The Centers for Medicare & Medicaid Services (CMS) emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home health agency (HHA) services may only be ordered or referred by a doctor of medicine (M.D.), doctor of osteopathy (D.O.) or doctor of podiatric medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.

(continued on next page)

Clarification *(continued)*

- Portable X-ray services may only be ordered by a doctor of medicine or doctor of osteopathy. Portable X-ray services ordered by any other practitioners will be denied.
- Optometrists may only order and refer laboratory and X-ray services.

MLN Matters® special edition articles SE1011 and SE1221 provide further details about edits on the ordering/referring provider information on claims. SE1011 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf* and SE1212 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1221.pdf*.

Additional information

For more information about the Medicare enrollment process, visit *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html* or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf*.

The *Medicare Learning Network*® (*MLN*) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf*.

MLN Matters® article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf*.

MLN Matters® article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf*.

MLN Matters® article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf*;

MLN Matters® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf*.

MLN Matters® Number: SE1201 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

Phase 2 of ordering/referring requirement

Note: This article was revised on September 17, 2012, to remove the word "Certified" from in front of clinical nurse specialist under *Background* (third bullet). All other information remains the same. This information was previously published in the June 2012 *Medicare B Connection*, Pages 43-46.

Provider types affected

This *MLN Matters*® special edition article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries
- Part B providers (including portable X-ray services) and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A home health agency (HHA) services who submit claims to RHHIs, fiscal intermediaries (who still maintain an HHA workload), and Part A/B MACs.

Provider action needed

Stop – impact to you

CMS will soon begin denying Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. These edits ensure that physicians and others who are eligible to order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60-day advanced notice prior to turning on the ordering/referring edits. CMS does not have a date at this time.

Caution – what you need to know

CMS shall authorize A/B MACs and DME MACs to begin editing Medicare claims with phase 2 ordering/referring edits. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral from a provider who does not have a Medicare enrollment record.

Go – what you need to do

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O).

Background

The Social Security Act (the Act) requires that all physicians and non-physician practitioners be uniquely identified for all claims for services that are ordered or referred. Effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the national provider identifier (NPI).

CMS began expanding the claims editing to meet the Act's requirements for ordering and referring providers as follows:

- **Phase 1**: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message in the remittance advice indicating that the claim failed the ordering/referring provider edits.

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry)
- Physician assistant

(continued on next page)

Phase 2 *(continued)*

- Clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Interns, residents, and fellows
- Certified nurse midwife
- Clinical social worker

The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264 Missing/incomplete/invalid ordering physician provider name

N265 Missing/incomplete/invalid ordering physician primary identifier

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544 Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272 Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

Note: If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

Phase 2: CMS has not announced a date when the edits for phase 2 will become active. CMS will give the provider community at least 60-day notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to be enrolled in Medicare and must be of a specialty that is eligible to order and refer. If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, but is not enrolled in Medicare, the claim will not be paid. In addition, if the ordering/referring provider is on the claim, but is not of a specialty that is eligible to order and refer, the claim will not be paid. Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D Referring/Ordering Provider Not Allowed To Refer

255D Referring/Ordering Provider Mismatch

289D Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

37236 – This reason code will assign when:

- The statement “From” date on the claim is on or after the date the phase 2 edits are turned on.
- The type of bill is ‘32’ or ‘33’

Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

(continued on next page)

Phase 2 *(continued)*

37237 – This reason code will assign when:

- The statement "From" date on the claim is on or after the date the phase 2 edits are turned on.
- The type of bill is '32' or '33'
- The type of bill frequency code is '7' or 'F-P'

Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

CMS published the final rule, CMS-6010-F, RIN 0938-AQ01, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements," on April 24, 2012, permitting phase 2 edits to be implemented.

CMS will announce the date via an updated article when it shall authorize Part A/B and DME MACs and Part A RHHIs to implement phase 2 edits.

Additional information

A note on terminology: Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred or certified an item or service reported in that claim. CMS has used this term on its website and in educational products. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services for a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

For more information about the Medicare enrollment process, visit *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*, or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf*.

The *Medicare Learning Network*® fact sheet, "Medicare Enrollment Guidelines for Ordering/Referring Providers" provides information about the requirements for eligible ordering/referring providers and is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf*.

You may find the following articles helpful in understanding this matter:

- *MLN Matters*® article MM6417, "Expansion of the Current Scope of Editing for Ordering /Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6417.pdf*.
- *MLN Matters*® article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6421.pdf*.
- *MLN Matters*® article MM6856, "Expansion of the Current Scope of Editing for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) claims processed by Medicare Regional Home Health Intermediaries (RHHIs)", is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf*.
- *MLN Matters*® article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7097.pdf*.
- *MLN Matters*® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6129.pdf*.

(continued on next page)

Phase 2 *(continued)*

- *MLN Matters*® special edition article SE1011, "Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf*.
- *MLN Matters*® special edition article SE1201 "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf*.
- *MLN Matters*® special edition article SE1208, "855-O Medicare Enrollment Application Ordering and Referring Physicians or Other Eligible Professionals," is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1208.pdf*.

If you have any questions, please contact your carrier, Part A/B MAC, RHHI, fiscal intermediary, 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*.

