Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers October 2012

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Influenza vaccine payment allowances – annual update for 2012-2013 season

Provider types affected

This *MLN Matters*® article is intended for physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and Part A/B Medicare administrative contractors (A/B MACs)) for influenza vaccines provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8047 in order to update payment allowances, effective August 1, 2012, for seasonal influenza virus vaccines when payment is based on 95 percent of the average wholesale price (AWP). Be sure your billing staffs are aware of this update.

Background

CR 8047 provides payment allowances for the following seasonal influenza virus vaccine codes when payment is based on 95 percent of the AWP (except for when payment is based on reasonable cost where the vaccine is furnished in a hospital outpatient department, a rural health clinic, or a federally qualified health center):

- *Current Procedural Terminology* (*CPT*) codes *90654, 90655, 90656, 90657, 90660*, and *90662*; and
- Healthcare Common Procedure Coding System (HCPCS) codes Q2034, Q2035, Q2036, Q2037, and Q2038.

Effective for dates of service on or after August 1, 2012, the Medicare Part B payment allowance for:

- *CPT 90655* is $16.456
- *CPT 90656* is $12.398
- *CPT 90657* is $6.023
- HCPCS Q2035 (Afluria®) is $11.543
- HCPCS Q2036 (Flulaval®) is $9.833
- HCPCS Q2037 (Fluvirin®) is $14.051
- HCPCS Q2038 (Fluzone®) is $12.046

Note: The Medicare Part B payment allowance for HCPCS Q2034 (Agriflu®) and HCPCS Q2039 (Flu vaccine adult - not otherwise classified) will be determined by the local claim processing contractor.

Payment for the following may be made if the local claim processing contractor determines its use is medically reasonable and necessary for the beneficiary:

- *CPT 90654* (Flu vaccine, intradermal, preservative free (Fluzone ID®));

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

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

Diagnostic Services

Documentation deficiencies in interpretation and report of diagnostic imaging services

Seventy percent of plain film studies, computed tomography, and magnetic resonance imaging scans did not follow one or more documentation practice guidelines promoted by the American College of Radiology (ACR), according to a 2008 Office of Inspector General (OIG) report. Three major documentation deficiencies missing from the interpretation and reports as noted by the OIG were: the time the exam was performed, the time the report was dictated and the date the report dictated.

Medicare expects the radiologist's report (may be on separate paper or within the body of the patient's record) to follow the ACR guidelines and include a minimum of the following:

- The name of the patient and other identification such as birth date and social security number
- The name of referring physician, if any
- The name or type of examination performed
- The date on which the X-ray was performed
- The name of the interpreting physician
- Authentication of non-handwritten note (e.g., legible initials, legible signature, electronic signature, etc.)
- The body of the report
  - Procedure and materials
  - Findings
  - Limitations
  - Clinical Issues
  - Comparative data, if indicated
- The diagnosis:
  - A prescribing diagnosis should be provided when possible
  - A differential diagnosis should be provided when appropriate

Documentation is essential to establish that the results of the interpretation and report were communicated in a timely manner to the treating physician in the emergency department. First Coast Service Options is encouraging providers to review their current documentation practices. The ACR Practice Guideline for Communication of Diagnostic Imaging Findings may be found at: *ACR Practice Guideline for Communication of Diagnostic Imaging Findings*.

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.

Drugs & Biologicals

Influenza *(continued from page 1)*

- *CPT 90660* (FluMist®, a nasal influenza vaccine); or
- *CPT 90662* (Fluzone high-dose®).

Effective for dates of service on or after August 1, 2012, when payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for:

- *CPT 90654* is $18.981
- *CPT 90660* is $23.456
- *CPT 90662* is $30.923

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files.

Note: Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

Additional information

The official instruction, CR 8047, issued to your Medicare contractor (carrier, (FI), and A/B MAC) regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2562CP.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: MM8047
Related Change Request (CR) #: CR 8047
Related CR Release Date: October 3, 2012
Effective Date: August 1, 2012
Related CR Transmittal #: R2562CP
Implementation Date: No later than December 28, 2012

Annual clotting factor furnishing fee update 2013

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers billing Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services related to the administration of clotting factors to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8049 and announces that for calendar year 2013, the clotting factor furnishing fee of $0.188 per unit is included in the published payment limit for clotting factors. For dates of service in 2013, the clotting factor furnishing fee of $0.188 per unit is added to the payment when no payment limit for the clotting factor is included in the average sales price (ASP) or not otherwise classified (NOC) drug pricing files. Please be sure your billing staffs are aware of this fee update.

Background

Section 1842(o)(5)(C) of the Social Security Act (added by the Medicare Modernization Act Section 303(e)(1)) requires, beginning January 1, 2005, that a clotting factor furnishing fee be paid separately if you furnish clotting factor; unless the costs associated with furnishing the clotting factor are paid through another payment system.

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the ASP Medicare Part B drug pricing file, or the NOC pricing file; your carrier, FI, RHHI, or A/B MAC must make payment for the clotting factor as well as make payment for the furnishing fee.

The clotting factor furnishing fees applicable for dates of service in each calendar year (CY) are listed below:

Clotting factor	Furnishing fee
CY 2005	$0.140 per unit
CY 2006	$0.146 per unit
CY 2007	$0.152 per unit
CY 2008	$0.158 per unit
CY 2009	$0.164 per unit
CY 2010	$0.170 per unit
CY 2011	$0.176 per unit
CY 2012	$0.181 per unit
CY 2013	$0.188 per unit

Additional information

The official instruction, CR 8049 issued to your Medicare carrier, FI, RHHI, or A/B MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2554CP.pdf*.

If you have any questions, please contact your carrier, FI, RHHI, 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: MM8049
Related Change Request (CR) #: 8049
Related CR Release Date: September 28, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2554CP
Implementation Date: January 7, 2013

Durable Medical Equipment

Reasonable charge update for 2013 for splints, casts, and certain intraocular lenses

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers billing Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs)) for splints, casts, and certain intraocular lenses provided to Medicare beneficiaries.

What you need to know

This article, based on change request (CR) 8051, instructs Medicare contractors regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in calendar year (CY) 2013.

Background

Payment continues to be made on a reasonable charge basis for splints and casts, as well as intraocular lenses implanted in a physician's office.

- For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.
- For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office (codes V2630, V2631, and V2632).

The 2013 payment limits for splints and casts will be based on the 2012 limits that were announced in CR 7628 last year, increased by 1.7 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2012. (You may view the article related to CR 7628 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//MM7628.pdf*.) The IIC update factor for 2013 is 1.7 percent.

A list of the 2013 payment limits for splints and casts is as follows:

2013 Payment Limits for Splints and Casts							
Code	**Allowance**	**Code**	**Allowance**	**Code**	**Allowance**	**Code**	**Allowance**
A4565	$8.26	Q4013	$15.13	Q4026	$113.30	Q4039	$7.91
Q4001	$47.00	Q4014	$25.51	Q4027	$18.15	Q4040	$19.77
Q4002	$177.62	Q4015	$7.57	Q4028	$56.67	Q4041	$19.20
Q4003	$33.75	Q4016	$12.75	Q4029	$27.75	Q4042	$32.78
Q4004	$116.86	Q4017	$8.75	Q4030	$73.05	Q4043	$9.61
Q4005	$12.45	Q4018	$13.94	Q4031	$13.87	Q4044	$16.39
Q4006	$28.05	Q4019	$4.38	Q4032	$36.52	Q4045	$11.15
Q4007	$6.23	Q4020	$6.98	Q4033	$25.88	Q4046	$17.93
Q4008	$14.02	Q4021	$6.47	Q4034	$64.38	Q4047	$5.56
Q4009	$8.31	Q4022	$11.68	Q4035	$12.94	Q4048	$8.97
Q4010	$18.70	Q4023	$3.25	Q4036	$32.20	Q4049	$2.03
Q4011	$4.15	Q4024	$5.84	Q4037	$15.79	Q4012	$9.36
Q4025	$36.29	Q4038	$39.56				

Medicare contractors will make payments for splints and casts furnished in 2013 based on the lower of the actual charge or the above payment limits.

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Splints *(continued)*

The official instruction, CR 8015, 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/R2565CP.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*.

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Effective Date: January 1, 2013
Related CR Transmittal #: R2565CP
Implementation Date: January 7, 2013

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Bidding for the Round 1 Recompete of the DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) is soliciting bids for the Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

All bids must be submitted in DBidS, the online bidding system, before 9:00 p.m. prevailing Eastern Time on December 14, 2012. All required hardcopy documents that must be included as part of the bid package must be received by the Competitive Bidding Implementation Contractor (CBIC) on or before December 14, 2012. The contract period for the Round 1 Recompete is January 1, 2014-December 31, 2016.

All bidders must submit certain required hardcopy documents as specified in the *Request for Bids (RFB) Instructions*. CMS urges all bidders to take advantage of the covered document review process. Under this process, we will notify suppliers that submit their hardcopy financial documents by the covered document review date (CDRD) of any missing financial documents. The CDRD for the Round 1 Recompete is November 14, 2012 – financial documents must be received on or before November 14, 2012, to qualify for the covered document review process. This process only determines if there are any missing financial documents. It does not indicate if the documents are acceptable, accurate, or meet applicable requirements. Suppliers that submit financial documents by the CDRD will be notified of any missing financial documents within 90 days of the CDRD. Suppliers will be required to submit the missing financial document(s) within 10 business days of the notification.

Competitive bidding areas and product categories for the Round 1 Recompete, DBidS information, bid preparation worksheets, educational materials, and complete RFB instructions can be found on the CBIC website. Suppliers should review this information prior to submitting their bids. CMS will send important bidding updates via e-mail, so all suppliers interested in bidding are urged to sign up for email updates on the CBIC website at *www.DMECompetitiveBid.com*. If you have any questions about the bidding process, please contact the CBIC customer service center at 1-877-577-5331.

The target registration dates for authorized officials (AOs) and backup authorized officials (BAOs) to register for a user ID and password have passed. Only suppliers that have registered in IACS and received a user ID and password will be able to access the online bidding system and submit bids. If your AO did not register, you cannot bid and will not be eligible for a contract.

Registration closed on October 19, 2012 – no AOs, BAOs, or EUs can register after registration closes. Suppliers that have not registered cannot bid and are not eligible for contracts. If you have any questions about the registration process, please contact the CBIC customer service center.

To bid, visit the CBIC website and click on Round 1 Recompete. Next click “BIDDING IS OPEN” above the clocks.

Please note that the RFB instructions initially posted on the CBIC website contained target bid submission deadlines. CMS is in the process of updating these instructions to reflect the actual bid submission deadlines, which are shown in this announcement.

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

Source: CMS PERL 201210-05

Education materials for Round 1 Recompete bidders

New educational materials for the Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program are now available on the Competitive Bidding Implementation Contractor (CBIC) website at *www.DMECompetitiveBid.com*. CMS urges all bidders to take advantage of these new materials as well as the many other helpful tools and resources on the CBIC website.

First, the *Quick Step by Step User Guide* to Submitting a Bid DBidS has been issued. This guide provides step-by-step instructions for using the DMEPOS Bidding System (DBidS), the online bidding system.

