

C Medicare B CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

November 2012



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Termination of the common working file eligibility query

Provider types affected

This *MLN Matters*[®] article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME/MACs), and Part B MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8086 which informs Medicare contractors about the changes being made to eliminate the ELGB (eligibility) query. See the Background and Additional information sections of this article for further details regarding these changes.

Background

Medicare providers use the common working file (CWF) ELGB query to obtain Medicare beneficiary information. However, the Centers for Medicare & Medicaid Services (CMS) must eliminate this query capability because the ELGB query is not HIPAA compliant because the incoming query and the outgoing response are not in X12 format. CMS is required by HIPAA to use the proper format when exchanging this information with any covered entity, which applies to all users of this query. As a result, CMS is eliminating this query. They can no longer support the approach of allowing providers online access to CWF non-HIPAA compliant data.

While the CWF ELGB query is discontinued, other query capabilities, such as the HIPAA Eligibility Transaction

System (HETS), are available. More information on HETS is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html>. You may also use your Medicare contractor's integrated voice response (IVR) system or their Web portal.

Additional information

The official instruction, CR 8086, issued to your carrier, DME MAC, and B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1140OTN.pdf>. If you have any questions, please contact your carrier, DME MAC, or B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.

MLN Matters[®] Number: MM8086
Related Change Request (CR) #: 8086
Related CR Release Date: November 2, 2012
Effective Date: April 1, 2013
Related CR Transmittal #: R1140OTN
Implementation Date: April 1, 2013

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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.

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About the Medicare B Connection

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website <http://medicare.fcso.com>. In some cases, additional unscheduled special issues may be posted.

Who receives the Connection

Anyone may view, print, or download the Connection from our provider education website(s). Providers who cannot obtain the Connection from the Internet are required to register with us to receive a complimentary hardcopy.

Distribution of the Connection in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the Connection be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The Connection is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific *CPT* and *HCPCS* procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **Electronic Data Interchange (EDI)** submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.

In addition to the above, other sections include:

- **Educational Resources**, and
- **Contact information** for Florida and the U.S. Virgin Islands.

The Medicare B Connection represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.



Advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at <http://www.cms.gov/manuals/downloads/clm104c30.pdf#page=41>.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at http://www.cms.gov/BNI/02_ABN.asp.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (waiver of liability statement on file).

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the Contact Information section of this publication for the address in which to send written appeals requests.

Ambulatory Surgical Center

Special report for ambulatory surgical center quality reporting

Provider types affected

This *MLN Matters*® special edition article is intended for ambulatory surgical centers (ASCs) that bill Medicare as a primary payer (from October 1, 2012, forward) or ASCs who bill Medicare as a primary or secondary payer (from January 1, 2013, forward).

What you need to know

Stop – impact to you

ASCs that do not meet program requirements for ASC quality reporting may receive a two percent reduction in their annual payment update. Separately identifiable entities certified as ASCs by Medicare are affected by program requirements and possible payment penalty under the ASC quality reporting program.

Caution – what you need to know

To meet the ASC Quality Reporting Program requirements and receive the full annual payment update for calendar year (CY) 2014, ASCs must submit quality-data codes (QDCs) on the paper or electronic version of the Form CMS-1500 for October 1, 2012, to December 31, 2012, services where Medicare is the primary payer. To meet requirements to receive the full annual payment update for CY 2015, ASCs must submit QDCs on their claims beginning with January 1, 2013, services where Medicare is the primary or secondary payer and submit structural measure data using a Web-based tool.

Go – what you need to do

The first step is to begin reporting with QDCs, which are specified CPT® category II codes, or level II G-codes that describe the presence or absence of an event. All claims must have at least two codes – no event documented (G8907) and an antibiotic code, or if a specified event occurs, the event code, codes in response to the other three events, and an antibiotic code. (See the chart below for details.) Claims submitted to Medicare must be completed using the appropriate codes and number of codes. ASCs must meet a completeness of reporting threshold of 50 percent. That is, 50 percent of their Medicare claims must have the appropriate QDCs.

Second, ASCs must register with QualityNet to establish a security administrator in order to report required structural measures data during the July 1, to August 15, 2013, time period and to access data submission reports. ASCs may register beginning in February 2013.

Below are guidelines to follow when reporting QDCs via claims:

1. QDCs must be submitted with a line item charge of zero dollars at the time the associated service is performed.
2. Claims may not be resubmitted for the sole purpose of adding QDCs.
3. Only one diagnosis code can be linked to each QDC.
4. Providers should work with their clearinghouse or vendor regarding line limitations to ensure that QDCs or nominal charge amounts are not dropped.

Background

A quality data reporting program for ASCs was finalized by CMS in the CY 2012 OPPTS/ASC final rule with comment period (CMS-1525-FC- <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS1253623.html>).

For CY 2014 payment determination, the data collected by CMS will be claims-based and not require abstraction. ASCs will start submitting QDCs on five different measures beginning with claims with dates of service for October 1, 2012, through December 31, 2012. For this time period, ASCs must submit at least 50 percent of their Medicare paid claims with the appropriate QDCs by April 30, 2013, to receive the full annual payment update.

For CY 2015 payment determination, in addition to the same claims-based measures used for CY 2014, CMS adopted two structural measures that will be reported via a Web-based tool. The reporting period for the structural measures will begin on July 1, 2013, and extend through August 15, 2013, for services furnished between January 1, 2012, and December 31, 2012.

(continued on next page)

ASC ... (continued)

The following chart contains the quality measures and applicable QDCs:

Ambulatory surgical center measure g-codes (QDCS)		
Measure	Measure description	QDC
ASC-1	Patient Burn	G8908: Patient documented to have received a burn prior to discharge
		G8909: Patient documented not to have received a burn prior to discharge
		G8910: Patient documented to have experienced a fall within the ASC
ASC-2	Patient Fall	G8911: Patient documented not to have experienced a fall within the ASC
		G8912: Patient documented to have experienced a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event
ASC-3	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	G8913: Patient documented not to have experienced a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event
		G8914: Patient documented to have experienced a hospital transfer or hospital admission upon discharge from ASC
ASC-4	Hospital Transfer/Admission	G8915: Patient documented not to have experienced a hospital transfer or hospital admission upon discharge from ASC
		G8916: Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time
		G8917: Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time
ASC-5	Prophylactic IV Antibiotic Timing	G8918: Patient without preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis
G8907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility. This code can be used in lieu of the other four codes if all are negative.		

The specifications manual for the program provides additional information for using the proper QDC and is available at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772475754>.

Additional information

The ACS listserv provides the latest information about the program and CMS updates about quality reporting for ASCs. To register for the listserv, go to <https://www.qualitynet.org> on the QualityNet Web page.

For further assistance regarding this information, please contact the Florida Medical Quality Assurance, Inc. (FMQAI), the ASC Quality Reporting Program Support Contractor, at 866-800-8756 or at <http://www.oqrsupport.com>.

If you have any questions, please contact your FI, carrier, DME MAC 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: SE1248
 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

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Consolidated Billing

Implementation of changes to the ESRD PPS consolidated billing requirements for daptomycin and a clarification of outlier services

Provider types affected

This *MLN Matters*[®] article for change request (CR) 7869 is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and/or A/B MACs) for end-stage renal disease (ESRD) services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7869 which provides an update to the end-stage renal disease prospective payment system (ESRD PPS) for calendar year (CY) 2013, including the billing requirements for daptomycin, and the CR clarifies outlier services for CY 2013.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b); see <http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf>) amends the Social Security Act (Section 1881(b)(12); see http://www.ssa.gov/OP_Home/ssact/title18/1881.htm) by requiring the implementation of an ESRD bundled PPS, effective January 1, 2011.

The ESRD PPS was implemented by CR 7064 (Transmittal 2134, End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services). See the *MLN Matters*[®] article, MM7064, corresponding to CR 7064 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7064.pdf>.

ESRD claims reporting ESRD-related drugs and biologicals

The *Medicare Benefit Policy Manual* (Chapter 11, Section 30.4.1; see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf>) lists the drugs and fluids that were included under the composite payment system, which are heparin, antiarrhythmics, protamine, local anesthetics, apresoline, dopamine, insulin, lidocaine, mannitol, saline, pressors, heparin antidotes, benadryl, hydralazine, lanoxin, solu-cortef, glucose, antihypertensives, antihistamines, dextrose, inderal, levophed, and verapamil.

The manual also explicitly states, "... drugs used in the dialysis procedure are covered under the facility's composite rate and may not be billed separately. Drugs that are used as a substitute for any of these items, or are used to accomplish the same effect, are also covered under the composite rate." Data analysis of 2011 ESRD claims indicate that ESRD facilities are reporting composite rate drugs resulting in duplicate payment to those ESRD facilities that are receiving a blended payment under the transition period and inappropriate inclusion in the outlier calculation (discussed below).

In addition, in the CY 2012 ESRD PPS final rule (see <http://www.gpo.gov/fdsys/pkg/FR-2011-11-10/pdf/2011-28606.pdf>) and in CR 7617 (Transmittal 150, Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2012), CMS discussed alteplase and other thrombolytic drugs. CMS indicated that a clinical review of the 2007 claims used to develop the ESRD PPS revealed that ESRD facilities routinely used alteplase and other thrombolytic drugs for access management purposes. CMS also indicated that because these drugs are used to accomplish the same effect (that is, vascular access management) as a composite rate drug, they are also considered to be composite rate drugs and, therefore, should not be reported on the ESRD claim. In CR 7617, CMS removed alteplase and other thrombolytic drugs from the outlier calculation but CMS did not implement edits to prevent separate payment to the ESRD facilities that are receiving a blended payment during the transition. See the *MLN Matters*[®] article, MM7617, corresponding to CR 7617, at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7617.pdf>. For CY 2013, separate payment for alteplase and other thrombolytics will not be paid separately under the composite rate portion of the blended payment for ESRD facilities receiving a blended payment during the transition.

(continued on next page)

Daptomycin ... (continued)

ESRD-related drugs and biologicals that qualify as outlier services

Medicare regulations at 42 CFR §413.237(a)(1)(i) (see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr413_main_02.tpl) provide that ESRD outlier services are those ESRD-related services that were or would have been considered separately billable under Medicare Part B for renal dialysis services furnished prior to January 1, 2011. Therefore, items and services that would have been included under the composite rate do not qualify as an outlier services.

ESRD claims reporting daptomycin

CR 7064 provided ESRD consolidated billing requirements for certain Part B services included in the ESRD PPS bundled payment.) See the *MLN Matters*® article, MM7064, corresponding to CR 7064 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7064.pdf>.) All drugs reported on the ESRD facility claim that do not have an AY modifier are considered included in the ESRD PPS. The list of drugs and biologicals for consolidated billing are designated as always ESRD-related and therefore separate payment is not made to ESRD facilities. daptomycin is included on the consolidated billing list.

Revision to ESRD claims reporting daptomycin, effective January 1, 2013

ESRD facilities have the ability to receive separate payment for Healthcare Common Procedure Coding System (HCPCS) code J0878 injection, daptomycin, 1 mg furnished on or after January 1, 2013, by placing the AY modifier on the 72X claim when daptomycin is furnished to an ESRD patient that is not for the treatment of ESRD. The ESRD facility is required to indicate (in accordance with diagnosis coding guidelines) the diagnosis code for which daptomycin is indicated.

Revision to ESRD claims reporting ESRD-related drugs and biologicals, effective January 1, 2013

Composite rate items and services should not be reported on the ESRD facility claim. Because ESRD facilities are continuing to inappropriately report composite rate drugs, CMS developed a list of certain drugs and biologicals based on the 2011 claims data that are considered to be composite rate drugs (see attachment A of CR 7869, which is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2588CP.pdf>). ESRD facilities that are receiving reimbursement under the transition and have been inappropriately reporting drugs and biologicals considered to be in the composite rate will no longer be separately paid in the composite rate portion of the blended payment for these drugs effective January 1, 2013. In addition, because these ESRD-related drugs are considered to be in the composite rate they are also considered to be always ESRD-related. Therefore, CMS is updating the list of items and services that, effective January 1, 2013, are subject to consolidated billing requirements which can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html. ESRD-related drugs and biologicals located on this list are not eligible to be paid separately with the AY modifier.

The list of ESRD-related drugs in attachment A of CR 7869 is not an all-inclusive list, and ESRD facilities should not be reporting any composite rate items and services on the ESRD claim. ESRD facilities should not change treatment behaviors to receive separate payment. For example drugs and biologicals used for the purpose of access management should not be reported on the claim because, in accordance with the *Medicare Benefit Policy Manual* (Chapter 11, Section 30.4.1; see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf>) those drugs are considered to be composite rate drugs. CMS is continuing to monitor the claims data for drug utilization.