MLN Matters® Number: SE1221 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

General Information

Expiration of 2012 therapy cap revisions and user-controlled mechanism to identify legislative effective dates

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), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for therapy services provided to Medicare beneficiaries.

Provider action needed

This article is informational in nature and is based on change request (CR) 7881 which implements the statutory expiration date of certain provisions affecting claims for therapy services, to which the therapy caps apply.

Provisions relating to therapy caps are among a number of legislative changes that may be extended from year to year or for portions of a year. These changes may currently require a non-recurring CR to change hard coded edits in Medicare systems. Frequently, these CRs cannot be implemented quickly enough to meet the changing effective dates. Therefore, CR 7881 creates a mechanism that MACs can use to extend the effective dates of certain policies in urgent situations. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, Section 3005; see *http://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.pdf*) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services. Previously, therapy services furnished in an outpatient hospital setting had been exempt from the application of the therapy caps.

However, MCTRJCA required original Medicare to apply the therapy caps temporarily to the therapy services furnished in an outpatient hospital on/after October 1, 2012, and on/before December 31, 2012. Although claims processing requirements associated with the cap are only applicable to hospitals on/after October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012, are included in calculating the cap beginning October 1, 2012.

(continued on next page)

Legislative *(continued)*

MCTRJCA also required a manual review process for those exceptions where the beneficiary therapy services for the year reach a threshold of $3,700. The separate thresholds triggering manual medical reviews build upon the separate therapy caps - one for physical therapy (PT) and speech-language pathology (SLP) services combined and one for occupational therapy (OT) services. The count of services to which these thresholds apply began on January 1, 2012.

Unless congressional action is taken, all of these provisions expire for dates of service after December 31, 2012. Provisions relating to the therapy caps are among a number of legislative changes that may be extended from year to year, or for portions of a year.

Medicare systems currently lack the flexibility to apply policies to claims based on frequently-changing effective dates. These changes may currently require a non-recurring CR to change hard coded edits in Medicare systems, and often, these CRs cannot be implemented quickly enough to meet the changing effective dates.

Therefore, CR 7881 creates a mechanism that MACs can use to extend the effective dates of certain policies based in urgent situations. This mechanism will be first used to set the expiration dates of the MCTRJCA (Section 3005) therapy provisions.

Additional information

The official instruction, CR 7881 issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2537CP.pdf*.

If you have any questions, please contact your carriers, FIs, A/B MACs, and 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*.

MLN Matters® Number: MM7881
Related Change Request (CR) #: CR 7881
Related CR Release Date: August 31, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2537CP
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.

Prohibition on balance billing qualified Medicare beneficiaries

Note: This article was revised on August 28, 2012, to clarify the section of the Social Security Act that prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing (under the “What you need to know” section).This article was previously updated on July 25, 2012, to reflect current Web addresses. All other content remains the same. This information was previously published in the October 2011 *Medicare B Connection*, Pages 28-29.

Provider types affected

All Medicare physicians, providers and suppliers who submit claims to Medicare for services and supplies provided to qualified Medicare beneficiaries (QMBs) are affected. This includes providers of services to enrollees of Medicare Advantage plans.

What you need to know

Stop – impact to you

This special edition *MLN Matters*® article provides guidance from the Centers for Medicare & Medicaid Services (CMS) to Medicare providers serving QMBs. All Medicare providers are reminded that they may not bill QMBs for Medicare cost-sharing.

Caution – what you need to know

All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs must be aware that they may not bill QMBs for Medicare cost-sharing. This includes deductible, coinsurance, and copayments, known as “balance billing.” Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing. QMBs

(continued on next page)

Prohibition *(continued)*

have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions.

Go – what you need to do

Refer to the *Background* and sections of this article for further details and resources about this guidance. Please ensure that you and your staffs are aware of the current balance billing law and policies regarding QMBs. Visit the state Medicaid agency websites of the states in which you practice to learn how to submit claims if you are not currently submitting claims to a state.

Background

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

Balance billing of QMBs is prohibited by federal law

Under current law, Medicare providers cannot balance bill a QMB. Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing. (Please note, this section of the Act is available at *http://www.ssa.gov/OP_Home/ssact/title19/1902.htm*.)

Specifically, the statute provides that the Medicare payment and any Medicaid payment are considered payment in full to the provider for services rendered to a QMB.

QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who balance bill QMB patients may be subject to sanctions based on Medicare provider requirements established in Sections 1902(n)(3)(C) and 1905(p)(3) of the Social Security Act. Medicare providers who violate these billing restrictions are violating their Medicare provider agreement.

Please note that the statute referenced above supersedes Section 3490.14 of the "State Medicaid Manual," which is no longer in effect, and therefore, may be causing confusion about QMB billing.

QMBs and benefits

QMBs are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the federal poverty level; and have been determined to be eligible for QMB status by their state Medicaid agency.

- Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs.
- At the state's discretion, Medicaid may also pay Part C Medicare Advantage premiums for joining a Medicare Advantage plan that covers Medicare Part A and B benefits and mandatory supplemental benefits.
- Regardless of whether the state Medicaid agency opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits.