Second, three new educational webcasts are now available for viewing. The first webcast, titled *Financial Documentation Requirements*, goes over the rules and requirements for the financial documents that you must submit in addition to your online bid. The second webcast, titled *How a Bid is Evaluated*, describes each step of the bid evaluation process, from receipt of electronic bid data and hardcopy documents through awarding of contracts. The final in this series of webcasts, titled *How to Submit a Bid*, explains how to submit a bid using the online bidding system, DBidS.

All webcasts are available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcasts, and a transcript for each webcast is also posted on the website. To view the webcasts, select Round 1 Recompete, then click *Educational Information*, and choose *Education Events*.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9:00 a.m. to 9:00 p.m. prevailing ET, Monday through Friday, throughout the registration and bidding periods.

Source: CMS PERL 201210-04

Laboratory/Pathology

New waived tests

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers billing Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services related to the administration of clotting factors to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 8054 which informs Medicare contractors that there are 36 newly-added waived tests. In addition, the new *CPT* code, *86803*QW, was assigned for the hepatitis C antibody test performed using the OraQuick HCV Rapid Antibody Test and OraQuick Visual Reference Panel.

Caution – what you need to know

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *CPT* codes that the Centers for Medicare & Medicaid Services (CMS) considers to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 8054, from which this article is taken, informs carriers and MACs about the latest new *CPT* codes that are subject to CLIA edits.

Go – what you need to do

Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

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Waived *(continued)*

Background

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level. If you do not have a valid, current Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare carrier or A/B MAC for a *Current Procedural Terminology* (*CPT*) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The *CPT* codes for the following new tests must have the modifier QW to be recognized as a waived test. (However, the tests mentioned on the first page of the list attached to CR 8054 (i.e., *CPT* codes *81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.)

CPT code	Effective date	Description
*86803*QW	November 29, 2011	OraQuick HCV Rapid Antibody Test and OraQuick Visual Reference Panel
*87809*QW	April 24, 2012	AdenoPlus (human eye fluid)
*81003*QW	May 8, 2012	McKesson 120 Urine Analyzer
*81003*QW	May 11, 2012	Acon Laboratories, Inc. Foresight U120 Urine Analyzer
*86294*QW	May 15, 2012	LifeSign Status BTA
*82055*QW	May 25, 2012	Alere Toxicology Services, iScreen Saliva Alcohol Test Strip
*82055*QW	May 25, 2012	American Screening Corporation, Reveal Saliva Alcohol Test Strip
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Cassette
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Cassette Amp/ Amphetamine
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Secobarbital Cassette
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Oxazepam Cassette
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Strip
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Strip Amp/Amphetamine
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Secobarbital Strip
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Oxazepam Strip
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (COC/Cocaine){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MET/Methamphetamine) {Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MDMA/ Methylenedioxymethamphetamine){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MOP/Morphine){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MTD/Methadone){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Morphine (2000){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (PCP/Phencyclidine){Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Notriptyline{Cup format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (COC/Cocaine){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MET/Methamphetamine) {Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MDMA/ Methylenedioxymethamphetamine){Dip card format}

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Waived *(continued)*

CPT code	Effective date	Description
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MOP/Morphine){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (MTD/Methadone){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Morphine (2000){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test (PCP/Phencyclidine){Dip card format}
G0434QW	May 29, 2012	BTNX Inc Rapid Response X-Press Drug Test Notriptyline{Dip card format}
*83036*QW	May 30, 2012	Bayer AICNow+ Professional Use
*87880*QW	June 7, 2012	Mooremedical Strep A Rapid Test - Dipstick
G0434QW	July 13, 2012	Ultimate Analysis Cup UA Cups
*86701*QW	July 20, 2012	bioLytical INSTI HIV-1 Antibody Test {Fingerstick Whole Blood}
G0433QW	July 20, 2012	OraSure Technologies OraQuick In-Home HIV Test {Oral Fluid}

The new *CPT* code, *86803*QW, has been assigned for the hepatitis C antibody test performed using the OraQuick HCV Rapid Antibody Test and OraQuick Visual Reference Panel.

Additional information

The official instruction, CR 8054, 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/R2553CP.pdf*.

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

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Medicare Physician Fee Schedule Database

October 2012 update to the Medicare physician fee schedule database

Note: This article was revised on October 1, 2012, to reflect a revised change request (CR). The CR changes include additional instructions clarifying the effective date for HCPCS code *43775*, which is June 27, 2012. The CR number, transmittal number and link to the CR are also changed. All other information is unchanged. This information was previously published in the September 2012 *Medicare B Connection*, Pages 9-10.

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).

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MPFSDB *(continued)*

Provider action needed

This article is based on CR 8017 which informs Medicare contractors that, in order to reflect appropriate payment policy in line with the calendar year (CY) 2012 Medicare physician fee schedule (MPFS) final rule, the MPFS database (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).

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 and 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 calendar year (CY) 2012 Medicare physician fee schedule (MPFS) final rule, the MPFS database (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 calendar year, 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.

Additional information

The official instruction, CR 8017, issued to your carrier, FI, A/B MAC, or RHHI regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2559CP.pdf*. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Radiology

Coding changes to ultrasound diagnostic procedures for transesophageal Doppler monitoring

Note: This article was rescinded because the related change request 7819 was rescinded. This information was previously published in the May 2012 *Medicare B Connection*, Page 17.

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Surgery

National coverage determination for transcatheter aortic valve replacement

Note: This article was revised on September 25, 2012, to reflect the revised change request (CR) 7897 issued on September 24. In this article, the CR release date, transmittal numbers, and the Web addresses for accessing the transmittals have been changed. All other information remains the same. This information was previously published in the August 2012 *Medicare B Connection*, Pages 7-10.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

Background

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

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Transcatheter *(continued)*

CR 7879, from which this article is taken announces that on May 1, 2012, CMS issued a NCD covering TAVR under CED and only when specific requirements are met.

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

CED coverage conditions with registry participation

1. It is furnished according to a Food and Drug Administration (FDA)-approved indication and when all of the following conditions are met:
   a. It is furnished with a complete aortic valve and implantation system that has received FDA premarket approval (PMA) for that system's FDA-approved indication
   b. Two cardiac surgeons have independently examined the patient face-to-face and evaluated the patient's suitability for open aortic valve replacement (AVR) surgery; and both surgeons have documented the rationale for their clinical judgment, and this rationale is available to the heart team
   c. The patient (preoperatively and postoperatively) is under the care of a heart team: a cohesive, multi-disciplinary, team of medical professionals that embodies collaboration and dedication across medical specialties to offer optimal patient-centered care
   d. It is furnished in a hospital with the appropriate infrastructure that includes (but is not limited to):
      - On-site heart valve surgery program
      - Cardiac catheterization lab or hybrid operating room/ catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering quality imaging

      - Non-invasive imaging such as echocardiography, vascular ultrasound, computed tomography (CT) and magnetic resonance (MR)
      - Sufficient space, in a sterile environment, to accommodate necessary equipment for cases with and without complications
      - Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures, and
      - Appropriate volume requirements per the applicable qualifications (specifically, for hospitals without TAVR experience and for those with experience performing the procedure), which follow.
2. Required qualifications for the hospitals and heart teams performing the procedure.

Hospitals <u>without</u> TAVR experience must have the following qualifications to begin a TAVR program:

a. ≥ 50 total AVRs in the previous year prior to TAVR, including ≥ 10 high-risk patients
b. ≥ Two physicians with cardiac surgery privileges, and
c. ≥ 1000 catheterizations per year, including ≥ 400 Percutaneous Coronary Interventions (PCIs) per year.

Heart teams <u>without</u> TAVR experience must include the following to begin a TAVR program:

a. A cardiovascular surgeon with: 1) ≥ 100 career AVRs including 10 high-risk patients; or, 2) ≥ 25 AVRs in one year; or, 3) ≥ 50 AVRs in two years; and which include at least 20 AVRs in the last year prior to TAVR initiation; and,
b. An interventional cardiologist with: 1) Professional experience with 100 structural heart disease procedures lifetime; or, 2) 30 left-sided structural procedures per year of which 60 percent should be balloon aortic valvuloplasty (BAV). Atrial septal defect and patent foramen ovale closure are not considered left-sided procedures, as well as
c. Additional members of the heart team such as echocardiographers, imaging specialists, heart failure specialists, cardiac anesthesiologists, intensivists, nurses, and social workers, and

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Transcatheter *(continued)*

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

Hospital programs with TAVR experience must have the following qualifications:

a. Maintain ≥ two physicians with cardiac surgery privileges

b. Perform ≥ 20 AVRs per year or ≥ 40 AVRs every two years, and

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

Heart teams with TAVR experience must have the following qualifications:

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

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

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

In addition, the heart team and hospital must be participating in a prospective, national, audited registry. The complete list of requirements for a qualifying registry can be found in the NCD, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R147NCD.pdf*. To date, CMS has approved one registry, the Transcatheter Valve Therapy Registry operated by the Society of Thoracic Surgeons and the American College of Cardiology.

Coverage conditions with clinical studies

For indications that are not approved by the FDA, CMS covers TAVR under CED when patients are enrolled in qualifying clinical studies. The clinical study requirements are available in the NCD, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R147NCD.pdf*. Approved studies are listed at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html*.

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

Coding requirements – professional claims

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

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

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

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

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

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Transcatheter *(continued)*

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

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

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

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

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

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

Coding requirements – inpatient hospital claims

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

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

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

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

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

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Transcatheter *(continued)*

Additional information

CR 7897 was issued to your Medicare contractor in two transmittals. The first transmittal modifies the *Medicare National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R147NCD.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2552CP.pdf*.

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

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Therapy Services

Reminders before completing the pre-approval of therapy services form

First Coast Service Options' (First Coast's) Medical Review department is returning a high volume of *pre-approval requests for therapy services forms* due to inaccurate, incomplete, or invalid information. Requests that are returned will not be processed. Corrections must be completed and a new request submitted. The following list has been developed to assist you in avoiding this situation.

These are some things you should check for before faxing or mailing your form:

- Verify that you are submitting the pre-approval request during your appropriate phase. Pre-approvals may not be submitted earlier than 15 days prior to the beginning of your applicable phase.
- Do not send in documentation without the completed pre-approval request form.
- Do not use your own coversheet when faxing the pre-approval form. The completed pre-approval form will serve as your coversheet.
- Do not split a single request into multiple faxes. All documentation for a single pre-approval request must be submitted together. Do not submit duplicate requests.
- Physical therapy (PT), occupational therapy (OT), or speech language pathology (SLP) must be checked on the pre-approval form to indicate the therapy discipline that the additional days are being requested for.
- If a patient is receiving multiple disciplines (e.g., OT, PT) that you are requesting additional therapy days for, two separate requests must be submitted.
- Provide the correct provider transaction access number (PTAN) and/or national provider identifier (NPI) of the applicable facility or individual depending on whether this is for a Part A facility/entity or Part B individual/performing provider. If listing a facility/entity, report the legal business name as reported to the Internal Revenue Service (IRS).
- You must include the name and telephone number of the person to contact regarding the pre-approval request.
- Providers and therapists that are currently on any type of corrective action (e.g., probe, prepayment review, probe, prepayment review, zone program integrity contractor, etc.) process are not exempt from prepayment review and should consider whether the pre-approval process is beneficial for your office. Regardless of whether you receive a confirmation for approval or denial of additional therapy days, once the services are rendered and a claim is submitted, First Coast will request the medical records for review prior to determining whether payment will be made.