The list of ESRD-related drugs and biologicals on attachment B of CR 7869 is not an all-inclusive list of the drugs and biologicals that are included in the ESRD PPS. For example, any anti-infective drugs that are used for access management are included in the ESRD PPS. Attachment B has been updated to reflect 2011 claims data. However, any drug or biological (even if not one of the categories in attachment B) that is used for the treatment of ESRD (that is, ESRD-related) is included in the ESRD PPS and is not separately paid.

(continued on next page)



Daptomycin ... (continued)**Clarification of ESRD-related drugs and biologicals that qualify as outlier services, effective January 1, 2013**

Because ESRD facilities are continuing to inappropriately report composite rate drugs, composite rate drugs are incorrectly being included in the outlier calculation. Therefore, we developed a list of drugs and biologicals (attachment A) from the 2011 claims data that are considered to be composite rate drugs. This is not an all-inclusive list and ESRD facilities should not be reporting composite rate items and services on the ESRD claim. The ESRD-related drugs and biologicals listed on attachment A will not qualify as outlier services.

Peginesatide, effective January 1, 2013

Peginesatide is a new erythropoiesis-stimulating agent (ESA) drug approved for the treatment of anemia in dialysis patients. Peginesatide has been assigned a permanent HCPCS code of J0890. This permanent code replaces the temporary code issued Q2047. Peginesatide is subject to ESRD consolidated billing requirements. The drug description indicates use while on dialysis, therefore, it would be inappropriate to bill J0890 with modifier AY. The consolidated billing requirement may not be overridden with the use of the AY modifier.

Additional information

The official instruction, CR 7869, issued to your carriers, DME MACs, FIs, and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2588CP.pdf>.

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

MLN Matters® article, MM7064 “End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services” may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7064.pdf>.

MLN Matters® article, MM7617 “Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2012” may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7617.pdf>.

MLN Matters® Number: MM7869

Related Change Request (CR) #: CR 7869

Related CR Release Date: November 5, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R2588CP

Implementation Date: January 7, 2013

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Quarterly update to the ESRD prospective payment system

Provider types affected

This MLN Matters® article for change request (CR) 7858 is intended for physicians, other providers, and suppliers including end-stage renal disease (ESRD) facilities and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers who submit claims to Medicare contractors (durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), carriers, and/or A/B MACs) for ESRD supplies and services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7858 which provides the October 2012 quarterly update to the ESRD prospective payment system (PPS). See the *Background* and *Additional information* sections of this article for further details regarding this ESRD PPS update.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b); see <http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf>) required the implementation of an ESRD PPS, effective January 1, 2011.

(continued on next page)

PPS ... (continued)

The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment. This includes supplies and equipment used to administer dialysis (in the ESRD facility or at a patient's home), drugs, biologicals, laboratory tests, training, and support services. Consolidated billing edits established with the implementation of the ESRD PPS prevent payment to other providers and suppliers billing for renal dialysis services. The ESRD PPS provides payment adjustments for co-morbid conditions identified by specific ICD diagnosis codes. The ICD diagnosis codes are updated annually and effective each year on the first day of October. The ESRD PPS also includes consolidated billing requirements for limited Part B services included in the ESRD facility's bundled payment.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. The ESRD PPS also provides outlier payments, if applicable, for high cost patients due to unusual variations in the type or amount of medically necessary care. You can find a list of 1) specific diagnosis codes that are eligible for a co-morbidity payment adjustment, 2) items and services that are subject to the ESRD PPS consolidated billing requirements, and 3) outlier services at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html>.

ICD diagnosis coding updates

There are no new or revised ICD diagnosis codes to implement for the October 1, 2012, ESRD PPS quarterly update.

Consolidated billing changes**ESRD-related drugs and biologicals**

The following new code is being added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management treatment effective July 1, 2012.

Added HCPCS code	Short description	Long description
Q2047	Peginesatide injection	Injection, Peginesatide, 0.1 mg (for ESRD on dialysis)

Peginesatide is used as anemia management for ESRD patients on dialysis, therefore the drug is considered to be always ESRD-related. Separate payment for Q2047 (Peginesatide) will not be made with or without the AY modifier.

The claims shall process the line item as covered with no separate payment under the ESRD PPS and under the ESRD PPS portion of the blended payment during the transition effective October 1, 2012. However, ESRD facilities that are receiving a blended payment during the transition will receive separate payment under the composite rate portion of the blend effective July 1, 2012.

In accordance with 42 CFR 413.237(a)(1), HCPCS code Q2047 (Peginesatide) is considered to be an eligible outlier service, and it will be included in the outlier calculation when CMS provides a fee amount on the average sales price (ASP) pricing file.

ESRD-related equipment and supplies

The following HCPCS code is being added to the list of items and services that are subject to ESRD PPS consolidated billing requirements effective October 1, 2012:

Added HCPCS code	Long description
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. In. Or less, without adhesive border, each dressing

HCPCS code A6216 is ESRD-related, however, this supply can be used for reasons other than for the treatment of ESRD, and it is covered under other Medicare benefit categories. Therefore, A6216 may be billed by DME suppliers with the AY modifier to receive separate payment effective October 1, 2012.

Changes to items and services that qualify as an outlier service

CMS is removing the following *Current Procedural Terminology (CPT)* code 83735 (*Assay of Magnesium*) from the list of outlier services. The "Assay of Magnesium" laboratory test was a composite rate service under the basic case-mix adjusted composite rate system. Consequently, it is considered a renal dialysis service under the ESRD PPS. Therefore, this laboratory test does not qualify as an outlier service under 42 CFR 413.237 effective October 1, 2012.

(continued on next page)

PPS ... (continued)

CR 7858 also includes the following two attachments:

- Attachment A which contains the following four tables:
 - DME ESRD Supply HCPCS for ESRD PPS Consolidated Billing Edits
 - DME ESRD Supply HCPCS Not Payable to DME Suppliers
 - Labs Subject to ESRD Consolidated Billing
 - Drugs Subject to ESRD Consolidated Billing
- Attachment B (outlier services) which includes one table with three sections:
 - Oral and Other Equivalent Forms of Injectable Drugs
 - Laboratory Tests
 - Syringes

Note: The tables in Attachments A and B are updated to include codes A6216 and Q2047, as presented in this article, where applicable.

Additional information

The official instruction, CR 7858, issued to your DME MACs, FIs, and A/B MACs, regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2486CP.pdf>.

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

MLN Matters® Number: MM7858

Related Change Request (CR) #: CR 7858

Related CR Release Date: June 8, 2012

Effective Date: Effective date for updates to the ESRD PPS consolidated billing requirements: October 1, 2012; effective date for updates to ESRD-related drugs and biologicals: July 1, 2012

Related CR Transmittal #: R2486CP

Implementation Date: October 1, 2012

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Manual updates to clarify skilled nursing facility claim processing

Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs), hospitals, and ambulance suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed**Stop – impact to you**

This article is based on change request (CR) 8044, which informs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) has updated the manuals by adding policy clarifications pertaining to the SNF consolidated billing provision and claims processing, including guidance issued previously in a series of *MLN Matters*® special edition articles on this subject. This article and CR 8044 contain no new policies.

Go – what you need to do

Make sure that your billing staffs are aware of the manual clarifications made in CR 8044, including information on:

- The definition of an inpatient for starting or ending a benefit period
- Part B consolidated billing and exclusions
- Emergency services

(continued on next page)

Competitive ... (continued)

- Hospice care
- Certain chemotherapy drugs
- Ambulance services
- Screening and preventive services
- Therapy services
- The three day qualifying hospital stay
- Daily skilled service, and
- The definition of a beneficiary's home for Part B durable medical equipment (DME) coverage.

Background

The purpose of CR 8044 is to update the Medicare manuals to clarify key components of SNF claim processing. The changes are intended only to clarify the existing policies. No new policies are contained in CR 8044. The updated manuals and sections are as follows:

- Chapters 1 and 3 of the *Medicare General Information, Eligibility, and Entitlement Manual* are revised to explain that the various Part A benefit categories are subject to separate and mutually exclusive day limits and explain the start and the end of a benefit period in a SNF.
- Chapter 6 of the *Medicare Claims Processing Manual* is revised to clarify the meaning of Part B consolidated billing (CB) for a SNF and explains that the SNF CB excludes certain practitioner services, emergency services performed in hospitals, hospice services, certain chemotherapy drugs, ambulance services, vaccines, certain therapy services, and certain dialysis services.
- Chapters 8 and 15 of the *Medicare Benefit Policy Manual* are revised to clarify the conditions under which SNF services may be covered; daily skilled services is clarified to mean that, unless there is a legitimate medical need for scheduling a skilled service each day, the "daily basis" requirement for SNF coverage would not be met; for rental and purchase of DME for home use, assisted living facilities and intermediate care facilities for the mentally-retarded (ICFs/MR) are provided as specific examples of a type of institution that is not a hospital or SNF and, therefore, can meet the definition of a beneficiary's "home" in this context.

Additional information

The official instruction, CR 8044, was issued to your FI and A/B MAC regarding this change via three transmittals, one for each manual being revised. The transmittal for the *Medicare General Information, Eligibility, and Entitlement Manual* is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R80GI.pdf>. The transmittal for the *Medicare Benefit Policy Manual* is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R161BP.pdf>. The transmittal for the *Medicare Claims Processing Manual* is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2573CP.pdf>. The revised manual chapters are attached to these transmittals.

If you have any questions, please contact your 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: MM8044

Related Change Request (CR) #: CR 8044

Related CR Release Date: October 26, 2013

Effective Date: April 1, 2013

Related CR Transmittal #: R161BP, R2573CP, and R80GI

Implementation Date: April 1, 2013

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Drugs and Biologicals

January 2013 quarterly ASP Medicare Part B drug pricing files and revisions to prior files

Provider types affected

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

Provider action needed

Stop – impact to you

Medicare will use the January 2013 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2013, with dates of service from January 1, 2013, through March 31, 2013.

Caution – what you need to know

Change request (CR) 8116, from which this article is taken, instructs Medicare contractors to download and implement the January 2013 ASP Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised January 2013, October 2012, July 2012, April 2012, and January 2012 files.

Go – what you need to do

Please ensure that your staffs are aware of this January 2013 quarterly update. Contractors will not search and adjust claims that have already been processed unless brought to their attention.

Background

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

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

Files	Effective for dates of service
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012

(continued on next page)



ASP (continued)

Additional information

You can find the official instruction, CR 8116, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2568CP.pdf>.

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

MLN Matters® Number: MM8116
Related Change Request (CR) #: CR 8116
Related CR Release Date: October 26, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2568CP
Implementation Date: January 7, 2013

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Laboratory/Pathology

New waived tests

Note: This information was previously published in the October 2012 *Medicare B Connection*, Pages 8-10. This article corrects the information in the “Provider types affected” field.

Provider types affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors (A/B MACs)) for services 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, 86803QW, 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.



(continued on next page)

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 & 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
86803QW	November 29, 2011	OraQuick HCV Rapid Antibody Test and OraQuick Visual Reference Panel
87809QW	April 24, 2012	AdenoPlus (human eye fluid)
81003QW	May 8, 2012	McKesson 120 Urine Analyzer
81003QW	May 11, 2012	Acon Laboratories, Inc. Foresight U120 Urine Analyzer
86294QW	May 15, 2012	LifeSign Status BTA
82055QW	May 25, 2012	Alere Toxicology Services, iScreen Saliva Alcohol Test Strip
82055QW	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 Nootriptyline{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 Nortiptyline{Dip card format}
83036QW	May 30, 2012	Bayer AICNow+ Professional Use
87880QW	June 7, 2012	Mooremedical Strep A Rapid Test - Dipstick
G0434QW	July 13, 2012	Ultimate Analysis Cup UA Cups
86701QW	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, 86803QW, 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>.

MLN Matters® Number: MM8054
 Related Change Request (CR) #: 8054
 Related CR Release Date: September 28, 2012
 Effective Date: January 1, 2013
 Related CR Transmittal #: R2553CP
 Implementation Date: January 7, 2013

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Medicare Physician Fee Schedule Database

Multiple procedure payment reduction on the technical component of diagnostic cardiovascular and ophthalmology procedures

Provider types affected

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

Provider action needed

Medicare is expanding the multiple procedure payment reduction (MPPR) policy by applying MPPRs to the technical component (TC) of diagnostic cardiovascular and ophthalmology procedures. Make sure that your billing staff is aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

(continued on next page)

MPPR (continued)

Background

Section 3134 of the Affordable Care Act added Section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a further step in implementing this provision, Medicare is expanding the MPPR policy by applying MPPRs to the TC of diagnostic cardiovascular and ophthalmology procedures.

The MPPRs on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient on the same day. The MPPRs apply independently to cardiovascular and ophthalmology services. The MPPRs apply to TC-only services, and to the TC of global services.