Ways to improve the claims process

Effective communications between you and state Medicaid agencies can improve the claims process for all parties involved. Therefore, CMS suggests that you take the following four actions to improve communications with state Medicaid agencies and better understand the billing process for services provided to QMB beneficiaries:

1. Determine if the state in which you operate has electronic crossover processes with the Medicare coordination of benefits contractor (COBC) in place or if direct submission to the state Medicaid agency is required or available. Nearly all states participate in the Medicare crossover process. It may just be that particular QMBs need to be added to the eligibility exchange between given states and Medicare. If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare remittance advice.
2. Recognize that you must meet any state-imposed requirements and may need to complete the provider registration process to be entered into the state payment system.
3. Understand the specific requirements for provider registration for the state(s) in which you work.
4. Contact the state Medicaid agency directly to determine the process you need to follow to begin submitting claims and receiving payment.

(continued on next page)

Prohibition *(continued)*

QMB eligibility and benefits

Dual eligibility	Eligibility criteria	Benefits
Qualified Medicare beneficiary (QMB only)	• Income cannot exceed 100 percent of the federal poverty level (FPL) • Resources cannot exceed $6,600 for a single individual or $9,910 for an individual living with a spouse and no other dependents	• Entitled to Medicare Part A • Eligible for Medicaid payment of Medicare Part B premiums, deductibles, co-insurance and co-pays (except for Part D)
QMB plus	• Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage • Individuals often qualify for full Medicaid benefits by meeting the medically needy standards, or through spending down excess income to the medically needy level.	• Entitle to all benefits available to QMB, as well as all benefits available under the state plan to a fully eligible Medicaid recipient

For more information about dual eligible categories and benefits, please visit *http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf*.

Additional information

For more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the *Medicare Learning Network®* publication titled *Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles)*, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf*.

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

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

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.

Important reminder about Medicare secondary payer laws

Provider types affected

This *MLN Matters®* article is intended for physicians, providers, and other suppliers that are taking payment from beneficiaries upon an office or hospital visit when the Medicare beneficiary has a group health plan that is primary to Medicare. The Centers for Medicare & Medicaid Services (CMS) is issuing this article as an important reminder and the article reflects no change in current Medicare policy.

Provider action needed

Stop – impact to you

This article is based on information received from Medicare contractors (carriers and Medicare administrative contractors (MACs)) indicating that physicians, providers and other suppliers are requesting a Medicare deductible, coinsurance payment, or other payments from a beneficiary prior to or at the time of services being rendered when another payer is primary to Medicare.

Caution – what you need to know

It is against the Medicare secondary payer laws to accept payment from a beneficiary upon admission or when services are being rendered when another insurer is primary to Medicare. If you are performing this practice, you must stop immediately.

(continued on next page)

Laws *(continued)*

Go – what you need to do

Participating Medicare providers, physicians, and other suppliers must not accept from the beneficiary any co-payment, coinsurance, or other payments, upon services rendered when the primary payer is an employer Managed-care organization (MCO) insurance, or any other type of primary insurance such as an employer group health plan. Providers must follow the Medicare secondary payer rules and bill Medicare as the secondary payer after the primary payer has made payment. Medicare will inform you on its remittance advice the amount you may collect from the beneficiary, if anything, after Medicare makes its payment. NOTE: In situations where you have taken payment from the beneficiary when services were rendered, the beneficiary has the right to recoup his/her payment from you when reimbursement is warranted.

Background

Section 1862(b)(2)(A)(i) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to: (i) A beneficiary entitled to Medicare on the basis of ESRD during the first 30 months of that entitlement; (ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or (iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

Additional information

If you have any questions, please contact your carrier or 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*.

MLN Matters® Number: SE1227
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

Medicare crossover process and Medicaid requirements for NDCs associated with Part B drugs

Provider types affected

This *MLN Matters*® special edition (SE) article is intended for physicians, hospitals, clinics, other providers, their billing vendors or clearinghouses that regularly include line-item billing for physician-administered drugs as part of the claims that they send to Medicare contractors (carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (MACs)).

Provider action needed

In this article, the Centers for Medicare & Medicaid Services (CMS) outlines guidance to help reduce the amount of claims being denied and/or not accepted by state Medicaid agencies in conjunction with the national coordination of benefits agreement (COBA) Medicare claims crossover process.

CMS is providing this guidance in an effort to improve the effectiveness of the Medicare claims crossover process.

(continued on next page)

Crossover *(continued)*

Background

Currently, many payers use both the 11-digit national drug code (NDC), reported in the 5-4-2 format, and the associated Healthcare Common Procedure Coding System (HCPCS) code for claims adjudication that include billing for physician-administered drugs. In accordance with the Deficit Reduction Act (DRA) of 2005 and its subsequent implementing regulation, as found in 42 *Code of Federal Regulations* (CFR) 447 Section 520, state Medicaid agencies must include information on individual NDCs directly related to physician-administered drugs when sending their billing to drug manufacturers to claim drug rebates under the Title XIX program. Such information is normally available to state Medicaid agencies through the national COBA Medicare claims crossover process, by which Medicare automatically transfers fully-adjudicated Medicare claims to title XIX Medicaid agencies for their supplemental, or tertiary, payment consideration.