General Coverage

Partial code freeze prior to ICD-10 implementation

Provider types affected

This *MLN Matters*® special edition article affects all Medicare fee-for-service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What you need to know

At a meeting on September 14, 2011, the ICD-9-CM Coordination & Maintenance (C&M) Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 which would end one year after the implementation of ICD-10. The implementation of ICD-10 was delayed from October 1, 2013, to October 1, 2014, by final rule CMS-0040-F August 24, 2012. This final rule is available at *http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html*.

There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made October 1, 2011.
- On October 1, 2012, and October 1, 2013, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by Section 503(a) of Pub. L. 108-173.
- On October 1, 2014, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by Section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
- On October 1, 2015, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2015 once the partial freeze has ended.

The code freeze was initially discussed at the September 15, 2010, meeting of the committee. To view the transcript of that meeting, go to *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html*. From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the "091510_Morning_Transcript" file. This section appears on page 4 of the 78-page document.

To view the Summary Report of the meeting, go to *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html*. From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the "091510_ICD9_Meeting_Summary_report.pdf" file. Information on the code freeze begins on page 5.

Additional information

CMS has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at *http://www.cms.gov/Medicare/Coding/ICD10/index.html*.

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Freeze *(continued)*

In addition, the following CMS resources are available to assist in your transition to ICD-10:

- **Medicare fee-for-service provider resources Web page:** This site links Medicare fee-for-service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this Web page. Bookmark *http://www.cms.gov/Medicare/Coding/ICD10/index.html* and check back regularly for access to ICD-10 implementation information of importance to you. **Note**: Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.
- **CMS-sponsored national provider conference calls**: During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit *http://www.cms.gov/Medicare/Coding/ICD10/index.html*.
- See *MLN Matters*® **special edition article, SE1239**, at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf* for an overview of what is needed to implement ICD-10.
- **Frequently asked questions (FAQs)**: To access FAQs related to ICD-10, please visit the CMS ICD-10 Web page at *http://www.cms.gov/Medicare/Coding/ICD10/index.html*, select the "Medicare Fee-for-Service Provider Resources" link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- Workgroup for Electronic Data Interchange (WEDI): *http://www.wedi.org*
- Health Information and Management Systems Society (HIMSS): *http://www.himss.org/icd10*

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Updated ICD-10 implementation information

Provider types affected

This *MLN Matters*® article is intended for all physicians, providers, suppliers, and other covered entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health care setting.

What you need to know

This *MLN Matters*® special edition article replaces article SE1019 and provides updated information about the implementation of the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/ICD-10-PCS) code sets to help you better understand (and prepare for) the United States health care industry's change from ICD-9-CM to ICD-10 for medical diagnosis and inpatient hospital procedure coding.

The ICD-10-related implementation date is October 1, 2014, as announced in final rule CMS-0040-F issued August 24, 2012. This final rule is available at *http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html*.

On October 1, 2014, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry.

Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

Background

ICD-10 implementation compliance date

On October 1, 2014, CMS will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets.

- ICD-10-CM diagnoses codes will be used by all providers in every health care setting.
- ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures.
- The compliance dates are firm and not subject to change.
  - There will be no delays.
  - There will be no grace period for implementation.

Important, please be aware:

- ***ICD-9-CM codes will not be accepted for services provided on or after October 1, 2014.***
- ***ICD-10 codes will not be accepted for services prior to October 1, 2014.***

  You **must** begin using the ICD-10-CM codes to report diagnoses from all ambulatory and physician services on claims with dates of service on or after October 1, 2014, and for all diagnoses on claims for inpatient settings with dates of discharge that occur on or after October 1, 2014.

  Additionally, you must begin using the ICD-10-PCS (procedure codes) for all hospital claims for inpatient procedures on claims with dates of discharge that occur on or after October 1, 2014.

Note: Only ICD-10-CM, not ICD-10-PCS, will affect physicians. ICD-10-PCS will only be implemented for facility inpatient reporting of procedures – it will not be used for physician reporting. There will be no impact on *Current Procedural Terminology*® (*CPT*®) and Healthcare Common Procedure Coding System (HCPCS) codes. You should continue to use these codes for physician, outpatient, and ambulatory services. Physician claims for services provided to inpatient patients will continue to report CPT and HCPCS codes.

What are the differences between the ICD-10-CM/ICD-10-PCS and ICD-9-CM Code Sets?

The differences between the ICD-10 code sets and the ICD-9 code sets are primarily in the overall number of codes, their organization and structure, code composition, and level of detail. There are approximately 70,000 ICD-10-CM codes compared to approximately 14,000 ICD-9-CM diagnosis codes, and approximately 70,000 ICD-10-PCS codes compared to approximately 4,000 ICD-9-CM procedure codes.

In addition, ICD-10 codes are longer and use more alpha characters, which enable them to provide greater clinical detail and specificity in describing diagnoses and procedures. Also, terminology and disease classification have been updated to be consistent with current clinical practice.

Finally, system changes are also required to accommodate the ICD-10 codes.

What are benefits of the ICD-10 coding system?

The new, up-to-date classification system will provide much better data needed to:

- Measure the quality, safety, and efficacy of care
- Reduce the need for attachments to explain the patient's condition
- Design payment systems and process claims for reimbursement
- Conduct research, epidemiological studies, and clinical trials
- Set health policy

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ICD-10 *(continued)*

- Support operational and strategic planning
- Design health care delivery systems
- Monitor resource utilization
- Improve clinical, financial, and administrative performance
- Prevent and detect health care fraud and abuse
- Track public health and risks

ICD-10-CM code use and structure

The ICD-10-CM (diagnoses) codes are to be used by all providers in all health care settings. Each ICD-10-CM code is three to seven characters, the first being an alpha character (all letters except U are used), the second character is numeric, and characters 3-7 are either alpha or numeric (alpha characters are not case sensitive), with a decimal after the third character. Examples of ICD-10-CM codes follow:

- A78 – Q fever
- A69.21 – Meningitis due to Lyme disease
- O9A.311 – Physical abuse complicating pregnancy, first trimester
- S52.131A – Displaced fracture of neck of right radius, initial encounter for closed fracture

Additionally, the ICD-10-CM coding system has the following new features:

1) Laterality (left, right, bilateral)

For example:

- C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast
- H16.013 – Central corneal ulcer, bilateral
- L89.022 – Pressure ulcer of left elbow, stage II

2) Combination codes for certain conditions and common associated symptoms and manifestations

For example:

- K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding
- E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
- I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

3) Combination codes for poisonings and their associated external cause

For example:

- T42.3x2S – Poisoning by barbiturates, intentional self-harm, sequela

4) Obstetric codes identify trimester instead of episode of care

For example:

- O26.02 – Excessive weight gain in pregnancy, second trimester

5) Character "x" is used as a 5th character placeholder in certain six character codes to allow for future expansion and to fill in other empty characters (e.g., character 5 and/or 6) when a code that is less than six characters in length requires a 7th character

For example:

- T46.1x5A – Adverse effect of calcium-channel blockers, initial encounter
- T15.02xD – Foreign body in cornea, left eye, subsequent encounter

6) Two types of excludes notes

Excludes 1 – Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).

For example:

- Q03 – Congenital hydrocephalus (Excludes1: Acquired hydrocephalus (G91.-)

Excludes 2 – Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).

- L27.2 – Dermatitis due to ingested food (Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)

7) Inclusion of clinical concepts that do not exist in ICD-9-CM (e.g., underdosing, blood type, blood alcohol level)

For example:

- T45.526D – Underdosing of antithrombotic drugs, subsequent encounter
- Z67.40 – Type O blood, Rh positive
- Y90.6 – Blood alcohol level of 120–199 mg/100 ml

8) A number of codes have been significantly expanded (e.g., injuries, diabetes, substance abuse, postoperative complications)

For example:

- E10.610 – Type 1 diabetes mellitus with diabetic neuropathic arthropathy
- F10.182 – Alcohol abuse with alcohol-induced sleep disorder

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ICD-10 *(continued)*

- T82.02xA – Displacement of heart valve prosthesis, initial encounter

9) Codes for postoperative complications have been expanded and a distinction made between intraoperative complications and postprocedural disorders

For example:

- D78.01 – Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen
- D78.21 – Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen

Finally, there are additional changes in ICD-10-CM, to include:

- Injuries are grouped by anatomical site rather than by type of injury
- Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM
- Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge
- New code definitions (e.g., definition of acute myocardial infarction is now four weeks rather than eight weeks)
- The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM.

To learn more about the ICD-10-CM coding structure you may review "Basic Introduction to ICD-10-CM" audio or written transcripts from the March 23, 2010, provider outreach conference call, which is available at *http://www.cms.gov/Medicare/Coding/ICD10/index.html*.

ICD-10-PCS code use and structure

The ICD-10-PCS codes are for use only on hospital claims for inpatient procedures. ICD-10-PCS codes are not to be used on any type of physician claims for physician services provided to hospitalized patients. These codes differ from the ICD-9-CM procedure codes in that they have 7 characters that can be either alpha (non-case sensitive) or numeric. The numbers 0 - 9 are used (letters O and I are not used to avoid confusion with numbers 0 and 1), and they do not contain decimals. For example:

- 0FB03ZX - Excision of liver, percutaneous approach, diagnostic
- 0DQ10ZZ - Repair, upper esophagus, open approach

Help with converting codes

The general equivalence mappings (GEMs) are a tool that can be used to convert data from ICD-9-CM to ICD-10-CM/PCS and vice versa. Mapping from ICD-10-CM/PCS codes back to ICD-9-CM codes is referred to as backward mapping. Mapping from ICD-9-CM codes to ICD-10-CM/PCS codes is referred to as forward mapping. The GEMs are a comprehensive translation dictionary that can be used to accurately and effectively translate any ICD-9-CM-based data, including data for:

- Tracking quality
- Recording morbidity/mortality
- Calculating reimbursement
- Converting any ICD-9-CM-based application to ICD-10-CM/PCS

The GEMs can be used by anyone who wants to convert coded data, including:

- All payers
- All providers
- Medical researchers
- Informatics professionals
- Coding professionals—to convert large data sets
- Software vendors—to use within their own products;
- Organizations—to make mappings that suit their internal purposes or that are based on their own historical data
- Others who use coded data

The GEMs are not a substitute for learning how to use the ICD-10 codes. More information about GEMs and their use can be found on the CMS website at *http://www.cms.gov/Medicare/Coding/ICD10/index.html* (select from the left side of the Web page ICD-10-CM or ICD-10-PCS to find the most recent GEMs).

Additional information about GEMs was provided on the following CMS sponsored conference call - May 19, 2009, "ICD-10 Implementation and General Equivalence Mappings" (*http://www.cms.gov/Medicare/Coding/ICD10/index.html*).

What to do now in preparation for ICD-10 implementation?

If you have not already done so, here are the steps you need to consider to implement ICD-10:

- Learn about the structure, organization, and unique features of ICD-10-CM - all provider types.

(continued on next page)

ICD-10 *(continued)*

- Learn about the structure, organization, and unique features of ICD-10-PCS - inpatient hospital claims.
- Learn about system impact and 5010.
- Use assessment tools to identify areas of strength/weakness in medical terminology and medical record documentation.
- Review and refresh knowledge of medical terminology as needed based on the assessment results.
- Provide additional training to refresh or expand knowledge in the biomedical sciences (anatomy, physiology, pathophysiology, pharmacology, and medical terminology).
- Plan to provide intensive coder training approximately 6 -9 months prior to implementation.
- Allocating 16 hours of ICD-10-CM training will likely be adequate for most coders, and very proficient ICD-9-CM coders may not need that much.