- For cardiovascular services, full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 75 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same group national provider identifier (NPI)) to the same patient on the same day.
- For ophthalmology services, full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 80 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same group NPI) to the same patient on the same day.

The MPPRs do not apply to professional component (PC) services. The current and proposed payments are summarized below in the following examples:

Sample cardiovascular payment reduction

	Code 78452	Code 93306	Total Current Payment	Total 2013 payment	Payment calculation
PC	\$77.00	\$65.00	\$142.00	\$142.00	no reduction
TC	\$427.00	\$148.00	\$575.00	\$538.00	\$427 + (.75 x \$148)
Global	\$504.00	\$213.00	\$717.00	\$680.00	\$142 + \$427 + (.75 x \$148)

Sample ophthalmology payment reduction

	Code 92235	Code 92250	Total Current Payment	Total 2013 Payment	Payment Calculation
PC	\$46.00	\$23.00	\$69.00	\$69.00	no reduction
TC	\$92.00	\$53.00	\$145.00	\$134.40	\$92 + (.80 x \$53)
Global	\$138.00	\$76.00	\$214.00	\$203.40	\$69 + \$92 + (.80 x \$53)

The complete lists of codes subject to the MPPRs on diagnostic cardiovascular and ophthalmology procedures are in Attachments 1 and 2 of CR 7848 respectively. CR 7848 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1149OTN.pdf>.

To accommodate implementation of this new proposal for certain bill types, the 2013 Medicare physician fee schedule will include the following changes:

1. A new multiple procedure (Field 21) value of '6' will denote diagnostic cardiovascular services subject to the MPPR methodology.
2. A new multiple procedure (Field 21) value of '7' will denote diagnostic ophthalmology services subject to the MPPR methodology.

When payments are reduced due to the MPPR, you will receive a claim adjustment reason code of 59 (Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.) and group code CO (contractual obligation).

(continued on next page)

MPPR (continued)

Additional information

The official instruction 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/R1149OTN.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>.

MLN Matters® Number: MM7848

Related Change Request (CR) #: CR 7848

Related CR Release Date: November 6, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R1149OTN

Implementation Date: January 7, 2013

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Preventive Services

Editing update for annual wellness visit

Provider types affected

This *MLN Matters*® article is for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, Medicare administrative contractors (MACs), and/or fiscal intermediaries (FIs)) for annual wellness visit (AWV) services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8107 and states that the Centers for Medicare & Medicaid Services (CMS) will pay either the practitioner or the facility for furnishing the AWV. Currently, for claims with dates of service on and after January 1, 2011, processed on and after April 4, 2011, the business requirements in CR 7079 allowed for an AWV visit (HCPCS G0438 or G0439) on an institutional claim and a professional claim for the same patient same day. This has resulted in some cases in overpayments. A separate instruction regarding the collection of overpayments will be forthcoming.



Background

CR 8107 provides instructions for edits to be modified and only allow payment for either the practitioner or the facility for furnishing the AWV. Typically, when a preventive service is posted to a beneficiary's utilization history, separate entries are posted for a "professional" service (the professional claim for the delivery of the service itself) and a "technical" service (the institutional claims for a facility fee). However, in the case of AWV services, since there is no separate payment for a facility fee, effective for claims processed on and after April 1, 2013, the AWV claim will be posted as the "professional" service only, regardless of whether it is paid on a professional claim or an institutional claim. As a result of CR 8107, Medicare contractors will pay either the practitioner or the facility for furnishing the AWV, but only a single payment under the Medicare physician fee schedule will be allowed for an AWV on the same date. That payment will be based on the first claim received.

Thus, when an institutional or professional claim is received with Healthcare Common Procedure Coding System (HCPCS) code G0438 and a previous claim was paid for code G0438, Medicare will line-item deny the subsequent service using claim adjustment reason code (CARC) 149 (Lifetime benefit maximum has been reached for this service/benefit category.), remittance advice remarks code (RARC) N117 (This service is paid only once in a patient's lifetime.), and a group code of PR. However, if the second claim is for the same date of service, the line item on the second claim is denied using a group code of CO, instead of PR.

(continued on next page)

AWV (continued)

Also, when an institutional or professional claim is received with HCPCS code G0439 and a previous claim was paid for code G0438 or G0439 within the past 12 months, Medicare will deny the subsequent claim using CARC 119 (Benefit maximum for this time period or occurrence has been reached.), RARC N130 (Consult plan benefit documents/guidelines for information about restrictions for this service.), and a group code of PR. However, if the subsequent claim is for the same date of service, the denial will reflect a CARC of B13 (Previously Paid. Payment for this claim/service may have been provided in a previous payment.), a RARC N130 (Consult plan benefit documents/guidelines for information about restrictions for this service.), and a group code of CO.

Additional information

The official instruction, CR 8107 issued to your Medicare carrier, FI or A/B MAC regarding this change may be viewed <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2575CP.pdf>.

To review the initial article, MM7079, that describes the AWV along with the particulars of the personalized prevention plan services (PPPS) go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf>.

To access all preventive services educational products for Medicare fee-for-service health care professionals, and their staff, information on coverage, coding, billing, reimbursement, and claim filing procedures go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html>.

MLN Matters® Number: MM8107

Related Change Request (CR) #: 8107

Related CR Release Date: October 26, 2012

Effective Date: April 1, 2013

Related CR Transmittal #: R2575CP

Implementation Date: April 1, 2013

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Surgery

Bariatric surgery for the treatment of morbid obesity NCD and addition of laparoscopic sleeve gastrectomy

Provider types affected

This *MLN Matters*® article is intended for physicians, suppliers, and providers billing Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MACs)) for services related to bariatric surgery for Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8028, which provides that, effective for claims with dates of service on or after June 27, 2012, Medicare contractors acting within their respective jurisdictions may determine coverage of stand-alone laparoscopic sleeve gastrectomy (LSG) for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions are satisfied:

- The beneficiary has a body-mass index (BMI) ≥ 35 kg/m²
- The beneficiary has at least one co-morbidity related to obesity
- The beneficiary has been previously unsuccessful with medical treatment for obesity

You may bill stand-alone LSG with Healthcare Common Procedure Coding System (HCPCS) code 43775 (*Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)*), which appears on the October 2012 Medicare physician fee schedule update.

Effective for discharges on or after June 27, 2012, inpatient hospital claims may be submitted with stand-alone LSG International Classification of Diseases (ICD-9) procedure code 43.82 (Laparoscopic sleeve gastrectomy covered at contractor's discretion).

(continued on next page)

Bariatric (continued)

Please make sure that your billing staffs are aware of this change.

Background

In 2006, the Centers for Medicare & Medicaid Services (CMS) released a final national coverage determination (NCD) on bariatric surgery for the treatment of morbid obesity (see the *NCD Manual*, Section 100.1, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part2.pdf). For Medicare beneficiaries who have a body mass index (BMI) ≥ 35 kg/m², at least one co-morbidity related to obesity, and who have been previously unsuccessful with medical treatment for obesity, the following procedures were determined to be reasonable and necessary:

- Open and laparoscopic Roux-en-Y Gastric Bypass (RYGBP)
- Laparoscopic Adjustable Gastric Banding (LAGB)
- Open and laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS)

In addition, the NCD stipulates that the above bariatric procedures are to be covered only when performed at facilities that are:

- Certified by the American College of Surgeons (ACS) as a Level 1 Bariatric Surgery Center, or
- Certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE) (Program Standards and requirements in effect on February 15, 2006).

Due to lack of evidence at the time, the 2006 NCD specifically did not cover open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding. In 2009, CMS updated the NCD to include type 2 diabetes mellitus as a co-morbidity.

In September 2011, CMS re-opened the NCD to determine whether new and emerging evidence supported inclusion of LSG as a reasonable and necessary bariatric surgery under Sections 1862 (a)(1)(A) and 1862 (a)(1) (E) of the Social Security Act. Open sleeve gastrectomy was not considered and remains non-covered.

Effective for claims with dates of service on or after June 27, 2012, Medicare contractors acting within their respective jurisdictions may determine coverage of stand-alone LSG for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions are satisfied:

- The beneficiary has a body-mass index (BMI) ≥ 35 kg/m²
- The beneficiary has at least one co-morbidity related to obesity
- The beneficiary has been previously unsuccessful with medical treatment for obesity

Note: Medicare contractors will not search their files to reprocess claims processed prior to implementation of CR 8028. However, upon implementation, the contractors will adjust claims that you bring to their attention.

Additional information

The official instructions regarding this change, CR 8028, was issued to your FI, carrier, or A/B MAC via two transmittals. The first transmittal revises the *NCD Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R148NCD.pdf>. The second updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2590CP.pdf>.

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

MLN Matters® Number: MM8028

Related Change Request (CR) #: CR 8028

Related CR Release Date: November 9, 2012

Effective Date: June 27, 2012

Related CR Transmittal #: R148NCD, R2590CP

Implementation Date: December 10, 2012

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General Coverage

Medicare guidance regarding meningitis outbreak

Provider types affected

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

What you need to know

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) is providing direction to Medicare contractors based on the Centers for Disease Control and Prevention’s (CDC) interim treatment guidance for central nervous system (CNS). This guidance is also related to parameningeal infections and septic arthritis associated with contaminated steroid products produced by the New England Compounding Center (NECC). This guidance is available on the CDC website at <http://www.cdc.gov/hai/outbreaks/clinicians/index.html>.

Caution – what you need to know

The CDC recommends diagnostic and therapeutic activities for symptomatic patients. Therefore, CMS believes that, aside from oral drugs, items and services to diagnose and treat patients who have received contaminated medications qualify for the Medicare Part A or Part B benefit.

CMS urges all Medicare contractors to review the CDC website at http://www.cdc.gov/hai/outbreaks/clinicians/faq_meningitis_outbreak.html regularly for updates and specific actions they should take to ensure timely access to CDC recommended items and services.

Due to the severity of this situation, CMS advises providers that Medicare contractors are expected to expedite all coverage determination requests for these items and services to include antifungal medication.

The CDC has identified the following states as having received potentially-contaminated steroid products:

California	Idaho	Minnesota	New York	South Carolina
Connecticut	Illinois	Nevada	North Carolina	Tennessee
Florida	Indiana	New Hampshire	Ohio	Texas
Georgia	Maryland	Michigan	Pennsylvania	Virginia
	Michigan	New Jersey	Rhode Island	West Virginia

While clinics in these states received contaminated products, patients in additional states may be affected. Check the CDC’s Multistate Fungal Meningitis Outbreak Investigation Web page regularly for the latest news and information about the outbreak. The website is available at: http://www.cdc.gov/hai/outbreaks/clinicians/faq_meningitis_outbreak.html.

Go – what you need to do

Make sure that your medical and billing staffs are aware of this guidance.

Additional information

If you have any questions, please contact your FI, carrier, DME MAC 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: SE1246
 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

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Medicare finalizes the provisions for the ESRD PPS, quality incentive program, and bad debt reductions for all Medicare providers

On Friday, November 2, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that will update Medicare policies and payment rates for end-stage renal disease (ESRD) facilities, while strengthening incentives for improved quality of care and better outcomes for beneficiaries diagnosed with ESRD. The provisions will affect payments for outpatient maintenance dialysis treatments furnished on or after January 1, 2013, under the bundled ESRD prospective payment system (PPS) that was implemented in CY 2011.

CMS is projecting that payment rates for outpatient maintenance dialysis treatments will increase by 2.3 percent, representing a projected inflation (or ESRD bundled market basket) increase of 2.9 percent reduced by a projected productivity adjustment of 0.6 percent. CMS estimates that payments to ESRD facilities in 2013 will total \$8.4 billion.

The rule also makes changes to the ESRD Quality Incentive Program (QIP) that provides payment incentives to dialysis facilities to improve the quality of dialysis care. Under the ESRD QIP, facilities that do not achieve a high enough total performance score with respect to quality measures established in regulation receive a reduction in their payment rates under the ESRD PPS of up to two percent. Please refer to the [ESRD Quality Improvement Initiative](#) website.

CMS is also codifying the provisions of Section 3201 of the Middle Class Tax Extension and Job Creation Act of 2012 (Pub. L. No. 112-96) that require reductions in bad debt reimbursement to all Medicare providers eligible to receive bad debt reimbursement; these provisions are specifically prescribed by statute and thus, are self-implementing. This reduction in bad debt reimbursement is projected to yield savings to the program of \$10.9 billion over 10 years. The rule also removes the cap on reimbursement of bad debt to ESRD facilities.

The rule ([CMS-1352-F](#)) can be viewed on the [ESRD Payment](#) website. For more information, see the [CMS fact sheet](#).