Through ongoing discussions with title XIX Medicaid agencies, CMS has determined that physician offices, outpatient hospital departments, and outpatient clinics do not always include a one-to-one reporting of an NDC for each Part B drug HCPCS (e.g., J3140) code reported on incoming Medicare claims. This trend was found mostly on multi-line claims. Consequently, the Medicaid agencies are either denying the COBA Medicare crossover claims that report Part B drug HCPCS codes without corresponding NDCs, or developing the required information with physicians and outpatient hospital and clinic providers.

Key points

Billing of NDCs on Health Insurance Portability and Accountability Act (HIPAA) 837 institutional claims sent to Medicare

When physician billing offices and hospital outpatient departments and outpatient clinic billing offices determine that their patients are: 1) dually entitled to Medicare and Medicaid, and 2) have received physician-administered drugs as part of a medical encounter, they should bill the physician-administered drug(s) on the resulting claims to Medicare as follows:

- For each line level reporting of a Part B physician-administered drug, continue to report the associated HCPCS (e.g., J3140) in 2400 SV202-2, with SV202-1=HC, and
- For each Part B drug HCPCS reported in 2400 SV202-2, complete the required associated 2410 LIN and CPT04 segments as follows:
  - Include the NDC in 2410 LIN03, with LIN02=N4
  - Include the quantity/unit count in 2410 CPT04, and
  - Input the needed information in 2410 CPT05 and CPT05-1

Billing NDCs on incoming CMS-1500 or UB04 hardcopy claims to Medicare

- Most physicians and providers may realize that Medicare transforms incoming CMS-1500 or UB04 hardcopy claims into their electronic equivalent HIPAA 837 professional and institutional formats as part of the Medicare claims crossover process. CMS previously issued guidance to physicians and providers about the reporting of NDCs and associated information (i.e., qualifier for NDC and qualifier for quantity/units, as well as reporting of quantity/unit count, including fractional units) on hardcopy CMS-1500 and UB04 claim formats during 2008. These directions, which remain unchanged, may be reviewed in:
  - *MLN Matters*® article MM5930, "Medicare Shared Systems Modifications Necessary to Capture and Crossover Medicaid Drug Rebate Data Submitted on Form UB 04 Paper Claims and Direct Data Entry (DDE) Claims," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5950.pdf*; and
  - *MLN Matters*® article MM5835, "Medicare Shared Systems Modifications Necessary to Accept and Crossover to Medicaid National Drug Codes (NDC) and Corresponding Quantities Submitted on CMS-1500 Paper Claims," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5835.pdf*.

Billing of NDCs via direct data entry (DDE) claims screen

- Outpatient hospital departments and outpatient clinics that bill via DDE and are experiencing non-acceptance and/or denial of Medicare crossover claims by state Medicaid agencies due to missing NDCs should contact their designated MAC or FI for assistance.

(continued on next page)

Crossover *(continued)*

Additional information

If you have any questions, please contact your carrier, FI, or 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*.

MLN Matters® Number: SE1234
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: September 5, 2012
Related CR Transmittal #: NA
Implementation Date: September 5, 2012

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.

Recoupment of Part B payments on inpatient admissions

Beginning August 31, 2012, First Coast Service Options Inc. (First Coast) began issuing notification letters advising Part B surgeons of the intent to recoup Part B payment. This is not an overpayment demand letter. The Part B surgeons will receive in a future correspondence the overpayment demand letter, which includes guidance regarding appeal rights. Here is an example of the notification letter:

Re: OVERPAYMENT RECOUPMENT ACTION
Beneficiary Name: [redacted]
HIC: [redacted]
ICN: [redacted]
Date(s) of Service: [redacted]

Dear Provider:

First Coast Service Options, Inc. (FCSO) serves as the Medicare Administrative Contractor (MAC) for Jurisdiction 9 (J9) which includes Florida, Puerto Rico and U.S. Virgin Islands. One of the primary responsibilities of the MAC is to prevent improper payments. The Centers for Medicare and Medicaid Services utilize the Comprehensive Error Rate Testing (CERT) program to measure improper payments made by the Medicare Fee-for-Service program. For more information regarding the CERT program, you can go to the following FCSO link: http://medicare.fcso.com/Landing/203608.asp.

One of the primary drivers of CERT payment errors nationally and in J9 involves inpatient hospital services where the patient was admitted for an inpatient procedure or required a procedure during hospitalization and documentation submitted by the hospital (e.g., physician H&P, progress notes, operative reports, etc.) failed to support medical necessity for the procedure. In some cases, the procedure(s) in question is subject to medical necessity requirements defined in national coverage determinations (NCD) and/or local coverage determinations (LCD). For more information on this issue go to http://medicare.fcso.com/CERT/index.asp and click on the link for "Improper Payments and Inpatient Prepayment Medical Review."

Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, Section 180 states that services "related to" noncovered services, including services that are not covered because they are determined to be not reasonable and necessary, are not covered services under Medicare. Therefore, FCSO has initiated overpayment recoupment of the Part B services performed by the surgeon, co-surgeon and assistant surgeon (as applicable) for the patient on the above identified date of service based on a medical necessity denial of the corresponding inpatient DRG claim.

This letter serves to notify you of the intent to recoup Part B payment. This is not an overpayment demand letter. You will receive the overpayment demand letter which includes your appeal rights in a future correspondence.