Additional information

To find additional information about ICD-10, visit *http://www.cms.gov/Medicare/Coding/ICD10/index.html*. In addition, CMS makes the following resources available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page**: This site links Medicare fee-for-service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this Web page. Bookmark *http://www.cms.gov/Medicare/Coding/ICD10/index.html* and check back regularly for access to ICD-10 implementation information of importance to you. Note: Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.
- **CMS-sponsored national provider conference calls**: During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration.

Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit *http://www.cms.gov/Medicare/Coding/ICD10/index.html*.

- **Frequently asked questions (FAQs)**: To access FAQs related to ICD-10, please visit the CMS ICD-10 Web page at *http://www.cms.gov/Medicare/Coding/ICD10/index.html*, select the “Medicare Fee-for-Service Provider Resources” link from the menu on the left side of the page, scroll down the page to the “Related Links Inside CMS” section and select “ICD-10 FAQs”. Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.
- See *MLN Matters*® special edition article, SE1240, at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1240.pdf* for a discussion of a partial freeze on ICD-10 code set prior to implementation.

The following organizations offer providers and others ICD-10 resources:

- Workgroup for Electronic Data Interchange (WEDI): *http://www.wedi.org*; and
- Health Information and Management Systems Society (HIMSS): *http://www.himss.org/icd10*.

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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.

ICD-10 conversion and related code infrastructure as it relates to NCDs

Provider types affected

This *MLN Matters*® article for change request (CR) 7818 is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers and A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on CR 7818, which creates and updates national coverage determination (NCD) hard-coded Medicare shared system edits that contain International Classification of Diseases, 9th Edition (ICD-9) diagnosis codes with comparable International Classification of Diseases, 10th Edition (ICD-10) diagnosis codes. The requirements described in CR 7818 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to numerous Medicare NCDs, which are identified in an attachment to CR 7818. In order to be prepared to meet the timeline to implement the new ICD-10 diagnosis codes October 1, 2014, the Medicare shared systems will begin implementation of the necessary changes to the NCDs in the January 2013, systems release. No DME MAC edits are included in this CR but will be addressed in subsequent CRs. All remaining changes to the Medicare shared systems, as they relate to Medicare NCDs, will be made in subsequent releases. See the *Background* and *Additional information* sections for further details regarding these changes and be sure that you are ready for ICD-10 implementation.

Background

On October 1, 2014, all Medicare claims submissions will convert from the ICD-9 to the ICD-10. The transition will require business and systems changes throughout the health care industry. All covered entities, as defined by the Health Insurance Portability and Accountability Act (HIPAA), must adhere to the conversion.

In accordance with HIPAA, the Secretary of the Department of Health and Human Services adopts standard medical data code sets for use in standard transactions adopted under this law. According to the ICD-10 final rule, published in the *Federal Register* of January 16, 2009 (see *http://www.gpo.gov/fdsys/pkg/FR-2009-01-16/pdf/E9-743.pdf*), the Secretary adopts the ICD-10-CM and ICD-10-PCS code sets for use in appropriate HIPAA standard transactions. Entities covered under HIPAA (which include Medicare and its providers submitting claims electronically) are bound by these requirements and must comply. Medicare will also require submitters of paper claims to use ICD-10 codes on their claims according to the same compliance date.

The purpose of CR 7818 is to both create and update NCD hard-coded Medicare shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes, plus all associated editing such as procedure codes, HCPCS/*CPT* codes, denial messages, frequency edits, place of service (POS)/type of bill (TOB)/provider specialty editing, etc. The requirements described in CR 7818 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the Medicare NCDs listed as an attachment to CR 7818.

Note: This exercise is in no way intended to expand, restrict, or alter existing Medicare national coverage. Also, it is not intended to minimize the authority granted to MACs in their discretionary implementation of NCDs or local coverage determinations (LCDs). However, where hard-coded edits were not initially implemented due to time and/or resource constraints, doing so at this time will better serve the intent and integrity of national coverage and the Medicare program overall.

Additional information

The official instruction, CR 7818 issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1122OTN.pdf*.

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

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Related Change Request (CR) #: CR 7818
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Revised and clarified place of service coding instructions

Note: This article was revised October 12 to reflect a revised change request (CR) 7631 issued October 11. The CR release date, transmittal number, and the Web address for accessing CR 7631 were revised. In addition, the article was revised October 4 & 5 adding a section regarding global surgery and discussions regarding registered inpatients and in hospital outpatient departments. POS code 26 (military treatment facility) was added to the list of facilities rate settings. Clarification on the POS for pathology services and independent laboratories will be provided through another CR. All other information is the same. This information was previously published in the April 2012 *Medicare B Connection*, Pages 50-53.

Provider types affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers and Medicare administrative contractors (A/B MACs)) for services paid for under the Medicare physician fee schedule (MPFS). This article also applies to certain services provided by independent laboratories.

What you need to know

This article is based on CR 7631. It revises and clarifies national policy for POS code assignment. Instructions are provided in CR 7631 regarding the assignment of POS for all services paid under the MPFS and for certain services provided by independent laboratories. In addition to establishing a national policy for the correct assignment of POS codes, instructions are provided for the interpretation or professional component (PC) and the technical component (TC) of diagnostic tests. Please make sure your billing staff is aware of these changes.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction includes a POS code from the POS code set maintained by the Centers for Medicare & Medicaid Services (CMS). Under Medicare, the correct POS code assignment is also required on the CMS-1500 form (or its electronic equivalent). While CMS currently maintains the national POS code set, it is used by all other public and private health insurers, including Medicaid.

At the time a POS code is developed, CMS determines whether a MPFS facility or non-facility payment rate is appropriate for that setting and Medicare contractors are required to make payment at the MPFS rate designated for each POS code. Under the MPFS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to beneficiaries. While Medicare contractors cannot create new POS codes, they are instructed to develop local policies that develop or clarify POS setting definitions in situations where national POS policy is lacking or unclear.

The importance of this national policy is underscored by consistent findings, in annual and/or biennial reports from calendar year (CY) 2002 through CY 2007, by the Office of the Inspector General (OIG) that physicians and other suppliers frequently incorrectly report the POS in which they furnish services. This improper billing is particularly problematic when physician and other suppliers furnish services in outpatient hospitals and in ambulatory surgical centers (ASCs). In a sample of paid services (for services possessing both non-facility and facility practice expenses), the OIG found a significant percent of the sampled physician/practitioner claims were incorrectly reported by physician/practitioners as occurring in the office POS when those services were furnished in outpatient hospitals or ASCs. As such, these claims were paid by the Medicare contractor at the non-facility rate – rather than the lower facility MPFS payment rate assigned to the POS codes for outpatient hospitals and ASCs.

The OIG has called on CMS to strengthen the education process and reemphasize to physicians (including non-physician practitioners and other suppliers) and their billing agents the importance of correctly coding the POS. Consequently, CR 7631 adds special considerations provisions regarding use of POS codes 22 and 24, for outpatient hospitals and ASCs.

A previous CMS instruction, Transmittal 1873 (now rescinded) regarding the assignment of POS codes, instructed physicians to use the two-digit POS code to describe where he/she was physically when rendering the service; in this instance, the POS code corresponded to the service location. (CMS-1500 form items 24B and 32, respectively, and the corresponding loops on the ANSI 12X N 837-P electronic format information). The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable “locality” and geographic practice cost index (GPCI)-adjusted payment for each service paid under the MPFS.

CR 7631 establishes that for all services – with two exceptions – paid under the MPFS, that the POS code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the

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POS *(continued)*

MPFS and anesthesia services, this rule will apply to the overwhelming majority of MPFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician/practitioner will be the setting in which the beneficiary received the (technical component (TC) of the service. For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary's MRI from his/her office location – POS code 22 will be used on the physician's claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

There are two exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as a registered inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service. The correct POS code assignment will be for that setting in which the beneficiary is receiving inpatient care or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22). In other words, reporting the inpatient hospital POS code 21 or the outpatient hospital POS code 22, is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient or an outpatient of a hospital respectively. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient (or hospital outpatient), the appropriate inpatient POS code (or appropriate outpatient POS code) may be reported consistent with the code list annotated in Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 26, Section 10.5. However, it is more important that the physician/practitioner report the POS consistent with the patient's general inpatient or outpatient hospital status than the precise inpatient/ outpatient POS code (in order to trigger the facility payment rate under the PFS). The *Medicare Claims Processing Manual* (Chapter 26) already requires this for physician services (and for certain independent laboratory services) provided to beneficiaries in the inpatient hospital and CR 7631 clarifies this exception and extends it to beneficiaries of the outpatient hospital, as well.

Facility and non-facility payment assignments

The list of settings where a physician's services are paid at the facility rate include:

- Inpatient hospital (POS code 21)
- Outpatient hospital (POS code 22)
- Emergency room-hospital (POS code 23)
- Medicare-participating ambulatory surgical center (ASC) for a Healthcare Common Procedure Coding System (HCPCS) code included on the ASC-approved list of procedures (POS code 24)
- Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24)
- Military treatment facility (POS code 26)
- Skilled nursing facility (SNF) for a Part A resident (POS code 31)
- Hospice – for inpatient care (POS code 34)
- Ambulance – land (POS code 41)
- Ambulance – air or water (POS code 42)
- Inpatient psychiatric facility (POS code 51)
- Psychiatric facility – partial hospitalization (POS code 52)
- Community mental health center (POS code 53)
- Psychiatric residential treatment center (POS code 56)
- Comprehensive inpatient rehabilitation facility (POS code 61)

Physicians' services are paid at non-facility rates for procedures furnished in the following settings:

- Pharmacy (POS code 01)
- School (POS code 03)
- Homeless shelter (POS code 04)
- Prison/correctional facility (POS code 09)
- Office (POS code 11)
- Home or private residence of patient (POS code 12)
- Assisted living facility (POS code 13)
- Group home (POS code 14)
- Mobile unit (POS code 15)
- Temporary lodging (POS code 16)
- Walk-in retail health clinic (POS code 17)
- Urgent care facility (POS code 20)
- Birthing center (POS code 25)
- Nursing facility and skilled nursing facilities (SNFs) to Part B residents - (POS code 32)
- Custodial care racility (POS code 33)
- Independent clinic (POS code 49)
- Federally qualified health center (POS code 50)
- Intermediate health care facility/mentally retarded (POS code 54)

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POS *(continued)*

- Residential substance abuse treatment facility (POS code 55)
- Non-residential substance abuse treatment facility (POS code 57)
- Mass immunization center (POS code 60)
- Comprehensive outpatient rehabilitation facility (POS code 62)
- End-stage renal disease treatment facility (POS code 65)
- State or local health clinic (POS code 71)
- Rural health clinic (POS code 72)
- Independent laboratory (POS code 81)
- Other place of service (POS code 99)

Special guidance for selected POS codes

CR 7631 adds clarifying or special consideration provisions for other settings as well. Those provisions are as follows:

Special considerations for mobile unit settings (code 15)

When services are furnished in a mobile unit, they are often provided to serve an entity for which another POS code exists. For example, a mobile unit may be sent to a physician's office or a SNF. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. However, if the mobile unit is not serving an entity which could be described by an existing POS code, the providers are to use the mobile unit POS code 15. Medicare will apply the non-facility rate to payments for services designated as being furnished in POS code 15 and apply the appropriate facility or non-facility rate for the POS code designated when a code other than the mobile unit code is indicated.