Home health prospective payment system rate update for calendar year 2013, Hospice quality reporting requirements, and survey and enforcement requirements for home health agencies

Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality reporting requirements, and survey and enforcement requirements for home health agencies [final rule](#) was put on display at the *Office of the Federal Register* on November 2, 2012. This final rule updates Medicare's home health prospective payment system (HH PPS) payment rates for CY 2013. Payments to home health agencies (HHAs) are estimated to remain virtually unchanged (decreasing by approximately 0.01 percent or -\$10 million). This reflects the net effect of a 1.3 percent home health payment update, an updated wage index, an update to the fixed-dollar loss (FDL) ratio, and a case-mix coding adjustment intended to offset coding changes unrelated to changes in patient health needs. The rule also rebases and revises the home health market basket, allows additional regulatory flexibility regarding therapy reassessments and face-to-face encounter requirements, and extends certain hospice quality reporting requirements to subsequent years. Lastly, this rule establishes new survey and certification requirements for HHAs and provides a number of alternative (or intermediate) sanctions if HHAs were out of compliance with federal requirements.

Source: CMS PERL 201211-03

CMS issues two payment rules

On Thursday, November 1, the Centers for Medicare & Medicaid Services (CMS) issued two final regulations updating Medicare payment rates and policies in calendar year (CY) 2013 for services furnished by physicians and other practitioners, and hospital outpatient departments and ambulatory surgical centers (ASCs).

The final CY 2013 Medicare physician fee schedule (MPFS) rule will be published on November 16, 2012. It will take effect January 1, 2013, with a comment period that closes on December 31, 2012.

- [Final rule with comment period](#)
- [Fact sheet](#)

The final CY 2013 hospital outpatient prospective payment system (OPPS) and ASC rule will be published on November 15, 2012. It will take effect January 1, 2013, with a comment period that closes on December 31, 2012.

- [Final rule with comment period](#)
- [Fact sheet](#)

Source: CMS PERL 201211-01

New informational unsolicited response process to identify previously paid claims for services furnished to incarcerated beneficiaries

Provider types affected

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

What you need to know

This article is based on change request (CR) 8007, which informs Medicare contractors about the creation of a new informational unsolicited response (IUR) process to identify and perform retroactive adjustments on any previously paid claims which may have been processed and paid erroneously during periods when the beneficiary data in the enrollment database (EDB) did not reflect the fact that the beneficiary was incarcerated.

Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated on the date of service that the items and services were furnished. Medicare is creating a new IUR process in its systems to identify previously paid claims that contain dates of service (DOS) that partially or fully overlap a period when the beneficiary was incarcerated (exceptions noted below). The IUR process will be initiated:

- When there is an automatic update to the beneficiary's record that indicates a change to the beneficiary's "incarcerated" start date or end date, or
- When there is a manual update to the beneficiary's record that indicates a change to the beneficiary's "incarcerated" start date or end date.

Upon receiving the IUR, Medicare contractors will initiate overpayment recovery procedures to recoup any Medicare Part A and Part B payments.

Make sure that your billing staffs are aware of this update.

Background

Under Sections 1862(a)(2) and (3) of the Social Security Act, the Medicare program will not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. Accordingly, the Centers for Medicare & Medicaid Services (CMS) presumes that a state or local government entity that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of medical services and Medicare will generally not reimburse claims for services rendered to a beneficiary while he/she is in such custody.

Regulations at 42 Code of Federal Regulations (CFR) Section 411.4(b) state that:

"Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The state or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Federal benefit entitlement information is provided to CMS by the Social Security Administration (SSA) on a daily basis. When the SSA learns of a beneficiary's incarceration, the beneficiary's record in the EDB is updated to reflect that fact and the effective date (or "start date") of the incarceration.

CMS transmittal AB-02-164, CR 2022, issued on November 8, 2002, implemented a Medicare systems edit to reject services billed to Medicare when information in the EDB indicates that, on the date of service, the beneficiary was incarcerated. Upon receipt of this rejection, Medicare contractors are instructed to deny the claims. CR 4352, which manualized CR 2022, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R883CP.pdf>.

OIG finding of vulnerability

The Office of Inspector General (OIG) has recently identified a vulnerability where there may be, in some instances, a period of time between when the beneficiary is incarcerated and when the SSA learns of this status and updates its records (and Medicare files are subsequently updated). During this time, it is possible that Medicare fee-for-service (FFS) claims for services would be paid erroneously because the beneficiary's entitlement data in the EDB is not up-to-date when the claims are adjudicated.

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Incarcerated (continued)

Creation of IUR to remedy vulnerability

CMS has identified the IUR process as a means to mitigate this vulnerability. An IUR identifies a claim that appears to need to be adjusted by a Medicare contractor. The contractor, when appropriate, initiates overpayment recovery procedures to retract Part A or Part B payment.

Therefore, the intent of CR 8007 is to create a new IUR process to identify and perform retroactive adjustments on any previously paid claims that may have been processed and paid erroneously during periods when the beneficiary data in the EDB did not reflect the fact that the beneficiary was incarcerated.

Additional information

The official instruction, CR 8007, issued to your FI, RHHI, carrier, DME MAC, and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1134OTN.pdf>.

If you have any questions, please contact your FI, RHHI, carrier, DME MAC, 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: MM8007
Related Change Request (CR) #: CR 8007
Related CR Release Date: November 1, 2012
Effective Date: April 1, 2013
Related CR Transmittal #: R1134OTN
Implementation Date: April 1, 2013

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Informational unsolicited response process to identify paid services furnished to beneficiaries classified as “unlawfully present” in the United States

Provider types affected

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

What you need to know

This article is based on change request (CR) 8009, which informs Medicare contractors about the creation of a new Informational unsolicited response (IUR) process to identify and perform retroactive adjustments on any previously paid claims that contain dates of service (DOS) that partially or fully overlap a period when the beneficiary was unlawfully present in the United States. The IUR process shall be initiated:

- When there is an **automatic** update to the beneficiary’s record in CWF via an EDB transaction which indicates a change to the beneficiary’s “unlawfully present” start date or end date, or
- When there is a **manual** update to the beneficiary’s record in CWF which indicates a change to the beneficiary’s “unlawfully present” start date or end date.

Upon receiving the IUR, Medicare contractors will initiate overpayment recovery procedures to recoup any Medicare Part A and Part B payments.

Background

Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) prohibited aliens who are not “qualified aliens” from receiving Federal benefits, including Medicare benefits. Consistent with this legislation, Section 10.1.4.8 of Chapter 1 of the *Medicare Claims Processing Manual* (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>) states that: “Medicare payment may not be made for items and services furnished to an alien beneficiary who was not lawfully present in the United States on the date of service.”

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Unlawfully *(continued)*

Federal benefit entitlement information is provided to the Centers for Medicare & Medicaid Services (CMS) by the Social Security Administration (SSA) on a daily basis. Such information is used in the adjudication of claims for healthcare services provided to Medicare beneficiaries. When the SSA learns of a beneficiary's status as "unlawfully present" in the United States, the beneficiary's record in Medicare's files is updated to reflect that fact and the effective date of that status.

CMS Transmittal AB-03-115, CR 2825, issued on August 1, 2003, implemented an edit in Medicare systems to reject services billed to Medicare when information in its files indicates that, on the date of service, the beneficiary was not lawfully present in the United States. Upon receipt of this rejection, Medicare contractors are instructed to deny the claim or claims.

OIG finding of vulnerability

The Office of Inspector General (OIG) has identified a vulnerability where there may be, in some instances, a period of time between when the beneficiary is deemed to be unlawfully present in the United States and when the SSA learns of this status and updates its records (and the Medicare files are subsequently updated). During this time, it's possible that Medicare fee-for-service (FFS) claims for services would be paid erroneously because the beneficiary's entitlement data is not up-to-date when the claims are adjudicated.

Creation of IUR to remedy vulnerability

CMS has identified a process to mitigate this vulnerability. An IUR identifies a claim that appears to need to be adjusted by a Medicare contractor. The contractor, when appropriate, initiates overpayment recovery procedures to retract Part A or Part B payment. Therefore, the intent of CR 8009 is to create a new process to identify and perform retroactive adjustments on any previously paid claims which may have been paid erroneously during periods when the beneficiary data in Medicare's files did not reflect the fact that the beneficiary was unlawfully present in the United States.

Additional information

You can find the official instruction, CR 8009, issued to your Medicare carrier, FI, DME MAC, RHHI, or A/B MAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1133OTN.pdf>.

If you have any questions, please contact your Medicare Carrier, FI, DME MAC, 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: MM8009

Related Change Request (CR) #: CR 8009

Related CR Release Date: November 1, 2012

Effective Date: April 1, 2013

Related CR Transmittal #: R1133OTN

Implementation Date: April 1, 2013

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Frequently asked questions on the three-day payment window for services provided to outpatients later admitted as inpatients

Provider types affected

This *MLN Matters*[®] special edition article is informational in nature. It is intended for all physicians and hospitals that provide Medicare-covered services in the fee-for-service (FFS) program.

Background

In the calendar year (CY) 2012 Medicare physician fee schedule (MPFS) final rule, the Centers for Medicare & Medicaid Services (CMS) finalized the three-day payment window for MPFS services, consistent with the Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA). CMS issued manual instructions in change request (CR) 7502 on December 21, 2011. Since the publication of these documents, CMS has received several frequently asked questions (FAQs) about the three-day payment window. For your reference, answers to these FAQs as they relate to MPFS services are listed below.

What is the three-day payment window?

Medicare's three-day (or one-day) payment window applies to outpatient services that hospitals and hospitals' wholly-owned or wholly-operated Part B entities furnish to Medicare beneficiaries. The statute requires that hospitals bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (e.g., therapeutic) with the claim for an inpatient stay when services are furnished to a Medicare beneficiary in the three days (or, in the case of a hospital that is not a subsection (d) hospital, during the one-day) preceding an inpatient admission in compliance with Section 1886 of the Social Security Act.



How does Section 102 of PACMBPRA change the way a physicians' practice, or any other Part B entity that a hospital wholly owns or wholly operates, bills and receives payment for Medicare services subject to the three-day window?

Section 102 of PACMBPRA significantly broadened the definition of related non-diagnostic services that are subject to the payment window to include any non-diagnostic service that is clinically related to the reason for a patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same. PACMBPRA made no changes to application of the three-day (or one-day) payment window policy to diagnostic services. Application of the payment window policy to diagnostic services has not changed since 1998.

Which services does Medicare consider "diagnostic"?

As discussed in the *Medicare Benefit Policy Manual*, Chapter 6, Section 20.4.1, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf>, a service is "diagnostic" if it is an examination or procedure to which you subject the patient, or which you perform on materials derived from a hospital outpatient, to obtain information to aid in your assessment of a medical condition or to identify a disease.

Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic X-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests you give to determine the nature and severity of an ailment or injury.

What type of hospital inpatient admissions would be subject to a one-day payment window?

The hospital and hospital units subject to the one-day payment window policy (instead of the three-day payment window) are:

- Psychiatric hospitals and units
- Inpatient rehabilitation hospitals and units
- Long-term care hospitals

(continued on next page)

Window (continued)

- Children's hospitals, and
- Cancer hospitals.

A wholly-owned or wholly-operated physician practice (or other Part B entity) of the aforementioned hospitals would also be subject to a one-day payment window when they furnish diagnostic services and related non-diagnostic services within one calendar day preceding an inpatient admission.

Are critical access hospitals (CAHs) subject to the payment window?

If the admitting hospital is a CAH, the payment window policy does not apply.

However, if the admitting hospital is a short stay acute hospital paid under the inpatient prospective payment system (IPPS) and the wholly-owned or wholly-operated outpatient entity is a CAH, the outpatient CAH services are subject to the payment window.

The CAH services are also subject to the payment window if the admitting hospital is a psychiatric hospital, inpatient rehabilitation hospital, long-term care hospital, children's hospital, or cancer hospital.

Does the three-day window (or one-day window) include the 72 hours (or 24 hours) directly preceding the inpatient hospital admission?

The three-day payment window applies to services you provide on the date of admission and the three calendar days preceding the date of admission that will include the 72-hour time period that immediately precedes the time of admission but may be longer than 72 hours because it is a calendar day policy.

The one-day payment window applies to the date of admission and the entire calendar day preceding the date of admission and will include the 24 hour period that immediately preceded the time of admission but may be longer than 24 hours.

What type of information about Medicare's three-day (or one-day) payment window did CMS publish in CR 7502?

CR 7502 provides implementing policy, billing, and claims processing instructions regarding Medicare's three-day (or one-day) payment window policy as it pertains to services furnished by hospital wholly-owned or wholly-operated physician practices or other Part B entities. These instructions include general background information on the payment window, implementation of the payment window policy in wholly-owned or wholly-operated entities, the definition of wholly-owned and wholly-operated entities, and how the payment window affects payment to wholly-owned and wholly-operated entities. (An *MLN Matters*[®] article related to CR 7502 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7502.pdf>.)