Implementation of award for the jurisdiction 5 Medicare administrative contractor

Background

The Centers for Medicare & Medicaid Services (CMS) is required to compete each A/B MAC workload at least once every five years. It recently did so for the J5 A/B MAC workload as well as the Title 18 legacy workload being processed by Wisconsin Physicians Service (WPS) under its Medicare Title 18 contract. CMS awarded this workload to WPS, the incumbent contractor for all of these workloads.

WPS address is:

Wisconsin Physicians Service

1751 West Broadway

Madison, WI 53713

CMS has determined that it will not need to change the current J5 A/B MAC workload numbers when the new contract is implemented. However, the reprocurement also included an existing Title 18 workload whose contractor workload number will need to be changed. This change is being made because CMS needs to identify each MAC workload using a standardized numbering system.

The workload number shall be changed and the WPS legacy Title 18 workload shall be transitioned to the J5 A/B MAC as indicated below.

Workload description: WPS Legacy

MAC workload number: 05901

Effective date: October 22, 2012

Current contractor workload no.: 52280

The following applications or business owners shall continue to accept the current J5 A/B MAC workload number as well as the new J5 A/B workload number once the above cited workload is transitioned to the J5 A/B MAC:

- CMS Analysis, Reporting and Tracking System (CMS ARTS)
- Contractor Administrative, Budget and Cost Reporting System (CAFM)
- Comprehensive Error Rate Testing System (CERT)
- Contractor Management Information System (CMIS)
- CMS Baltimore Data Center
- Coordination of Benefits Agreement program (COBA)
- Coordination of Benefits Contractor (COBC)
- Contractor Reporting of Operational Workload Data System (CROWD)
- Common Working File (CWF)
- CWF Part B Eligibility and Security Maintenance (CWF ELGE)
- Customer Service Assessment and Management System (CSAMS)
- Debt Collection System (DCS)
- Electronic Correspondence Referral System (ECRS)
- Electronic Health Records Incentive Program (EHR)
- Enterprise Data Centers (EDCs)
- Expert Claims Processing System (ECPS)
- Fiscal Intermediary Shared System (FISS)
- Health Care Information System (HCIS)
- Healthcare Integrated General Ledger Accounting System (HIGLAS)
- Health Insurance Master Record (HIMR)
- Intern and Resident Information System (IRIS)
- Local Coverage Determination Database (LCD)

(continued on next page)

Contractor *(continued)*

- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Multi-Carrier System (MCS)
- National Data Warehouse (NDW)
- National Level Repository (NLR)
- National Part B Pricing Files
- National Provider Identifier Crosswalk (NPI)
- Next Generation Desktop (NGD)
- Part B Analytics Reporting System (PBAR)
- Physician/Supplier Overpayment report (PSOR)
- Production Performance Monitoring System (PULSE)
- Provider Enrollment, Chain, and Ownership System (PECOS)
- Provider Customer Service Program Contractor Information Database (PCID)
- Provider Inquiry Evaluation System (PIES)
- Program Integrity Management Reporting System (PIMR)
- Program Safeguard Contractor (PSC)
- Provider Overpayment Reporting System (PORS)
- Provider Statistical and Reimbursement System (PS and R)
- Quality Improvement Evaluation System (QIES)
- Recovery Auditors (RA)
- Recover Management and Accounting System (REMAS)
- Renal Management Information System (REMIS)
- System Tracking for Audit and Reimbursement (STAR)
- ZIP Code File
- Zone Program Integrity Contractors (ZPICs)