A physician or practitioner's office, even if mobile, qualifies to serve as a telehealth originating site. Assuming such an office also fulfills the requirement that it be located in either a rural health professional shortage area as defined under Section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or in a county that is not included in a metropolitan statistical area as defined in Section 1886(d)(2)(D) of the Social Security Act, the originating physician's office should use POS code 11 (office) in order to ensure appropriate payment for services on the list of Medicare Telehealth Services.

Special considerations for walk-in retail health clinic (code 17) (effective no later than May 1, 2010)

It should be noted that, while some entities in the industry may elect to use code 17 to track the setting of immunizations, Medicare continues to require its billing rules for immunizations claims, which are found in Chapter 18, Section 10 of the *Medicare Claims Processing Manual* found at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*.

Providers and suppliers of immunizations must continue to follow these Medicare billing rules. However, Medicare contractors will accept and adjudicate claims containing POS code 17, even if its presence on a claim is contrary to these billing instructions.

Special considerations for services furnished to registered inpatients

When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, will, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code list annotated in this section (instead of POS 21). For example, a physician/practitioner may use POS 31, for a patient in a SNF receiving inpatient skilled nursing care, POS 51, for a patient registered in a psychiatric inpatient facility, and POS 61 for patients registered in a comprehensive inpatient rehabilitation facility.

Special considerations for outpatient hospital departments

When a physician/practitioner furnishes services to an outpatient of a hospital, payment is made under the MPFS at the facility rate. Physicians/practitioners who furnish services to a hospital outpatient, including in a hospital outpatient department (including in a provider-based department of that hospital) or under arrangement to a hospital will, at a minimum, report the outpatient hospital POS code 22 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the outpatient hospital POS code 22 is a minimum requirement for purposes of triggering the facility payment amount under the PFS when services are provided to a registered outpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered hospital outpatient, the appropriate outpatient facility POS code may be reported consistent with the code list annotated in this section (instead of POS 22). For example, physicians/practitioners may use POS code 23 for services furnished to a patient registered in the emergency room, POS 24 for patients registered in an ambulatory surgical center, and POS 56 for patients registered in a psychiatric residential treatment center.

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POS *(continued)*

Note: Physicians/practitioners who perform services in a hospital outpatient department will use, at a minimum, POS code 22 (outpatient hospital). Code 22 (or other appropriate outpatient department POS code as described above) will be used unless the physician maintains separate office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65. Physicians will use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.6. Use of POS code 11(office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357.

Special consideration for ambulatory surgical centers (code 24)

When a physician/practitioner furnishes services to a patient in a Medicare-participating ASC, the POS code 24 (ASC) will be used.

Note: Physicians/practitioners who perform services in a Medicare-participating ASC will use POS code 24 (ASC). Physicians are not to use POS code 11 (office) for ASC based services unless the physician has an office at the same physical location of the ASC which meets all other requirements for operating as a physician office at the same physical location as the ASC – including meeting the "distinct entity" criteria defined in the ASC State Operations Manual that precludes the ASC and an adjacent physician office from being open at the same time – and the physician service was actually performed in the office suite portion of the facility. That information is in Appendix L of that manual which is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_l_ambulatory.pdf*.

Special considerations for Hospice (code 34)

When a physician/practitioner furnishes services to a patient under the hospice benefit, use the following guidelines to identify the appropriate POS.

When a beneficiary is in an "inpatient" respite or general "inpatient" care stay, the POS code 34 (hospice) will be used. When a beneficiary who has elected coverage under the Hospice benefit is receiving inpatient hospice care in a hospital, SNF, or hospice inpatient facility, POS code 34 (Hospice) will be used to designate the POS on the claim.

For services provided to a hospice beneficiary in an outpatient setting, such as the physician/nonphysician practitioner's office (POS 11); the beneficiary's home (POS 12), i.e., not operated by the hospice; or other outpatient setting (e.g., outpatient hospital (POS 22)), the patient's physician or nonphysician practitioner or hospice independent attending physician or nurse practitioner, will assign the POS code that represents that setting, as appropriate.

There may be use of nursing homes as the hospice patient's "home," where the patient resides in the facility but is receiving a home level of care. In addition, hospices are also operating "houses" or hospice residential entities where hospice patients receive a home level of care. In these cases, physicians and nonphysician practitioners, including the patient's independent attending physician or nurse practitioner, will use the appropriate POS code representing the particular setting, e.g., POS code 32 for nursing home, POS code 13 for an assisted living facility, or POS code 14 for group home.

Clarifications regarding global services

When a physician performs a diagnostic test under arrangement to a hospital and the test and the interpretation are not separately billable, the interpretation cannot be billed by the physician. In this scenario, the hospital is the only entity that can bill for the diagnostic test which encompasses the interpretation. There is no POS code for the interpretation since a physician claim is not generated.

Billing globally for services that are split into PC and TC components is only possible when the TC and the physician who provides the PC of the diagnostic service are furnished by the same physician or supplier entity and the PC and TC components are furnished within the same MPFS payment locality. Merely applying the same POS code to the PC as that of the TC does not permit global billing for any diagnostic procedure.

Clarification regarding determination of payment locality

Under the MPFS, payment amounts are based on the relative resources required to provide services and vary among payment localities as resource costs vary geographically as measured by the geographic practice cost indices (GPCIs). The payment locality is determined based on the location where a specific service code was furnished. For purposes of determining the appropriate payment locality, CMS requires that the address, including the ZIP code for each service code be included on the claim form in order to determine the appropriate payment locality. The location in which the service code was furnished is entered in item 32 on the CMS-1500 form (or its electronic equivalent).

Global service code

If the global diagnostic service code is billed, the biller (either the entity that took the test, physician who interpreted the test, or separate billing agent) must report the address and ZIP code of where the test was furnished on the bill for the global diagnostic service

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POS *(continued)*

code. In other words, when the global diagnostic service code is billed, for example, chest x-ray as described by HCPCS code 71010 (no modifier TC and no modifier -26), the locality is determined by the ZIP code applicable to the testing facility, i.e. where the TC of the chest x-ray was furnished. The testing facility (or its billing agent) enters the address and ZIP code of the setting/location where the test took place. This practice location is entered in item 32 on the CMS-1500 form (or its electronic equivalent). As explained above, in order to bill for a global diagnostic service code, the same physician or supplier entity must furnish both the TC and the PC of the diagnostic service and the TC and PC must be furnished within the same MPFS payment locality.

A listing of the current PFS locality structure, including state, locality area (and when applicable, counties assigned to each locality area) may be accessed from *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*. (Select "Medicare PFS Locality Configuration" from the menu on left.)

Separate billing of professional interpretation

If the same physician or other supplier entity does not furnish both the TC and PC of the diagnostic service, or if the same physician or other supplier entity furnishes both the TC and PC but the professional interpretation was furnished in a different payment locality from where the TC was furnished, the professional interpretation of a diagnostic test must be separately billed with modifier 26 by the interpreting physician.

When the physician's interpretation of a diagnostic test is billed separately from the technical component, as identified by modifier 26, the interpreting physician (or his or her billing agent) must report the address and ZIP code of the interpreting physician's location on the claim form. If the professional interpretation was furnished at an unusual and infrequent location for example, a hotel, the locality of the professional interpretation is determined based on the Medicare enrolled location where the interpreting physician most commonly practices. The address and ZIP code of this practice location is entered in item 32 on the CMS-1500 form (or its electronic equivalent).

Additional information

The official instruction, CR 7631, issued to your carrier and/or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2563CP.pdf*.

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

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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.

Review of Medicare payments exceeding charges for outpatient services for the period January 2008 through June 2009

The Office of Inspector General (OIG) recently completed a review of outpatient claims processed by First Coast Service Options Inc. (First Coast) in Jurisdiction 9 (J9) for the period January 1, 2008, through June 30, 2009. The OIG's goal with this review was to determine whether certain Medicare payments that First Coast made to providers in excess of charges for outpatient services were correct.

Medicare guidelines require providers to submit accurate claims for outpatient services. Medicare uses an outpatient prospective payment system (OPPS) to pay certain outpatient providers. With this method of reimbursement, the Medicare payment is not based on the amount the provider charges, therefore the billed charges generally do not affect the current Medicare prospective payment amounts. Billed charges usually exceed the Medicare payment amount; therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

Summary of findings

During the audit period, approximately 78 million line items for outpatient services were processed by First Coast. Of the 295 line items selected for review, 179 were correct. Providers refunded overpayments on three line items totaling more than $544K. The remaining 113 line items were incorrect and included overpayments totaling over $847K.

Of the 113 incorrect line items:

- Providers reported incorrect units of service on 71 line items, resulting in overpayments totaling more than $485K.
- Providers reported a combination of incorrect units of service claimed and incorrect Healthcare Common Procedure Coding System (HCPCS) codes on 29 line items, resulting in overpayments totaling nearly $206K.
- Providers used HCPCS codes that did not reflect the procedures performed on 10 line items, resulting in overpayments totaling nearly $151K.
- Providers did not provide the supporting documentation for three line items, resulting in overpayments totaling nearly $5,700.

Incorrect payments were made due to the following reasons:

- Providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors.
- The Medicare Fiscal Intermediary Shared System (FISS) and common working file (CWF) had insufficient edits in place during the audit to prevent or detect overpayments.

Issues identified as overpayments

- Incorrect number of units of service
  - **Example**: Incorrect service units for intravenous immune globulin treatment.
  - **Example**: Clerical error. Billed 500 units of service instead of 200.
- Combination of incorrect number of units of service and incorrect HCPCS codes
  - **Example**: Billed cancer treatment procedure with 440 units of service, however treatment coded incorrectly. A different code should have been billed with 15 units of service.
- Incorrect HCPCS
  - **Example**: Provider billed infusion therapy using incorrect chemotherapy injection code.
- Unsupported services
  - Providers did not provide supporting documentation.

First Coast implemented edits to address excessive charges; many of those edits were revised or implemented after the OIG audit concluded.

Provider education resources

Providers are responsible for ensuring that the appropriate HCPCS codes and units of service are billed correctly

(continued on next page)

2008 *(continued)*

for services rendered to Medicare beneficiaries, and are in accordance with coding guidelines. Providers are to use the appropriate HCPCS codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS is associated with a drug, the number of units administered.

The following resources provide information that will assist you with proper billing of outpatient services.

- *Medicare Claims Processing Manual* Publication 100-04
  - Chapter 1 - General Billing Requirements, Section 80.3.2.2 FI Consistency Edits – *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf*
  - Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, Section 20.2 Reporting of Service Units with HCPCS (A – D) – *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf*
  - Chapter 12 - Physicians/Nonphysician Practitioners – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf*
  - Chapter 17 - Drugs and Biologicals, Section 70 Claims Processing Requirements - General – *http://www.cms.gov/manuals/downloads/clm104c17.pdf*
  - Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.3 Use and Acceptance of HCPCS Codes and Modifiers – *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*
- Medically Unlikely Edits (MUEs) - billing the correct number of units – *http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp*

Review of Medicare payments exceeding charges for outpatient services January 2006 through December 2007

The Office of Inspector General (OIG) recently completed a review of outpatient claims processed by First Coast Service Options Inc. (First Coast) in Jurisdiction 9 (J9) for the period January 1, 2006, through December 31, 2007. The OIG's goal with this review was to determine whether certain Medicare payments that First Coast made to providers in excess of charges for outpatient services were correct.