CR 7502 also includes instructions regarding how you should identify services subject to the three-day (or one-day) payment window, how the payment window policy affects payment and billing for surgical services with a global period, as well as business requirements for Medicare claim processing contractors.

Although CR 7502 includes comprehensive and detailed explanation of the three-day (or one-day) payment window policy, much of the information (i.e. definition of a wholly-owned or wholly-operated hospital and application of the policy to diagnostic services) has not changed since 1998 and has been long-standing Medicare payment policy.

Does CR 7502 furnish any specific billing instructions for hospitals?

No, CR 7502 only provides billing instructions for the wholly-owned or wholly-operated physician practice or other Part B entity that furnish services subject to the three-day (or one-day) payment window.

CMS published hospital instructions for the implementation of this provision in CR 7142, "Clarification of Payment Window for Outpatient Services treated as Inpatient Services." An *MLN Matters*[®] article related to that CR is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7142.pdf>.

How do I know if my physician practice, or other Part B entity, meets the statutory requirements of hospital wholly-owned or wholly-operated?

Wholly-owned or wholly-operated entities are defined in 42 CFR 412.2. "An entity is wholly-owned by the hospital if the hospital is the sole owner of the entity," and "an entity is wholly-operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entities routine operations, regardless of whether the hospital also has policy making authority over the entity." [Emphasis added] The hospital and associated physician practice or other Part B entity must determine whether the entity is wholly owned or wholly operated.

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Window *(continued)***When would the three-day (or one-day) payment window not apply?**

The three-day (or one-day) payment window does not apply in the circumstances described below:

- If the hospital and the physician office or other Part B entity are both owned by a third party, such as a health system; and
- If the hospital is not the sole or 100 percent owner of the entity, for example, if the hospital has a financial or administrative partner, or if physicians or other practitioners have an ownership interest in the hospital, physician practice or Part B entity. We provide several examples of arrangements where an entity is not wholly-owned or wholly-operated by the hospital. See the February 11, 1998 *Federal Register*, pages 6866-6867 and the CY 2012 Medicare physician fee schedule final rule (MPFS), published November 28, 2011, pages 73285 -73286).

Will CMS make a determination as to whether a specific entity meets the definition of wholly owned or wholly operated?

Given the multitude of possible business and financial arrangements that may exist between a hospital and a physician practice or other Part B entity, CMS will not make individual determinations as to whether a specific physician practice or other Part B entity is wholly owned or wholly operated by an admitting hospital.

In general, if a hospital has direct ownership or control over another entity's operations, then services that other entity provides are subject to the payment window policy. However, if a third organization owns or operates both the hospital and the entity, then the payment window provision does not apply. While CMS cannot anticipate every arrangement scenario or make case by case decisions based upon hypothetical scenarios, we have provided several illustrative examples of how we apply this general policy in the CY 2012 MPFS final rule, published on November 28, 2011. The final rule, 76 FR 73285 -73286, is available at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-28/pdf/2011-28597.pdf>.

Who makes the determination as to whether a specific entity meets (or does not meet) the definition of wholly owned or wholly operated?

The hospital and its owned or operated physician practice (or other Part B entity) are collectively responsible for determining whether the owned or operated physician practice or other Part B entity meets the definition of hospital wholly owned or hospital wholly operated subject to the payment window policy.

If a hospital has recently purchased my physician practice, should I update my ownership status with Medicare?

Yes, you must notify Medicare of any change of ownership within 30 days of the change. You may notify us by submitting an 855B Medicare enrollment application to your Medicare administrative contractor, or you can complete this information on-line in the Provider Enrollment Chain and Ownership System (PECOS).

What if the determination of wholly owned or wholly operated of a specific arrangement is still unclear (after review by my legal counsel)?

CMS believes that ownership and operational issues are inherently fact-specific and hospitals and hospital-owned and operated entities will best know and understand their individual circumstances and whether the physician practice is subject to the payment window policy. If you determine that you are not wholly-owned or wholly-operated and not subject to the payment window policy, we recommend that you maintain documentation to support that determination.

How will a wholly-owned or wholly-operated entity know when a beneficiary has been admitted as a hospital inpatient?

The admitting hospital is responsible for notifying the entity of an inpatient admission of a Medicare beneficiary who received services in a wholly-owned or wholly-operated entity within the three-day (or one-day) payment window prior to the inpatient admission.

Do the ICD-9 diagnosis codes for the inpatient admission and outpatient non-diagnostic service need to be an exact match to be considered related?

No. That is the exact policy that PACMBRA changed. Prior to the enactment of PACMBRA, related non-diagnostic services were those services where there was an exact match on the ICD-9 diagnosis code between pre-hospitalization services and the inpatient admission. The only change that PACMBRA made was to expand the definition of 'related to' services to "all services that are not diagnostic services unless the hospital demonstrates...that such services are not related...to such admission.

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Window *(continued)*

The three-day payment policy now applies to all non-diagnostic services provided during the payment window unless the hospital attests that the services are clinically unrelated.

Diagnostic services always are subject to the payment window, irrespective of whether they are considered clinically related.

Will CMS furnish a list of non-diagnostic service codes that they will consider “related to” an inpatient admission?

No, CMS will not develop a definitive list of services that are clinically related to an inpatient admission. As discussed in the CY 2012 MPFS final rule, CMS believes that the determination of whether an outpatient service is clinically related requires knowledge of the specific clinical circumstances surrounding a patient’s inpatient admission and can only be determined on a case-by-case basis (76 FR 73282).

Who is responsible for making the determination as to whether a non-diagnostic service is (or is not) related to the beneficiary’s inpatient admission?

The hospital that owns the wholly-owned or wholly-operated physician practice (or other Part B entity) and submits the claim to Medicare for the inpatient admission determines that an outpatient service is clinically related to an inpatient admission when it submits an inpatient claim. Once the hospital makes this determination, the Part B claim for physician fee schedule services must be submitted consistent with the decision the hospital made.

How does the three-day payment window affect wholly-owned or wholly-operated physician practices (or other Part B entities)?

The technical component for all diagnostic services and those direct expenses that otherwise would be paid through non-facility practice expense relative value units for non-diagnostic services related to the inpatient admission, that a wholly-owned or wholly-operated entity provides within the payment window, are considered hospital costs and must be included on the hospital’s bill for the inpatient stay.

Medicare will pay the wholly-owned or wholly-operated entity through the MPFS for the professional component (PC) for service codes with a technical/professional component (TC/PC) split that are provided within the payment window, and at the facility rate (i.e. exclusive of those direct practice expenses that are included in the hospital’s charges) for service codes without a TC/PC split.

How will a wholly-owned or wholly-operated physician practice or other Part B entity identify services subject to the three-day (or one-day) payment window on their claims?

Physician practices or other Part B entities should use modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly-owned or operated entity to a patient who is admitted as an inpatient within three days or one day) to identify HCPCS codes for services subject to the payment window.

When is the effective date for modifier PD?

Wholly-owned or wholly-operated entities have the discretion to apply the modifier PD for claims with dates of service on and after January 1, 2012, but must have begun using the modifier PD for eligible services in the three-day (or one-day) payment window no later than July 1, 2012. Additionally, hospitals and physician practices (or other part B entities) must have coordinated billing procedures for services subject to the three-day (or one-day) payment window in place no later than July 1, 2012.

What if the hospital determines that non-diagnostic outpatient service(s) furnished within the payment window are not related to the inpatient admission?

Non-diagnostic preadmission services furnished within the payment window that the hospital determines are not clinically related to an inpatient admission are not subject to the three-day (or one-day) payment window policy. As such, do not append the modifier PD to the unrelated non-diagnostic service(s).

Should I use condition code 51 to identify unrelated non-diagnostic services furnished in a wholly-owned or wholly-operated physician practice (or other Part B entity)?

No. Only hospitals should use condition code 51 when they bill separately for unrelated outpatient non-diagnostic service claims. You should not append the modifier PD to an unrelated non-diagnostic service furnished in a wholly-owned or wholly-operated physician practice (or other Part B entity).

The absence of the modifier PD would serve as the attestation that the hospital that wholly owns or wholly operates the physician practice believes that the non-diagnostic service was unrelated to the hospital admission.

(continued on next page)

Window (continued)**Does CMS consider all non-diagnostic services furnished on the date of admission to be related to the inpatient admission?**

Yes, non-diagnostic services a wholly-owned or wholly-operated physician practice (or other Part B entity) furnishes on the date of a beneficiary's inpatient admission to the hospital are always deemed to be related to the admission. The admitting hospital's wholly-owned or wholly-operated physician practice (or other Part B entity) should use modifier PD to identify non-diagnostic services they furnished on the date of a beneficiary's admission.

What if a diagnostic service is unrelated to the inpatient hospital admission?

The TC of all diagnostic services furnished by a wholly-owned or wholly-operated entity to a Medicare beneficiary who is admitted as an inpatient within three calendar days are subject to the three-day payment window policy (or one day if applicable).

How should a wholly-owned or wholly-operated physician practice bill for diagnostic services subject to the payment window?

The wholly-owned or wholly-operated physician practice (or other Part B entity) should only bill for the professional component of a diagnostic service subject to the three-day (or one-day) payment window. They must append modifier 26 and modifier PD to the diagnostic HCPCS code for the service. Please note that this policy has been longstanding and has not changed since 1998.

Should the wholly-owned or wholly-operated physician practice bill for the technical component of a diagnostic service?

No, the wholly-owned or wholly-operated physician practice (or other Part B entity) should not bill for the TC of a diagnostic service subject to the payment window. The modifier PD does not apply to the TC of a diagnostic service. The TC of a diagnostic service (e.g. taking the X-ray) subject to the payment window is considered part of the admitting hospitals costs and therefore, included on the bill for the inpatient stay.

Should an ambulatory surgical center (ASC) use the modifier PD?

Yes, a wholly-owned or wholly-operated ASC would use the modifier PD to identify outpatient physician or practitioner services subject to the three-day (or one-day) payment window.

If a wholly-owned or wholly-operated physician practice furnishes a related outpatient evaluation and management (E/M) visit within the payment window, does the admitting hospital include any costs associated with the outpatient visit with the outpatient bill?

The wholly-owned or wholly-operated physician practice would bill the related outpatient E/M visit with modifier PD and the Medicare claim processing contractor would pay the physician practice at the facility rate. Medicare would pay the hospital for the direct practice expense associated with the related outpatient E/M visit through payment for the inpatient admission. Direct practice costs (clinical staff, equipment and supplies) for non-diagnostic services related to the inpatient admission the wholly-owned or wholly-operated entity provides within the payment window are considered hospital costs and must be included on the hospital's bill for the inpatient stay and on the hospital's cost report.

Should I use the modifier PD to identify outpatient physician practitioner services, subject to the payment window, that are performed in the hospital?

No, do not use modifier PD for outpatient services subject to the three-day (or one-day) payment window that are furnished in the hospital.

For example, do not append the modifier PD to physician and practitioner professional services furnished in the hospital outpatient department, including the emergency department, patients receiving observation services, or other outpatient services furnished in a provider-based department of the hospital.

Use modifier PD should only for diagnostic and related non-diagnostic outpatient services paid under the MPFS that are furnished in a wholly-owned or wholly-operated physician practice (or other Part B entity) of the hospital.

Do not append modifier PD to a claim where the payment window policy applies but the service was provided in a hospital. In other words, use the modifier PD to identify related outpatient services subject to the payment window furnished in the physician's office and not by the physician at the hospital.

Hospitals follow different billing instructions from a wholly-owned or wholly-operated physician practice (or other Part B entity) for billing outpatient services subject to the three-day payment window furnished in an outpatient department of the hospital. (Refer to the *Medicare Claims Processing Manual*, Chapter 4, Section 10.12 at <http://>

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Window (continued)

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf for billing instructions for hospitals furnishing outpatient services subject to the payment window policy.)

Must I append modifier PD to services I provide to an inpatient?

No, use the modifier PD should only for outpatient services you provide in the window prior to an inpatient admission subject to the payment window and that you furnish in a wholly-owned or wholly-operated physician practice or other Part B entity. Do not apply modifier PD to physician fee schedule claims for services provided after the patient has been admitted as inpatient to the hospital.

Are rural health clinics (RHCs) or federally qualified health centers (FQHCs) subject to the three-day (or one-day) payment window policy?

No, the three-day (or one-day) payment window policy does not apply to RHCs or FQHCs. Medicare pays for RHC and FQHC services through an all-inclusive rate that incorporates payment for all covered items and services and related services and supplies an RHC/FQHC physician or practitioner provides to a beneficiary on a single day.

It is not possible to distinguish within the all-inclusive rate the amount of the payment for any particular patient that represents the professional versus the technical portion. Given that the three-day payment window policy does not include professional services, and that RHCs and FQHCs are paid an all-inclusive rate that includes payment for professional services, RHCs and FQHCs currently are not subject to the three-day payment window policy.