Policy

N/A

Source: Pub. 100-20, Transmittal: 1119, CR 8059

Quarterly provider update

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

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

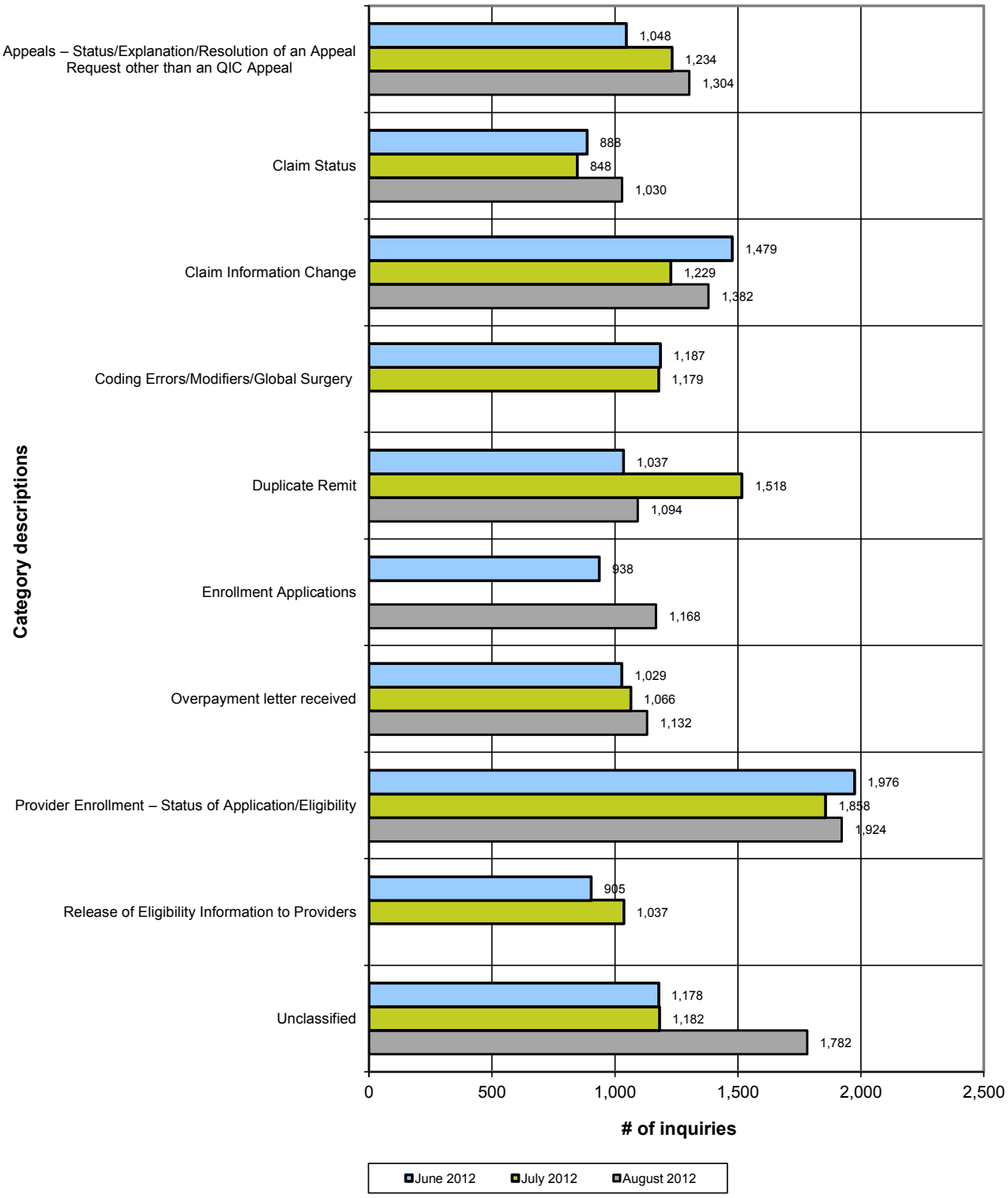
CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at *http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html.*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

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. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during June-August 2012.

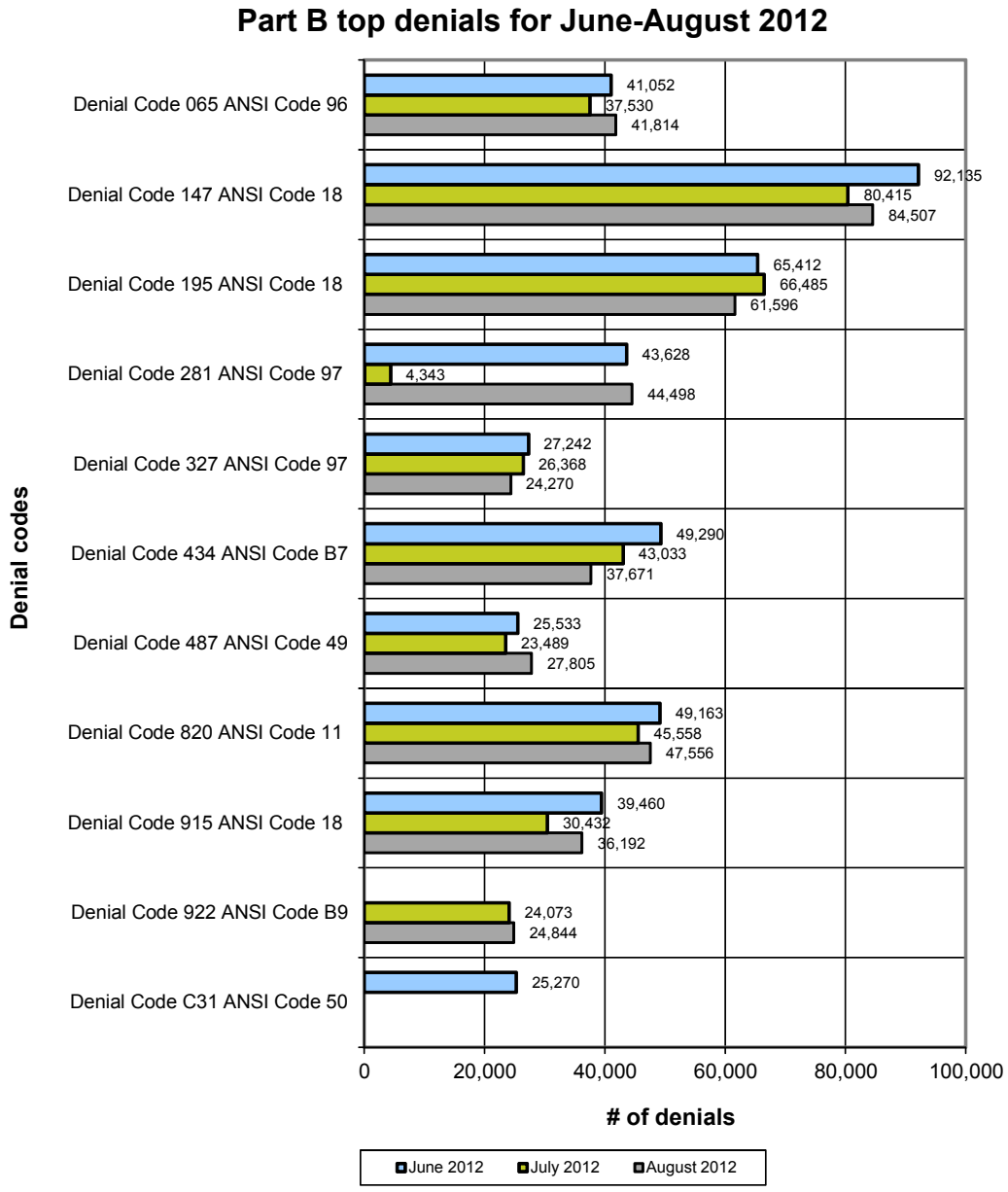
For tips and resources to help providers avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Part B top inquiries for June-August 2012