Medicare guidelines require providers to submit accurate claims for outpatient services. Medicare uses an outpatient prospective payment system (OPPS) to pay certain outpatient providers. With this method of reimbursement, the Medicare payment is not based on the amount the provider charges; therefore, the billed charges generally do not affect the current Medicare prospective payment amounts. Billed charges usually exceed the Medicare payment amount; therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

Summary of findings

During the audit period, approximately 91 million line items for outpatient services were processed by First Coast. Of the 326 line items selected for review, 67 were correct. Providers refunded overpayments on six line items totaling nearly $73K. The remaining 253 line items were incorrect and included overpayments totaling almost $1.7M.

Of the 253 incorrect line items:

- Providers reported incorrect units of service on 203 line items, resulting in overpayments totaling more than $1.4M.
- Providers reported a combination of incorrect units of service claimed and incorrect Healthcare Common Procedure Coding System (HCPCS) codes on 22 line items, resulting in overpayments totaling more than $93K.
- Providers used HCPCS codes that did not reflect the procedures performed on 17 line items, resulting in overpayments totaling more than $101K.
- Providers did not provide the supporting documentation for 11 line items, resulting in overpayments totaling nearly $86K.

Incorrect payments were made due to the following reasons:

- Providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors.

(continued on next page)

2006 *(continued)*

- The Medicare Fiscal Intermediary Shared System (FISS) and common working file (CWF) had insufficient edits in place during the audit to prevent or detect overpayments.

Issues identified as overpayments

- Incorrect number of units of service
  - **Example**: One provider billed Medicare for incorrect service units on six line items. Rather than billing between one and 485 service units (the correct HCPCS codes associated with these line items), the provider billed between 250 and 4,850 service units. The units were overstated because the pharmacy's drug conversion factor table was not current.
  - **Example**: Another provider billed Medicare for incorrect service units on eight line items. The provider incorrectly charged multiple service units for increments of operating room time instead of one service unit for the ambulatory surgery performed. These errors occurred because the provider did not have electronic edits in place.
- Combination of incorrect number of units of service and incorrect HCPCS codes
  - Example: One provider billed Medicare for a procedure with 200 units of service. However, both the procedure billed and the units of service were incorrect. The provider should have billed using a different procedure code with one unit of service.
- Incorrect HCPCS
  - Example: Because of human error, a provider billed Medicare for nine line items of infusion therapy using incorrect HCPCS codes.
- Unsupported services
  - Providers did not provide supporting documentation.

First Coast currently has threshold edits in place that target excessive charges; many of these edits were revised and/or implemented since the end of the review period.

Provider education resources

Providers are responsible for ensuring that the appropriate HCPCS codes and units of service are billed correctly for services rendered to Medicare beneficiaries, and are in accordance with coding guidelines. Providers are to use the appropriate HCPCS codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS is associated with a drug, the number of units administered.

Providers are responsible for ensuring the appropriate HCPCS codes and units of services are billed correctly

The following resources provide information that will assist you with proper billing of outpatient services.

- *Medicare Claims Processing Manual* Publication 100-04
  - Chapter 1 - General Billing Requirements, Section 80.3.2.2 FI Consistency Edits – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf*
  - Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, Section 20.2 Reporting of Service Units with HCPCS (A – D) – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf*
  - Chapter 12 - Physicians/Nonphysician Practitioners – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf*
  - Chapter 17 - Drugs and Biologicals, Section 70 Claims Processing Requirements - General – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf*
  - Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.3 Use and Acceptance of HCPCS Codes and Modifiers – *https://www.cms.gov/manuals/downloads/clm104c23.pdf*
- Medically Unlikely Edits (MUEs) - billing the correct number of units – *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*

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A physician's guide to Medicare Part D Medication Therapy Management programs

Provider types affected

This *MLN Matters*® special edition article about Medication Therapy Management (MTM) services is intended for physicians, pharmacists, nurses, and other health care providers who treat Medicare beneficiaries with Part D coverage.

Provider action needed

This *MLN* release is intended to make you aware of changes in Medicare Part D MTM programs that will affect your patients, and introduce you to three new MTM forms that your patients are likely to share with you.

Your patients may ask you if they would benefit from MTM services. If you have patients enrolled in Part D MTM programs, you may also be contacted by MTM providers who are required to monitor patients' medication therapies from all their health care providers. This may result in recommendations that are shared with you about unsafe or dangerous interactions and therapeutic alternatives. Your patients may also receive recommendations about how to use their medications properly.

MTM providers are important partners with you

MTM providers work with physicians to deliver the best medication therapy to patients and to coordinate their medication therapy across multiple practitioners. The latest clinical information is used by MTM providers when reviewing patients' medication therapy, such as updates to the Beers criteria for high-risk medications and revised monographs for old and new medications. MTM providers also listen to patients' concerns about their medications and may offer recommendations to physicians and patients to help achieve their goals of therapy. As always, physicians make the final decisions about changes in drug therapy.

When will MTM providers contact you?

Your patients enrolled in MTM may receive an interactive comprehensive medication review (CMR) any time during the year.

- The MTM provider may reach out to you in order to clarify your patient's medical history prior to a review or information received from your patient during the review, such as why and how they are supposed to use their medications.
- After a CMR, the MTM provider may contact you with questions or recommendations about your patient's medications, or your patient may call you to discuss suggestions they received from the MTM provider.

Targeted medication reviews (TMRs) are processed throughout the year, no less often than quarterly, to identify specific or potential medication-related problems. You may be contacted by the MTM provider if a TMR identifies a potential medication-related problem for your patient.

Other communications may be sent to you periodically throughout the year. These communications are intended to help resolve other potential medication-related problems or identify other opportunities to optimize your patient's medication use.

What is changing?

Beginning January 2013, if your patients are enrolled in a Part D MTM program, they will receive a printed standardized summary, Form CMS-10396, as a reference about their CMR. This summary will include a cover letter, medication action plan, and personal medication list. Your patients are encouraged to share these documents with you and other healthcare providers at their regular visits and request updates as needed. Examples of the three forms follow:

Cover letter

Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood
Medicare Plus

January 30, 2013

Mr. John Smith
999 Straight Road
Washington, DC 80008

Dear Mr. Smith:

Thank you for talking with me on January 14, 2013 about your health and medications. Medicare's MTM (Medication Therapy Management) program helps you make sure that your medications are working.

Along with this letter are an action plan (Medication Action Plan) and a medication list (Personal Medication List). **The action plan has steps you should take to help you get the best results from your medications. The medication list will help you keep track of your medications and how to use them the right way.**

- Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other healthcare providers.
- Ask your doctors, pharmacists, and other healthcare providers to update them at every visit.
- Take your medication list with you if you go to the hospital or emergency room.
- Give a copy of the action plan and medication list to your family or caregivers.

If you want to talk about this letter or any of the papers with it, please call Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday. I look forward to working with you and your doctors to help you stay healthy through the Birchwood Medicare Plus MTM program.

Sincerely,
Jane Doe
Jane Doe, PharmD
Pharmacy Manager

Page 1 of 1

- The cover letter reminds your patient of their CMR, introduces the medication action plan and personal medication list, and describes how to contact the MTM program.

(continued on next page)

MTM *(continued)*

Medication action plan

Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood Medicare Plus

MEDICATION ACTION PLAN FOR Mr. John Smith, DOB: 07/04/1940

This action plan will help you get the best results from your medications if you:

- Read "What we talked about."
- Take the steps listed in the "What I need to do" boxes.
- Fill in "What I did and when I did it."
- Fill in "My follow-up plan" and "Questions I want to ask."

Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers. Share this with your family or caregivers too.

DATE PREPARED: 01/14/2013

What we talked about:	
What I need to do:	What I did and when I did it:
What we talked about:	
What I need to do:	What I did and when I did it:
What we talked about:	
What I need to do:	What I did and when I did it:

Page 1 of 2

What we talked about:	
What I need to do:	What I did and when I did it:
What we talked about:	
What I need to do:	What I did and when I did it:
What we talked about:	
What I need to do:	What I did and when I did it:

My follow-up plan (add notes about next steps):

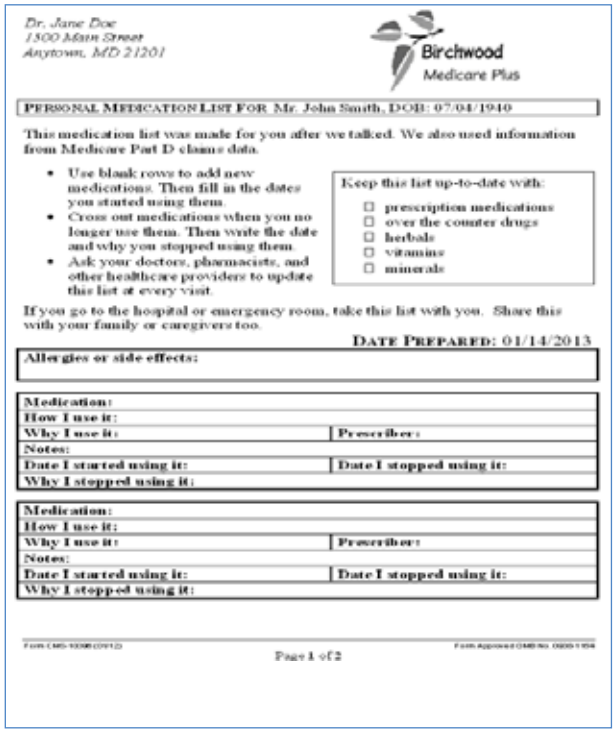
Questions I want to ask (include topics about medications or therapy):

If you have any questions about your action plan, call Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday.

Page 2 of 2

- The medication action plan describes the specific action items for your patient to help resolve issues of current drug therapy and achieve the goals of medication treatment. Your patient can keep notes of their progress and use it to clarify and discuss any concerns about their medications and treatment plans with you.
- The MTM provider will send separate recommendations to you if needed.

Personal medication list



Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood Medicare Plus

PERSONAL MEDICATION LIST FOR Mr. John Smith, DOB: 07/04/1940

This medication list was made for you after we talked. We also used information from Medicare Part D claims data.

- Use blank rows to add new medications. Then fill in the dates you started using them.
- Cross out medications when you no longer use them. Then write the date and why you stopped using them.
- Ask your doctors, pharmacists, and other healthcare providers to update this list at every visit.