Do I append modifier PD to “incident to” services?

Yes, if an admitted inpatient received services at a wholly-owned or wholly-operated entity prior to his or her admission and some of the services were furnished incident to a physician’s or other practitioner’s services, the physician would bill for those services according to the three-day (or one-day) payment window policy.

How does the presence of the modifier PD affect Medicare payment for non-diagnostic services?

For services without a technical and professional component split, modifier PD triggers the claim system to pay the facility rate without a TC/PC split (for example, outpatient physician’s visit). In other words, the presence of modifier PD on professional non-diagnostic service codes instructs the Medicare claims processing contractors to pay the “facility” payment amount in circumstances where, in the absence of the three-day (or one-day) payment window policy, the non-facility payment amount may have otherwise applied.

The lower facility physician fee schedule payment reflects that the direct expenses associated with providing the service are now hospital costs and included on the hospital’s inpatient bill rather than being paid to the physician.

Should I append the modifier PD to global surgical services furnished within the payment window?

Yes, a patient could have a surgical service furnished in a wholly-owned or wholly-operated physician office or other Part B entity within the payment window and, due to complications, be admitted as an inpatient within the payment window. In such cases, the physician practice would bill modifier PD with the specific surgical service code performed (for example, a diagnostic colonoscopy).

Would there be circumstances in which the pre- and post-operative services included with the global surgical package are also subject to the three-day payment window policy?

As indicated in the *Medicare Claims Processing Manual*, Chapter 12, Section 90.7.1, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>, related surgical procedures a wholly-owned or wholly-operated physician practice (or other Part B entity) furnishes within the three-day payment window are subject to the three-day payment window policy. A surgical service with a global period payment would be subject to the three-day payment window policy, when the wholly-owned or wholly-operated physician practice (or other Part B entity) furnishes the surgical service and the date of the actual outpatient surgical procedure falls within the three-day payment window.

When would the actual outpatient surgery and the pre- and post-operative services furnished during the global surgery time frame not be subject to the payment window policy?

If the initial surgical procedure that started the global period is furnished outside the payment window, the three-day (or when applicable one-day) payment window makes no change in billing a surgical service with a global period, even if some of the post-operative visits that are included in the surgical package occur in the three-day payment window.

Should a wholly-owned or wholly-operated physician practice bill for both the inpatient surgical procedure and initial related surgical procedure performed in the wholly-owned or wholly-operated physician office that started

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Window (*continued*)

the global period under the three-day payment window policy?

The three-day payment window policy does not apply to inpatient services. The physician performing the inpatient surgical procedure would bill for the inpatient surgery service code according to normal Medicare rules (e.g. no modifier PD). The wholly-owned or wholly-operated physician practice would bill for the preceding outpatient surgical procedure with the modifier PD if the surgeon was part of the wholly-owned or wholly-operated physician practice.

What Part B services are not subject to the three-day (or one-day) payment window?

We have excluded outpatient maintenance dialysis services and ambulance services from the pre-admission services that are subject to the payment window.

Should I apply the modifier PD to outpatient services related to the inpatient admission when there is no Part A coverage for the inpatient stay?

No, do not apply the modifier PD to related outpatient services when there is no Part A coverage for the inpatient stay. In the event that there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services must be bundled. Therefore, preadmission outpatient diagnostic and related non-diagnostic services furnished within the payment window would not be subject to the three-day (or one-day) payment window policy.

Should the wholly-owned or wholly-operated physician practice (or other Part B entity) modify its actual charge for a related non-diagnostic service to accommodate a facility payment (instead of a non-facility payment)?

The wholly-owned physician practice should include its actual charge when submitting Part B claims for outpatient services subject to the three-day (or one-day) payment window. Medicare does not require that the wholly owned physician practice modify its charge structure to accommodate a facility payment (instead of a non-facility payment); although the physician practice may choose to do so.

When did the three-day (or one-day) payment window policy become effective?

On February 11, 1998, beginning on page 6864 of the *Federal Register*, CMS published a final rule indicating that the payment window applies to diagnostic and related non-diagnostic outpatient services that are otherwise billable under Part B and does not apply to nonhospital services that are generally covered under Part A (such as home health, skilled nursing facility, and hospice). In addition, the rule defined an entity as hospital wholly-owned or hospital wholly-operated if a hospital is the sole owner of the entity or has the exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. The 1998 final rule also defined non-diagnostic services as being related to the admission only when there is an exact match between the ICD-9-CM diagnosis code assigned for both the preadmission services and the inpatient stay. The three-day payment window policy became effective March 13, 1998.

In the FY 2011 IPPS final rule, published August 16, 2010, beginning on page 50346 of the *Federal Register*, CMS discussed changes to the payment window policy (as required by Section 102 of the PACMBPRA of 2010). Effective June 25, 2010, the payment window policy applies to non-diagnostic outpatient services clinically related to the inpatient admission furnished to a Medicare beneficiary by a hospital (or an entity wholly-owned or wholly-operated by the admitting hospital). The payment window policy for diagnostic services remained unchanged. CMS implemented the changes to the definition of "related to" the inpatient admission on April 4, 2011 via CR 7142, Transmittal 796, which was published October 29, 2010.

Moreover, in the CY 2012 MPFS final rule, published November 28, 2011, beginning on page 73279 of the *Federal Register*, CMS finalized the payment window policy as required by the PACMBPRA of 2010, as it relates to wholly-owned or wholly-operated physician practices. The implementing manual instructions became effective January 1, 2012, with a compliance date of July 1, 2012.

For more information

For more information on Medicare's three-day payment window policy, please review the following publications:

- [Change request 7502](#), Transmittal 2373, published December 21, 2011, titled "Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Practices,"
- [Medicare Claims Processing Manual, Publication 100-04, Chapter 12](#), Sections 90.7 and 90.7.1,

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Window (continued)

- [CY 2012 MPFS final rule](#), published November 28, 2011 (76 FR 73279 -73286),
- [FAQs for CR 7502](#),
- [MLN Matters® article MM7502: Bundling of Payment for Services Provided to Outpatients Who Later Are Admitted as Inpatients; 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Offices](#)
- [Physician Fee Schedule page](#), and
- [Hospital Prospective Payment System page](#).

MLN Matters® Number: SE1232
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation Date: NA

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Effect of beneficiary agreements not to use Medicare and when payment is made to beneficiary for opt-out provider services

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8100 which informs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) is amending Chapter 15, Section 40.6 of the *Medicare Benefit Policy Manual* to be consistent with current regulations. In addition, CMS is making some other minor changes to sections 40 through 40.40 of the same manual in order to update those sections of the manual.

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.

Background

Section 4507 of the Balanced Budget Act of 1997 amended section 1802 of the Social Security Act ("the Act") to permit certain physicians and practitioners to opt-out of Medicare if certain conditions were met, and to provide through private contracts services that would otherwise be covered by Medicare.

The purpose of CR 8100 is to modify Section 40.6 of the *Medicare Benefit Policy Manual*, Chapter 15, because to be consistent with the policy described

in Medicare regulations at 42 CFR 405.435(c). That regulation permits Medicare payment to be made for claims submitted by a beneficiary for the services of an opt out physician or practitioner when the physician or practitioner did not privately contract with the beneficiary for services that were not emergency care services or urgent care services and that were furnished no later than 15 days after the date of a notice by the Medicare contractor that the physician or practitioner has opted out of Medicare.

Additional information

The official instruction, CR 8100, 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/R160BP.pdf>. The revised manual sections are attached to CR 8100.

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>.

MLN Matters® Number: MM8100
Related Change Request (CR) #: CR 8100
Related CR Release Date: October 26, 2012
Effective Date: January 28, 2013
Related CR Transmittal #: R160BP
Implementation Date: January 28, 2013

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Issues completing the PWK fax/mail coversheet

First Coast Service Options' (First Coast's) claims department is receiving a high volume of invalid or unnecessary PWK (5010 paperwork segment) fax/mail coversheets. If a coversheet is received containing inaccurate, incomplete, or invalid information, the coversheet will be either faxed or mailed back to the originating source, but without the documentation. Coversheets returned in this manner should not be resent; instead, the provider should await an additional documentation request (ADR) before submitting the documentation again to First Coast.

PWK issues

In other cases, the coversheets and additional documentation are not able to be appropriately attached to a claim due to several reasons. The following list has been developed to assist you in avoiding these situations.

1. PWK coversheet is received, completed accurately with documentation, but the claim was submitted without the indicators in the PWK loop.
 - This will not allow us to assign the documentation in the system to the appropriate claim. If the claim requires documentation, an ADR letter will be sent and providers will need to respond to the letter.
2. PWK coversheet is received with the related documentation attached and a copy of our additional documentation request (ADR) letter. Again, the PWK loop indicators are not on the claim.
 - There are two issues here: 1) without the PWK loop completed, the claim will not suspend to look for any anticipated documentation. Most importantly 2) the claim has already suspended for additional documentation; therefore, providers only need to respond to the ADR letter with appropriate documentation.
3. PWK coversheet is received with a request for an appeal/redetermination in the information box.
 - The PWK process may only be used on initial claim submission. PWK cannot be used to bypass the standard appeals process. Please use the appropriate level of the appeals process if your claim has been denied or you need to make adjustments/corrections. Appeal requests submitted via the PWK fax/mail process will not be acknowledged.
4. In all of these instances, since the PWK fax/mail coversheet and/or claim is not being submitted correctly or with the correct information, the supporting documentation submitted to us is not being utilized to adjudicate the claim. Also, since in most cases this is outside of the standards for PWK, providers affected by these scenarios will not receive a response concerning the outcome or lack thereof.
5. Our internal claims area is being negatively impacted as well as our electronic storage capacity is being overwhelmed by unneeded, unusable documentation. Providers affected by this will more than likely never receive any indication of the negative impacts this is having on their claims.

Reminders

Here are some items to verify before faxing or mailing your form:

- Verify you have indicated the ACN (attachment control number [submitted in the PWK06 segment]), DCN (document control number [Part A]), ICN (internal control number [Part B]), the beneficiary's health insurance claim number (HICN)/Medicare number, billing provider's name and NPI (national provider identifier) on the fax/mail coversheet.
- Include an address to mail the coversheet to, in case we are unable to fax it back to the originating number.
- Do not send in documentation without the completed fax/mail coversheet.
- Do not use the PWK coversheet for any reason other than the PWK process.



Go green to get your green faster

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

January 2013 ASC X12 837 (electronic healthcare claim) CMS edits implementation

As previously communicated, the Centers for Medicare & Medicaid Services (CMS) implemented some of the January 2013 electronic healthcare claim edits in October 2012 per CMS Technical Direction Letter (TDL 12458). That article can be found on our website at the following link:

http://medicare.fcso.com/5010_News/243905.asp.

CMS change request 7880 will implement the edits listed below on January 7, 2013.

- X222.116.2000B.SBR03.004
- X222.480.2430.SVD05-040
- X222.305.2320.AMT.040
- X223.109.2000B.SBR03.004
- X223.364.2320.AMT.040

Electronic claim submission analysis indicates two of the new edits being implemented January 7, 2013, will result in potentially higher than normal claim rejections. New edits, X222.116.2000B.SBR03.004 (professional claims edit) and X223.109.2000B.SBR03.004 (institutional claims edit) will result in a claim rejection if any value is present in 2000B SBR03-Medicare Subscriber Group Number.

Currently Medicare does not assign a group number; therefore, it is not appropriate to submit data in 2000B SBR04, the Medicare Subscriber Group Number field, on the ASC X12 837 (electronic healthcare claim.)

If any data is received in the Destination Payer Medicare Subscriber Group Number field - 2000B SBR04 the claim will be rejected. The rejected claim will be returned on the 277CA (claim acknowledgement) for correction. 277CA Claim Status Codes A8, 163 and 732 and IL will be returned when data has been received in the Subscriber Group Number field

The CMS edit spreadsheets for January 2013 (and for prior quarters) are located at <http://www.cms.gov/Medicare/Billing/MFFS5010D0/Technical-Documentation.html>.



Calculate the possibilities ...

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 new Tool center.

Alert concerning impacts arising from having non-compliant physical or practice address information on file with Medicare

Provider types affected

This *MLN Matters*[®] special edition article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, durable medical equipment Medicare administrative contractors (DME MACs) and A/B MACs) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The purpose of this article is to alert physicians, providers, and suppliers that you need to ensure that your designated FI, carrier, DME MAC or A/B MAC no longer has a post office (P.O.) box or lock box address in association with your billing provider address information on file for you.

Impacts to institutional providers

- For 837 institutional claims, the volume of claims that receive error H25375—"The Billing Provider Address must be a street address. Post office box or lock box addresses are to be sent in the Pay-to Provider Address" – and therefore are not crossed over for processing by another payer is approximately 7,500 claims per week.
- The problem of institutional claims rejecting with error H25375 is particularly acute for providers in Puerto Rico, some of whom unfortunately may be experiencing a 100 percent rejection rate for their institutional crossover claims.