(continued on next page)

Top *(continued)*



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.

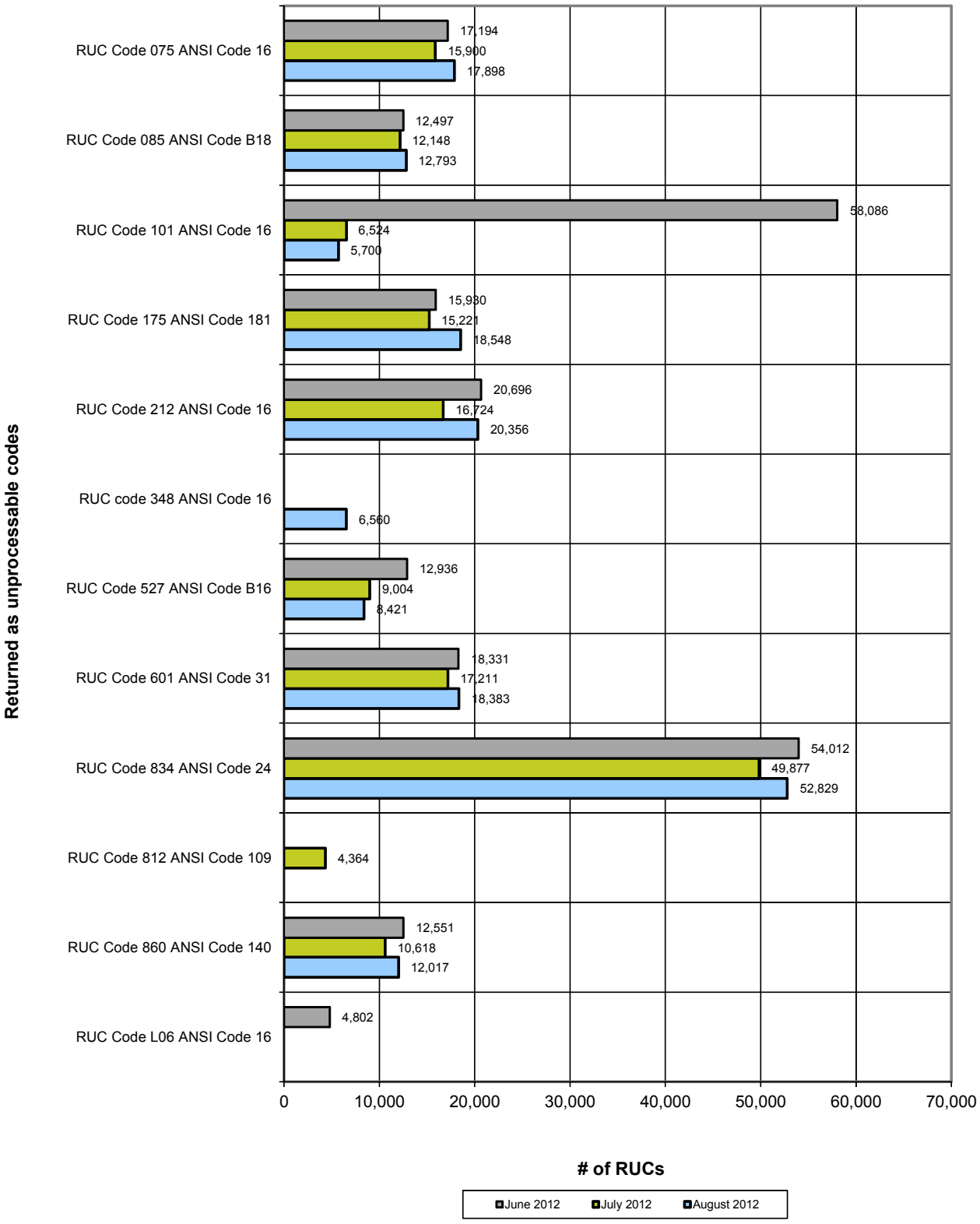
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

Refer to the *Claim completion FAQs*, *Billing issues FAQs*, and *Unprocessable FAQs* on the First Coast 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 June-August 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 First Coast eNews mailing list. Simply go to

http://medicare.fcso.com/Header/137525.asp, enter your email address and select the subscription option that best meets your needs.