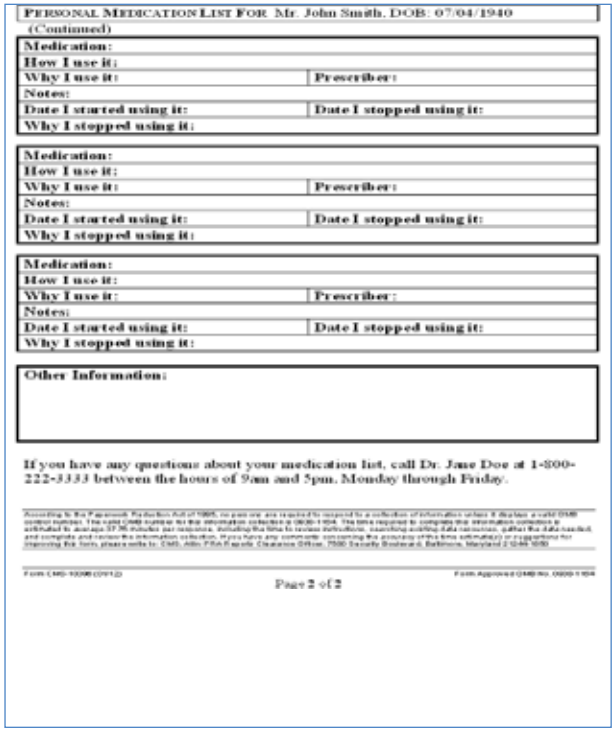
Keep this list up-to-date with:
- ☐ prescription medications
- ☐ over the counter drugs
- ☐ herbals
- ☐ vitamins
- ☐ minerals

If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

DATE PREPARED: 01/14/2013

Allergies or side effects:	
Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	
Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	

Page 1 of 2



PERSONAL MEDICATION LIST FOR Mr. John Smith, DOB: 07/04/1940 (Continued)

Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	
Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	
Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	

Other Information:

If you have any questions about your medication list, call Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday.

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(continued on next page)

MTM *(continued)*

- The personal medication list is a reconciled list of the medications used by your patient at the time of the review. Information from your patient, Medicare Part D claims data, or other sources may be used to develop the list. It is intended to help your patient understand their medications and how they relate to their treatment plans. Your patient can make notes on their Personal Medication List such as when and why they stopped taking a medication.
- You can use the personal medication list as verification of your patient's current medication regimen and provide written adjustments, as needed. The medication list can also improve communication with you and other healthcare providers seen by your patient.

How do you refer patients to MTM services?

Calling the prescription drug plan directly is the best way to find out if your patient is eligible for that plan's MTM services. You can also refer your patient to their local State Health Insurance Assistance Program (SHIP) office. A local SHIP counselor can be found through a search function at *https://shiptalk.org/public/home.aspx?ReturnUrl=%2fdefault.aspx*.

Summary

Medicare Part D MTM programs promote coordinated care and improve medication use through services that engage the patient, their physicians, and other healthcare providers. Starting in 2013, you will begin to see three new forms that your patients may receive if they are enrolled in a Part D MTM program. These forms are intended to provide the patient with information about their medication use and also be used as a platform for discussion with you and their other health care providers.

Additional information

For additional information about Medicare Part D MTM programs and the standardized CMR summary documents, go to *http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html*.

Please send any general questions about Part D MTM programs to *PartD_MTM@cms.hhs.gov* via e-mail. Questions about a specific plan's MTM services or eligibility criteria should be addressed to that Part D plan.

MLN Matters® Number: SE1229
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.

Interactive voice response and contact center hours for Puerto Rico and the U.S. Virgin Islands

Effective November 5, 2012, the customer service and interactive voice response (IVR) hours of operation are as follows:

Part A IVR

Monday-Friday
8:00 a.m.-8:00 p.m. Atlantic Time (AT)

Saturday
8:00 a.m.-4:00 p.m. AT

Part B IVR

Monday-Friday
8:00 a.m.-7:30 p.m. AT

Saturday
8:00 a.m.-4:00 p.m. AT

Customer service representatives

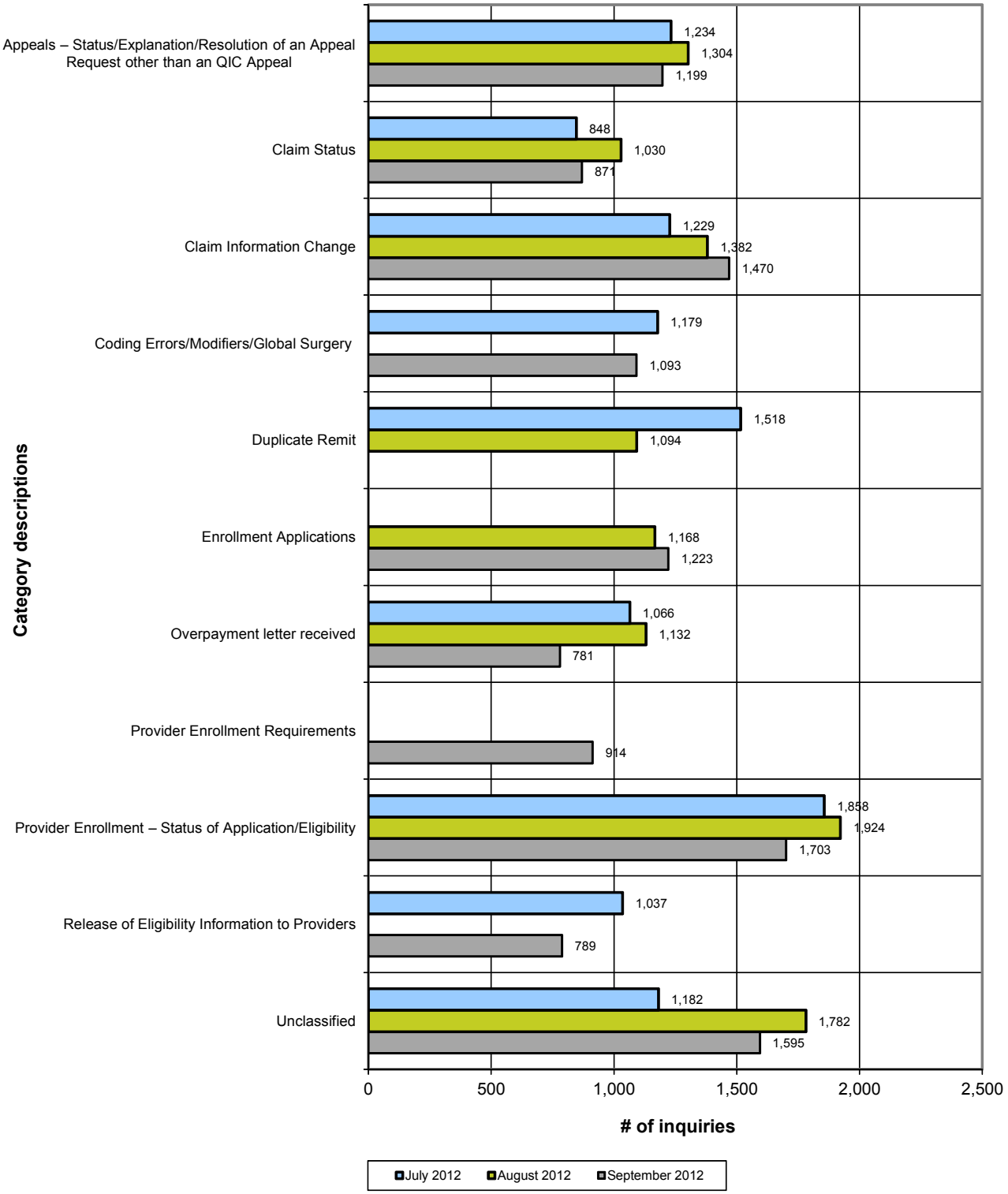
The Monday-Friday hours (8:00 a.m.-4:00 p.m. AT), with the exception of training closures, remain unchanged.

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 July-September 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 July-September 2012



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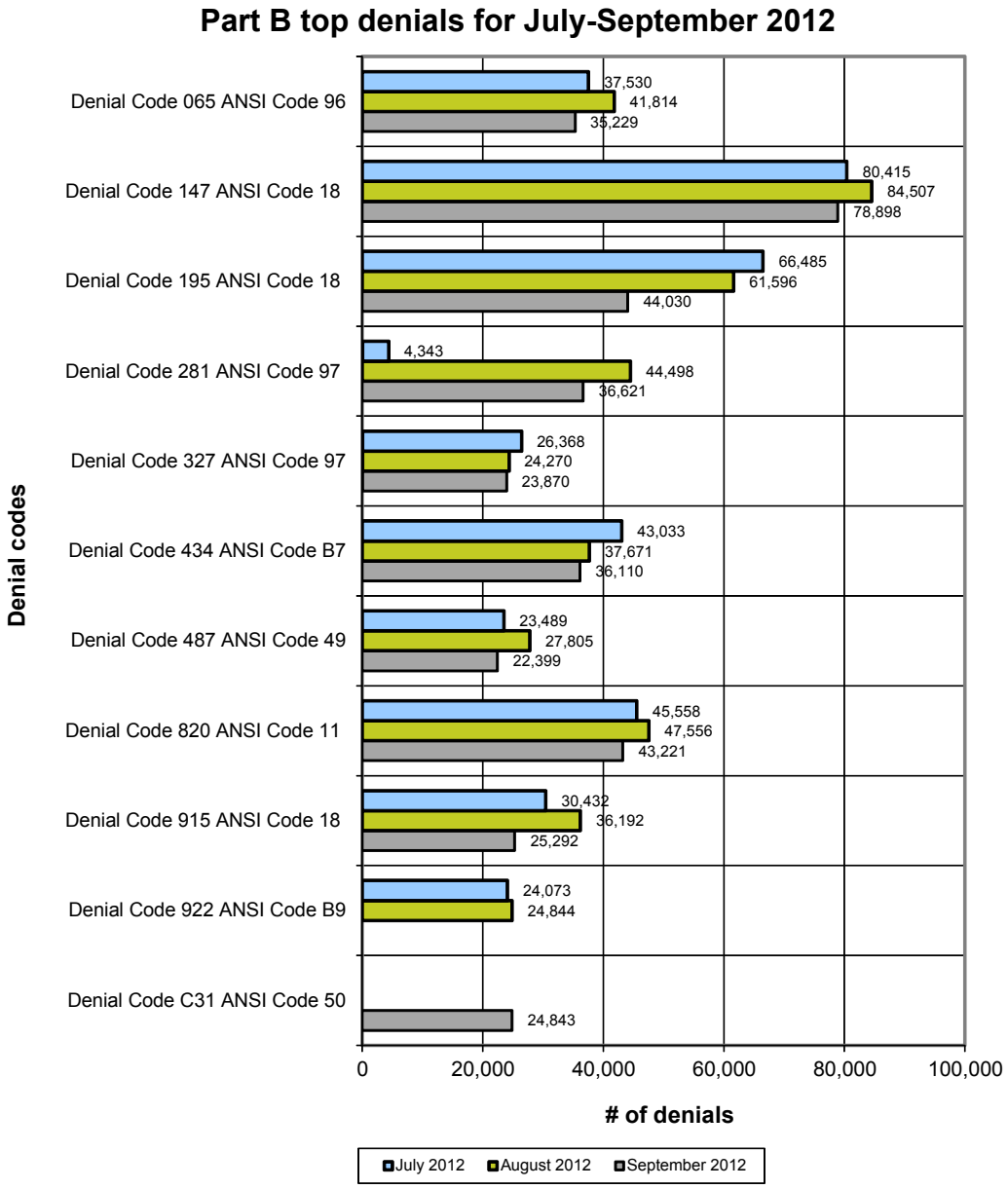