Impacts to physicians and suppliers

- Nationally, by comparison, the incidence of H25375 rejections for 837 professional claims for all states and United States territories is roughly 1,000 per week.

Caution – what you need to know

The Accredited Standards Committee (ASC) X12 Standard for Electronic Data Interchange (EDI) Technical Report Type 3 (TR-3) Guides prohibit inclusion of a P.O. Box or lock box address within the billing provider address (2010AA N301 and N302) segments of any health care claims exchanged electronically between or among Health Insurance Portability and Accountability Act (HIPAA) "covered entities," which include providers, health plans, and clearinghouses.

Creation of bill-to provider address information on outbound Medicare coordination of benefits (COB) claims

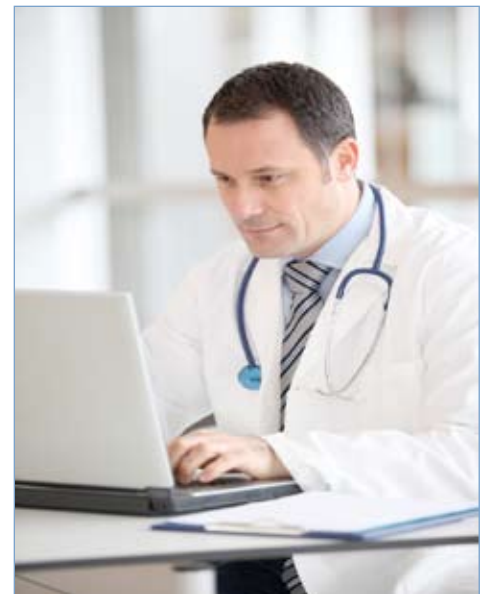
Medicare uses information stored within its internal provider or supplier files for claims payment as well as for coordination of benefits (COB)/Medicare claim crossover purposes. Specifically, the Medicare claim processing systems use on-file physical or practice address information from these data sources in the creation of the required bill-to provider (2010AA) name and address elements.

HIPAA compliance errors impacting Medicare crossover claims

The Centers for Medicare & Medicaid Services (CMS) highlighted the ongoing problem of Medicare crossover claims failing HIPAA compliance at its coordination of benefits contractor (COBC) due to the presence of a P.O. box or lock box within the 2010AA N301 and N302 segments at recent Provider Enrollment, Chain, and Ownership System (PECOS) conferences. This *MLN Matters*[®] special edition article also alerts you to this important concern so that you can act to remedy the problem if it affects you.

Go – what you need to do

If you or your billing offices are receiving provider notification letters from Medicare that reflect error H25375 as the basis for why your patients' claims cannot be crossed over - or that otherwise are encountering a 100 percent incidence of their patients' Medicare claims not being crossed over - you should contact your local jurisdictional FI, carrier, DME MAC, or A/B MAC to confirm what street address information Medicare has on file for you.



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Address *(continued)*

Your Medicare contractor will be able to advise you about what actions involving completion of an on-line 855 application may be necessary to ensure that PECOS and the associated internal Medicare provider and supplier files will reflect your street address for your physical address or practice address, as applicable. Make sure that your billing staffs comply with this special notice, if necessary.

Additional information

If you have any questions, please contact your FI, carrier, DME MAC, 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: SE1245

Related Change Request (CR) #: Not applicable (N/A)

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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General update to the *Program Integrity Manual*

Provider types affected

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

What you need to know

This article is based on change request (CR) 8019, which updates Chapter 15 of the *Medicare Program Integrity Manual (PIM)*. That chapter deals with Medicare provider enrollment. The majority of the revisions are editorial in nature. However, there are several policy updates in this CR related to:

- Correspondence addresses
- Out-of-state practice locations
- Submission of Change of Ownership (CHOW) applications after an initial or CHOW application has been submitted, and
- The scope of revocations and re-enrollment bars.

Make sure that your enrollment staffs are aware of these manual updates. See the Background Section for more details on the policy changes.

Background

The key changes made to Chapter 15 of the *PIM* are as follows:

Correspondence addresses

The correspondence address must be one where the Medicare contractor can contact the applicant to resolve any issues once the provider is enrolled in the Medicare program. It can be any address the provider chooses, including that of a billing agency, management services organization, chain home office, or the provider's representative (e.g., attorney, financial advisor). The provider, however, remains ultimately responsible for all Medicare enrollment-related correspondence that the contractor sends to him/her/it at this address. For instance, if a provider uses its chain home office as the correspondence address, the provider is still the party responsible for replying to revalidation letters, requests for information, etc.

Also, an email address listed on your enrollment application can be a generic email address. It need not be that of a specific individual. Note that the contractor may accept a particular email address if it has no reason to suspect that it does not belong to or is not somehow associated with the provider.

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Manual (continued)**Out-of-state practice locations – Form CMS-855A**

If a provider is adding a practice location in another state that is within the provider's current contractor's jurisdiction, a separate, initial Form CMS-855A enrollment application is not required if the following five conditions are met:

- The location is not part of a separate organization (e.g., a separate corporation, partnership)
- The location does not have a separate tax identification number (TIN) and legal business name (LBN)
- The state in which the new location is being added does not require the location to be surveyed
- The applicable Medicare regional office (RO) does not require the new location or its owner to sign a separate provider agreement, and
- The location is not a federally qualified health center (FQHC), which are required to separately enroll each site.

Consider the following examples:

1. The Medicare contractor's jurisdiction consists of states X, Y and Z. Jones Skilled Nursing Facility (JSNF), Inc., is enrolled in state X with three sites. It wants to add a fourth site in state Y. The new site will be under JSNF, Inc. JSNF will not be establishing a separate corporation, LBN or TIN for the site, and - per the state and RO - a separate survey and provider agreement is not necessary. Since all five conditions above are met, JSNF can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). To the extent required, the contractor shall create a separate Provider Enrollment, Chain, and Ownership System (PECOS) enrollment record for the state Y location.
2. The contractor's jurisdiction consists of states X, Y and Z. JSNF, Inc., is enrolled in state X with three locations. It wants to add a fourth location in state Y but under a newly created, separate legal entity - JSNF, LP. The fourth location must be enrolled via a separate, initial Form CMS-855A.
3. The contractor's jurisdiction consists of states X, Y and Z. Jones Hospice (JH), Inc., is enrolled in state X with one location. It wants to add a second location in state Z under JH, Inc. However, it has been determined that a separate survey and certification of the new location are required. A separate initial Form CMS-855A for the new location is required.

Out-of-state practice locations – Form CMS-855B

If a supplier is adding a practice location in another state that is within the contractor's jurisdiction, a separate, initial Form CMS-855B enrollment application is not required if the following five conditions are met:

- The location is not part of a separate organization (e.g., a separate corporation, partnership)
- The location does not have a separate tax identification number (TIN) and legal business name (LBN)
- The state that the new location is being added does not require the location to be surveyed
- The applicable RO does not require the new location or its owner to sign a separate supplier agreement, and
- The location is not an independent diagnostic testing facility (IDTF), which is are required to separately enroll each site.

Consider the following examples:

1. The contractor's jurisdiction consists of states X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in state X with three locations. It wants to add a fourth location in state Y. The new location will be under JGP, Inc. JGP will not be establishing a separate corporation, LBN or TIN for the fourth location. Since there is no state or RO involvement with group practices, all five conditions are met. JGP can add the fourth location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure, new managing employees). To the extent required, the contractor shall create a separate enrollment record in the Provider Enrollment, Chain, and Ownership System (PECOS) for the state Y location.
2. The contractor's jurisdiction consists of states X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in state X with three locations. It wants to add a fourth location in state Y, but under a newly created, separate entity - Jones Group Practice, LP. The fourth location must be enrolled via a separate, initial Form CMS-855B.

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Manual (continued)

3. The contractor's jurisdiction consists of states X, Y and Z. Jones Group Practice (JGP), Inc., is enrolled in state X with three locations. It wants to add a fourth location in state Q. Since state Q is not within the contractor's jurisdiction, a separate initial enrollment for the fourth location is necessary.
4. The contractor's jurisdiction consists of states X, Y and Z. Jones Ambulatory Surgical Center (JASC), Inc., is enrolled in state X with three locations. It wants to add a fourth location in state Z under JASC, Inc. However, it has been determined that a separate survey and certification of the new site are required. A separate, initial Form CMS-855B is therefore necessary.

Out-of-state practice locations – Form CMS-855I

If a supplier is adding a practice location in another state that is within the contractor's jurisdiction, a separate, initial Form CMS-855I enrollment application is not required if the following conditions are met:

- The location is not part of a separate organization (e.g., a separate solely-owned corporation), and
- The location does not have a separate tax identification number (TIN) and legal business name (LBN).

Consider the following examples:

1. The contractor's jurisdiction consists of states X, Y and Z. Dr. Jones, a sole proprietor, is enrolled in state X with two locations. He wants to add a third location in state Y under his social security number and his sole proprietorship's employer identification number. He can add the third location via a change of information request, rather than an initial application. The change request must include all information relevant to the new location (e.g., licensure). To the extent required, the contractor shall create a separate PECOS enrollment record for the state Y location.
2. The contractor's jurisdiction consists of states X, Y and Z. Dr. Jones, LLC (a solely-owned limited liability company) is enrolled in state X with two locations. Dr. Jones wants to add a third location in state Y but as a sole proprietorship, not as part of Dr. Jones, LLC. Since the new location is not part of the same organizational entity, it must be enrolled via a separate, initial Form CMS-855I.

Submission of CHOW applications after an initial or CHOW application has been submitted

(This section does not apply to home health agencies)

In situations where (1) the provider submits a Form CMS-855A initial application or CHOW application and (2) a Form CMS-855A CHOW application is subsequently submitted but before the Medicare contractor has received the tie-in notice from the RO, the contractor shall abide by the following:

- **Situation 1** – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval has not yet been made with respect to the initial application – The contractor shall reject both applications and require the provider to re-submit an initial application with the new owner's information.
- **Situation 2** – The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has not been made for the first application – The contractor shall process both applications – preferably in the order in which they were received – and shall, if recommendations for approval are warranted, refer both applications to the state/RO in the same package. The accompanying notice/letter to the state/RO shall explain the situation.
- **Situation 3** – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made – The contractor shall:
 1. Reject the CHOW application.
 2. Notify the state/RO via letter (sent via mail or email) that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.
 3. Request via letter that the provider submit a new initial Form CMS-855A application containing the new owner's information within 30 days of the date of the letter. If the provider fails to do so, the contractor shall reject the initial application and notify the provider and the state/RO of this via letter. If the provider submits the application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the state/RO with an explanation of the situation; the initially submitted application becomes moot. If the newly submitted application is denied, however, the initially submitted application is denied as well; the contractor shall notify the provider and the state/RO accordingly.

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Manual *(continued)*

- **Situation 4** – The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:
 1. Notify the state/RO via emailed letter that a CHOW application has been submitted (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.
 2. Process the new CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the state/RO with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted CHOW application is denied, the first application is denied as well; the contractor shall notify the provider and the state/RO accordingly.

Scope of revocation and reenrollment bar

A chart has been added to Chapter 15 of the *PIM* that outlines the extent to which (1) a particular revocation generally applies to the provider's other locations and (2) the re-enrollment bar applies. The chart is in Section 15.27.2.F of that chapter.

Additional information

The official instruction, CR 8019, issued to your FI, RHHI, carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R435PI.pdf>. The entire revised Chapter 15 of the *PIM* is attached to that CR.

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

MLN Matters® Number: MM8019

Related Change Request (CR) #: CR 8019

Related CR Release Date: October 19, 2012

Effective Date: November 20, 2012

Related CR Transmittal #: R435PI

Implementation Date: November 20, 2012

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Revision to Chapter 15 of the Medicare Program Integrity Manual

Provider types affected

This *MLN Matters*® article for change request (CR) 7864 is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries where payment is reassigned to another Medicare Part A or Part B entity other than physician/practitioner group practices.

Provider action needed**Stop – impact to you**

This article is based on CR 7864 which revises the *Medicare Program Integrity Manual* (Chapter 15, Section 15.5.20) to be consistent with the policies outlined in 42 CFR 424.80(b)(1) and the *Medicare Claims Processing Manual* (Chapter 1, Sections 30.2.1(D) & (E), and Sections 30.2.6 & 30.2.7).

Caution – what you need to know

CR 7864 points out that Part A and Part B entities other than physician/practitioner group practices can receive reassigned benefits, assuming that the requirements for a reassignment exception are met and that the reassignee meets all enrollment requirements. The entity receiving the reassigned benefits must enroll with the contractor via a Form CMS-855B, and the physician or other supplier reassigning benefits must complete and submit a Form CMS-855I and Form CMS-855R.