More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

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

Revisions to LCDs

J2778: Ranibizumab (Lucentis®) – revision to the LCD

LCD ID number: L29266 (Florida)
LCD ID number: L29383 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ranibizumab (Lucentis®) was most recently revised June 14, 2011. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was updated to include a new indication approved by the Food and Drug Administration (FDA) for Lucentis® August 10, 2012, for the treatment of diabetic macular edema (DME). Also, changes were made to clarify the language in the "Limitations" section of the LCD related to chronic blepharitis versus ocular or peri-ocular infection. In addition, the "Sources of Information and Basis for Decision" section of the LCD was also updated.

Effective date

This LCD revision is effective for claims processed **on or after September 13, 2012**, for services rendered **on or after August 10, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "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*.

J9055: Cetuximab (Erbitux®) – revision to the LCD

LCD ID number: L29097 (Florida)
LCD ID number: L29112 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cetuximab (Erbitux®) was most recently revised November 7, 2011. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was updated to include the following new Food and Drug Administration (FDA) approved labeled indications:

- Indication of K-Ras mutation-negative (wild-type), EGFR-expressing, metastatic colorectal cancer as determined by FDA-approved tests. Erbitux is not indicated for treatment of K-Ras mutation-positive colorectal cancer.
- Also, Cetuximab is indicated for use in combination with Folfiri for first-line treatment as determined by FDA-approved tests for this use. FDA also approved the Therascreen KRAS RGQ PCR Kit (QIAGEN Manchester, Ltd) concurrent with this cetuximab approval.

In addition, the "Sources of Information and Basis for Decision" section of the LCD was also updated.

Effective date

This LCD revision is effective for claims processed **on or after September 11, 2012**, for services rendered **on or after July 6, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "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*.

22533: Lumbar spinal fusion for instability and degenerative disc conditions – revision to the LCD

LCD ID number: L32076 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for lumbar spinal fusion for instability and degenerative disc conditions was most recently revised January 1, 2012. Since that time, the LCD was revised based on an external reconsideration request. The LCD was revised to clarify language under the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after September 4, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "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*.

Additional Information

Clarification of the proper use and billing of adenosine injections

First Coast Service Options Inc. has been made aware of a potential billing concern where providers may be purchasing generic equivalents for Adenocard® (HCPCS code J0150) for use and billing under HCPCS code J0152 (Adenoscan®) in error. As a reminder, drugs approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective when used for indications specified on the labeling, and providers are required to code services billed for Medicare reimbursement according to the most accurate code descriptor for the service they are reporting. Per the American Medical Association (AMA) 2012 HCPCS Level II coding book, the following descriptors indicate Adenocard (HCPCS code J0150) is intended for therapeutic use, and Adenoscan® (HCPCS code J0152) is intended for diagnostic use.

- HCPCS code J0150 injection national drug code (NDC): Adenocard® (adenosine injection), is for therapeutic use and is indicated for conversion to sinus rhythm of paroxysmal supraventricular tachycardia (PSVT), including that associated with accessory bypass tracts (Wolff-Parkinson-White Syndrome). Adenocard® is supplied in 6 mg (2ml) and 12 mg (4ml) prefilled syringes.
- HCPCS code J0152 injection NDC: Adenoscan® (adenosine injection), is for diagnostic use and is indicated as an adjunct to thallium-201 myocardial perfusion scintigraphy in patients unable to exercise adequately. Adenoscan® is supplied in 60 mg (20 ml) and 90 mg (30 ml) single use vials developed for individual procedures.

Please note that per the HCPCS 2012 Level II coding book, adenosine phosphate compounds should be billed using HCPCS code A9270 (Non-covered item or service).

The average sales price (ASP) based payment system is designed to align payments more closely to providers' acquisition costs. A particular NDC should therefore be billed under the HCPCS code to which that NDC is assigned. Providers are encouraged to perform a self-audit and when appropriate, submit voluntary overpayments within 45 days of this notice.

Educational Events

Upcoming provider outreach and educational events
November 2012

Medicare "ask-the-Contractor" teleconference (ACT): Part B claim edits for ordering/referring providers

When: Thursday, November 15
Time: 2:00-3:30 p.m.

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

Two easy ways to register

Online – Visit our provider training website at *www.fcsouniversity.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to 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 First Coast Medicare training website and explore our catalog of online courses.

Educational Resources

CMS Medicare Provider e-News

The Centers for Medicare & Medicaid Services (CMS) Medicare Provider e-News is an official *Medicare Learning Network*® (*MLN*)-branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate. 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 Medicare FFS Provider e-News': August 22, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-22e-News.pdf*
- CMS e-News for Wednesday, August 29, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-29-e-News.pdf*
- 'CMS Medicare FFS Provider e-News': September 5, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-05e-News.pdf*
- 'CMS Medicare FFS Provider e-News': September 12, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-12-e-News.pdf*
- 'CMS Medicare FFS Provider e-News': September 19, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-19-e-News.pdf*

Source: CMS PERL 201208-09, 201208-12, 201209-02, 201209-03, 201209-07

Find out first: Subscribe to First Coast *eNews*

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

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. (First Coast), 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. (First Coast), 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 First Coast Service Options Inc. 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