What to do when your claim is denied

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

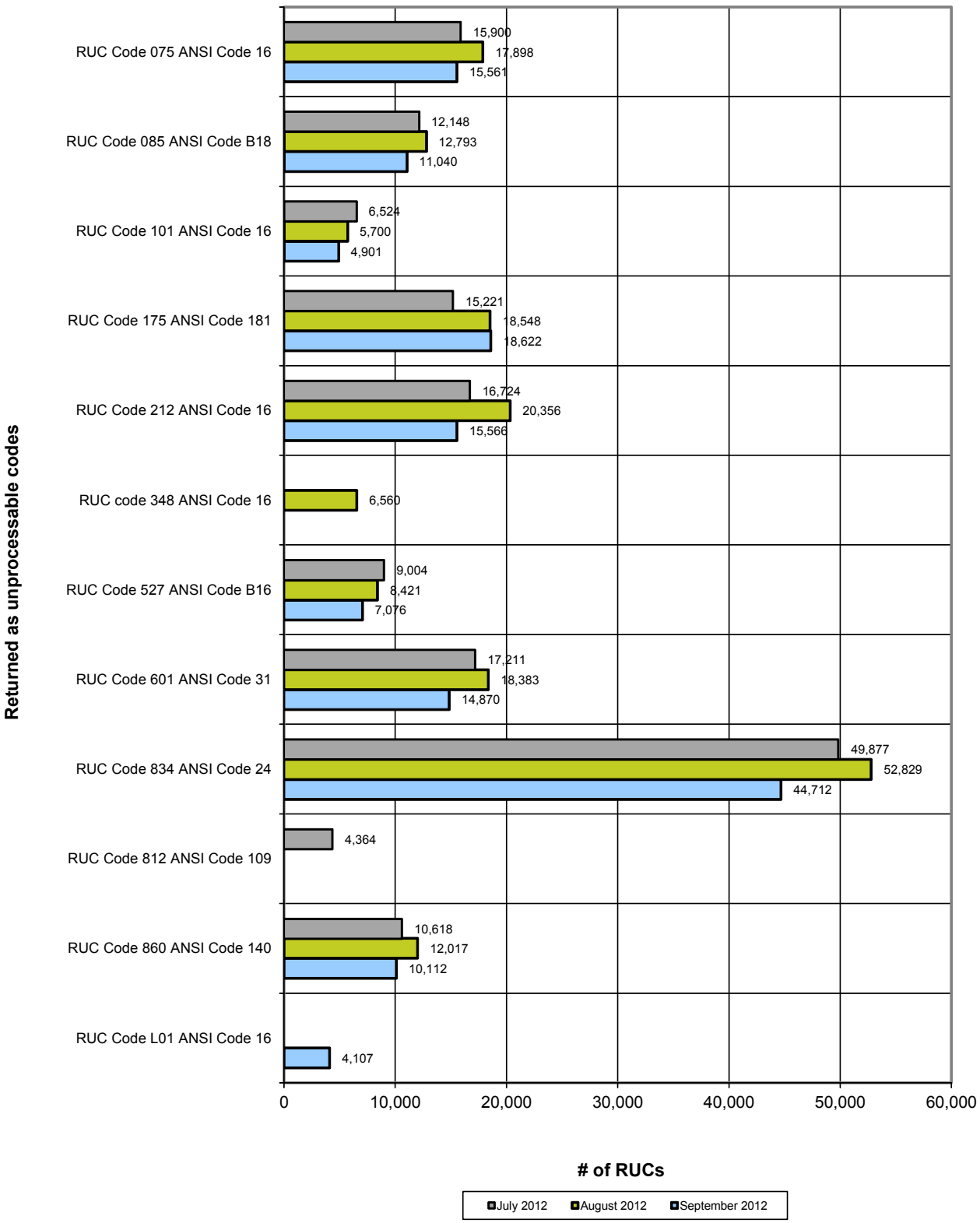
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

Refer to the *Claim completion FAQs*, *Billing issues FAQs*, and *Unprocessable FAQs* on the 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 July-September 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

THERSVCS: Therapy and rehabilitation services – revision to the LCD

LCD ID number: L29289 (Florida)
LCD ID number: L29399 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for therapy and rehabilitation services was most recently revised March 1, 2012. Since that time, based on change request 7785, language was added to the Centers for Medicare & Medicaid Services (CMS) Manual System, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5, Sections 10.3-10.5 (Financial Limitations). Therefore, the "Financial Limitations for Therapy Caps" section of the LCD was revised to replace CMS language with specific website links to the Internet-only manual (IOM) sections. In addition, the LCD was updated to reflect current CMS language.

Effective date

This LCD revision is effective for services rendered **on and after October 1, 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*.

Calculate the possibililtes ...

Whether you're estimating the amount of a Medicare payment, the length of an ESRD coordinating period, or the deadlines for sending an appeals request or responding to an additional development request, try the easy way to calculate the possibilities. Find everything you need to "do it yourself" in our *Tool center*.

Educational Events

Upcoming provider outreach and educational events
November-December 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.

Medicare Part B changes and regulations

When: Wednesday, December 19
Time: 11:30 a.m.-1:00 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 conducted a pilot that ended September 30, 2012; however, CMS is extending it until further notice. The following are links to the latest e-News:

- 'CMS Medicare FFS Provider e-News': September 26, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-26-e-News.pdf*
- 'CMS Medicare FFS Provider e-News': October 4, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-04-e-News.pdf*
- CMS e-News for Wednesday, October 11, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-11-e-News.pdf*
- 'CMS Medicare FFS Provider e-News': October 18, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-18-e-News.pdf*

Source: CMS PERL 201209-09, 201210-01, 201210-03, 201210-06

CMS fraud prevention training modules for providers

In June 2012, the Centers for Medicare & Medicaid Services (CMS) produced two fraud prevention training modules that are currently available on the Medscape website. These modules provide key information to health care practitioners and professionals on how they can assist CMS in preventing fraud and abuse, as well as highlight CMS' efforts to fight fraud and abuse and explain how health care professionals can be part of these efforts.

The first module, "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients," presents CMS' provider-focused fraud awareness and prevention initiatives. The goal of this activity is to provide health care professionals with actionable ideas for working with CMS and other agencies that investigate suspected fraud and abuse. This module also informs providers about how they can reduce the risk of fraud and abuse for their practices and patients. This module can be found at *http://www.medscape.org/viewarticle/764496*.

The goal of the second module, "How CMS Is Fighting Fraud: Major Program Integrity Initiatives," describes recent and on-going strategies that CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. The goal of this activity is to increase awareness amongst providers about the strategies CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. This module can be found at *http://www.medscape.org/viewarticle/764791*.

The modules feature Dr. Peter Budetti, Deputy Administrator of the Center for Program Integrity; Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity; and Mary Agnes Laureno, former Deputy Director of the Center for Program Integrity.

A total of 1.25 hours of continuing medical education (CME) credit can be earned for any Medscape user registered as a doctor or health care professional. Medscape accounts are free, and users do not have to be health care professionals to register for them. Registration is on the landing page of *www.medscape.com*.

Instructions for accessing the Medscape modules

Step 1: Access the website *www.medscape.org*. Medscape accounts are free of charge.

Step 2: Registration is on the upper right hand corner of the home page of *www.medscape.org* next to the log in field.

Step 3: To access the modules, first enter your membership log in information.

Step 4: To view the "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients" module, use this link: *http://www.medscape.org/viewarticle/764496*.

Step 5: To view the "How CMS Is Fighting Fraud: Major Program Integrity Initiatives" module, use this link: *http://www.medscape.org/viewarticle/764791* .

Source: TDL 12472

Preventive Resources

2012-2013 seasonal influenza resources for health care professionals

Provider types affected

All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries

What you need to know

- Keep this *MLN Matters*® special edition article and refer to it throughout the 2012-2013 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the New Year.
- Don't forget to immunize yourself and your staff.

Introduction

Annual outbreaks of seasonal flu typically occur as early as October and as late as May, with peak months in January and February. Illness from seasonal flu usually lasts one to two weeks, and flu-related complications include pneumonia and dehydration. Approximately 5 to 20 percent of Americans catch the seasonal flu each year. Getting the flu vaccine is your best protection against the flu.[1]

[1] Flu.gov. 2012. Seasonal Flu [online]. Washington D.C.: The U.S. Department of Health and Human Services, 2010 [cited 3 October 2012]. Available from the World Wide Web: http://www.flu.gov/about_the_flu/seasonal/index.html

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

Protect you and your family from the flu

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff.

Educational products for health care professionals

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for seasonal flu vaccines and their administration.

MLN Seasonal Influenza Related Products for Health Care Professionals

- ***MLN Matters*® article MM8047: Influenza Vaccine Payment Allowances – Annual Update for 2012-2013 Season**: This article contains the payment allowances for the 2012-2013 flu season. You can download it at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8047.pdf*.
- ***Quick Reference Information: Medicare Part B Immunization Billing***: This educational tool is designed to provide education on Medicare-covered preventive immunizations. Available in print and as a downloadable PDF at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf*.
- ***Quick Reference Information: Preventive Services***: This educational tool is designed to provide education on the Medicare-covered preventive services. Available as a downloadable PDF at *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf*.
- ***MLN* Preventive Services Educational Products Web Page**: This *MLN*® Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. View this page at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html*.
- ***Preventive Services Educational Products***: This PDF provides a list of all *MLN* products related to Medicare-covered preventive services. View this PDF at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf*.

(continued on next page)

Influenza *(continued)*

Other CMS resources

- Seasonal influenza vaccines 2012 pricing is at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2012ASPFiles.html*.
- Prevention General Information Overview is at *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*.
- CMS frequently asked questions are available at *http://questions.cms.gov/faq.php*.
- *Medicare Benefit Policy Manual* – Chapter 15, Section 50.4.4.2 – Immunizations available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*.
- *Medicare Claims Processing Manual* – Chapter 18, Preventive and Screening Services available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*.

Other resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2012-2013 flu season:

- Advisory Committee on Immunization Practices is at *http://www.cdc.gov/vaccines/recs/acip/default.htm*.
- American Lung Association's Influenza (Flu) Center is at *http://www.lungusa.org*. This website provides a flu clinic locator at *http://www.fluclinicslocator.org*. Individuals can enter their ZIP code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- Other sites with helpful information include:
  - **Centers for Disease Control and Prevention** – *http://www.cdc.gov/flu*
  - **Flu.gov** – *http://www.flu.gov*
  - **Food and Drug Administration** – *http://www.fda.gov*
  - **Immunization Action Coalition** – *http://www.immunize.org*
  - **Indian Health Services** – *http://www.ihs.gov/*
  - **National Alliance for Hispanic Health** – *http://www.hispanichealth.org*
  - **National Foundation For Infectious Diseases** – *http://www.nfid.org/influenza*
  - **National Library of Medicine and NIH Medline Plus** – *http://www.nlm.nih.gov/medlineplus/immunization.html*
  - **National Network for Immunization Information** – *http:/www.immunizationinfo.org*
  - **National Vaccine Program** – *http://www.hhs.gov/nvpo*
  - **Office of Disease Prevention and Health Promotion** – *http://odphp.osophs.dhhs.gov*
  - **Partnership for Prevention** – *http://www.prevent.org*
  - **World Health Organization** – *http://www.who.int/en*

Beneficiary information

For information to share with your Medicare patients, please visit *http://www.medicare.gov*.

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Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation Date: NA

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.

Take advantage of First Coast's exclusive PDS report

Did you know that First Coast's exclusive provider data summary (PDS) report can help you improve the accuracy and efficiency of the Medicare billing? Accessible through First Coast's PDS's portal at *http://medicare.fcso.com/PDS/index.asp*, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specific time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your business botton line.

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