(continued on next page)

Revision (continued)**Go – what you need to do**

See the *Background* and *Additional information* sections of this article for further details regarding reassigned benefits.

Background

Consistent with 42 CFR § 424.80(b)(1) and (b)(2), and the *Medicare Claims Processing Manual* (Chapter 1, Sections 30.2.1(D) & (E), 30.2.6, and 30.2.7), Medicare may pay:

- 1) A physician or other supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services; or
- 2) An entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other supplier under a contractual arrangement with that entity.

You can review 42 CFR § 424.80(b)(1) and (b)(2) at http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=0b629bfa5fc2351c4fbf9486863d5234&c=ecfr&tpl=/ecfrbrowse/Title42/42cfrv3_02.tpl, and the *Medicare Claims Processing Manual* (Chapter 1, Section 30.2.1(D) & (E); Section 30.2.6, and Section 30.2.7) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>.

This means that Part A and Part B entities other than physician/practitioner group practices can receive reassigned benefits, assuming that the requirements for a reassignment exception are met and that the reassignee meets all enrollment requirements.

For example, for Part A, this might occur with:

- 1) A physician or other supplier reassigning benefits to a hospital, skilled nursing facility (SNF), or critical access hospital (CAH), or
- 2) A nurse practitioner reassigning benefits to a CAH.

The entity receiving the reassigned benefits must enroll with the contractor via a Form CMS-855B, and the physician or other supplier reassigning benefits must complete and submit a Form CMS-855I and Form CMS-855R.

You can find these enrollment forms (CMS-855) at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf>.

Additional information

The official instruction, CR 7864, issued to your carriers and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R437PI.pdf>.

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

MLN Matters® Number: MM7864

Related Change Request (CR) #: CR 7864

Related CR Release Date: November 2, 2012

Effective Date: February 1, 2013

Related CR Transmittal #: R437PI

Implementation Date: February 1, 2013

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Phase 2 of ordering/referring requirement

Note: This article was revised on November 1, 2012, to replace a reference to the Social Security Act with a reference to the Affordable Care Act. Also, a clarification was made regarding the type of providers who may order/refer portable X-ray services. All other information remains the same. This information was previously published in the September 2012 *Medicare B Connection*, Pages 43-46.

Provider types affected

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

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

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

Background

The Affordable Care Act requires physicians or other eligible professionals to be enrolled in the Medicare Program to order/ refer items or services for Medicare beneficiaries. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the national provider identifier (NPI).

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

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

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

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry)
- Physician assistant
- Clinical nurse specialist
- Nurse practitioner
- Clinical psychologist

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Phase *(continued)*

- Interns, residents, and fellows
- Certified nurse midwife
- Clinical social worker

The following exception is applicable for Part B services:

- Only doctors of medicine or osteopathy may order/refer portable X-ray services.

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

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

N264 Missing/incomplete/invalid ordering physician provider name

N265 Missing/incomplete/invalid ordering physician primary identifier

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

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

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

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

N272 Missing/incomplete/invalid other payer attending provider identifier

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

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

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

254D	Referring/Ordering Provider Not Allowed To Refer
255D	Referring/Ordering Provider Mismatch
289D	Referring/Ordering Provider NPI Required

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

37236 – This reason code will assign when:

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

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

37237 - This reason code will assign when:

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

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Phase (continued)

- The type of bill frequency code is '7' or 'F-P'
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

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

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

Additional information

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

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

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

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

- *MLN Matters*[®] article MM6417, "Expansion of the Current Scope of Editing for Ordering /Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6417.pdf>.
- *MLN Matters*[®] article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6421.pdf>.
- *MLN Matters*[®] article MM6856, "Expansion of the Current Scope of Editing for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) claims processed by Medicare Regional Home Health Intermediaries (RHHIs)", is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf>.
- *MLN Matters*[®] article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7097.pdf>.
- *MLN Matters*[®] article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6129.pdf>.
- *MLN Matters*[®] special edition article SE1011, "Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696)," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf>.
- *MLN Matters*[®] special edition article SE1201 "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf>.

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Phase (continued)

- *MLN Matters*[®] special edition article SE1208, “855-O Medicare Enrollment Application Ordering and Referring Physicians or Other Eligible Professionals,” is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1208.pdf>.

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

MLN Matters[®] Number: SE1221 *Revised*

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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Physician Quality Reporting System incentive payments for the 2011 reporting period

The Centers for Medicare & Medicaid Services (CMS) established the Physician Quality Reporting System to allow eligible professionals to participate in a voluntary quality-reporting program. Eligible professionals, who successfully report a designated set of quality measures on claims for the reporting period, receive an annual incentive payment.

The annual incentive payments for the 2011 reporting period were issued on October 24, 2012.

If you receive an electronic remittance notice, your Physician Quality Reporting System incentive payment can be identified by the following message: “LE-P4R”.

If you receive a paper remittance notice, your Physician Quality Reporting System incentive payment can be identified by the following message: “This is a PQRS incentive payment”.

For more information on the Physician Quality Reporting System, access the following link: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.



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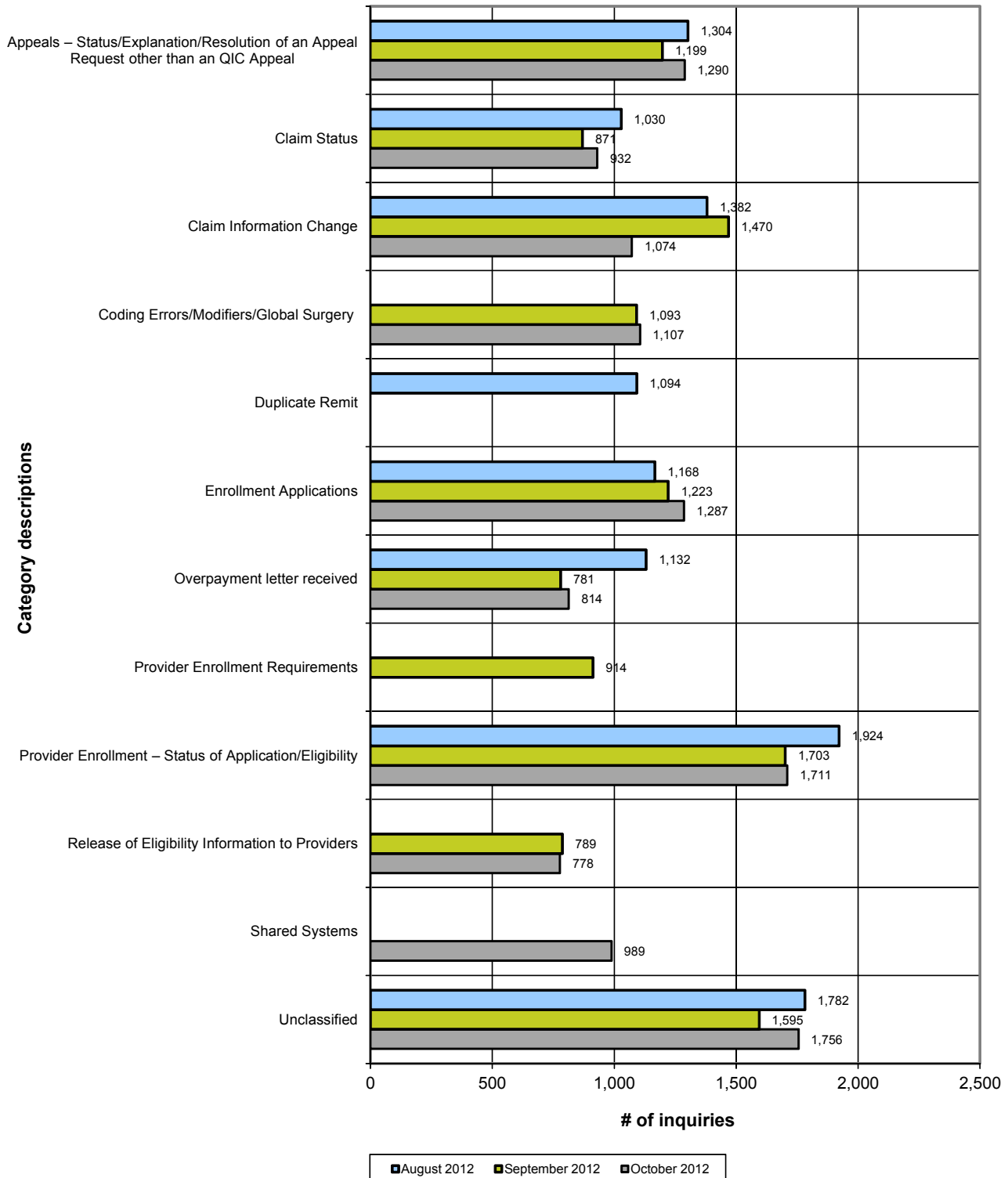
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Top inquiries, denials, and return unprocessable claims

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 August-October 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.

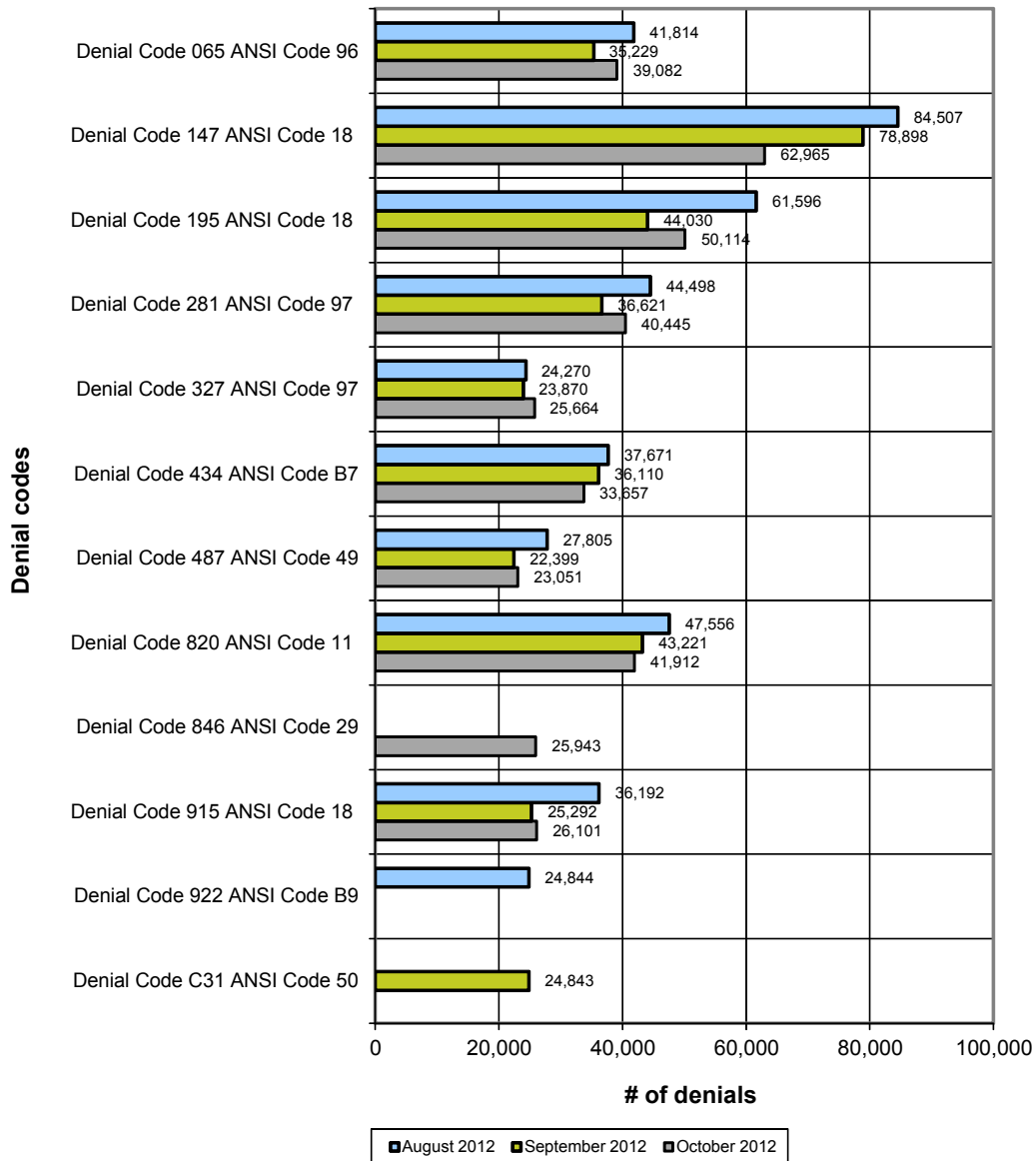
Part B top inquiries for August-October 2012



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Top (continued)

Part B top denials for August-October 2012



What to do when your claim is denied

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

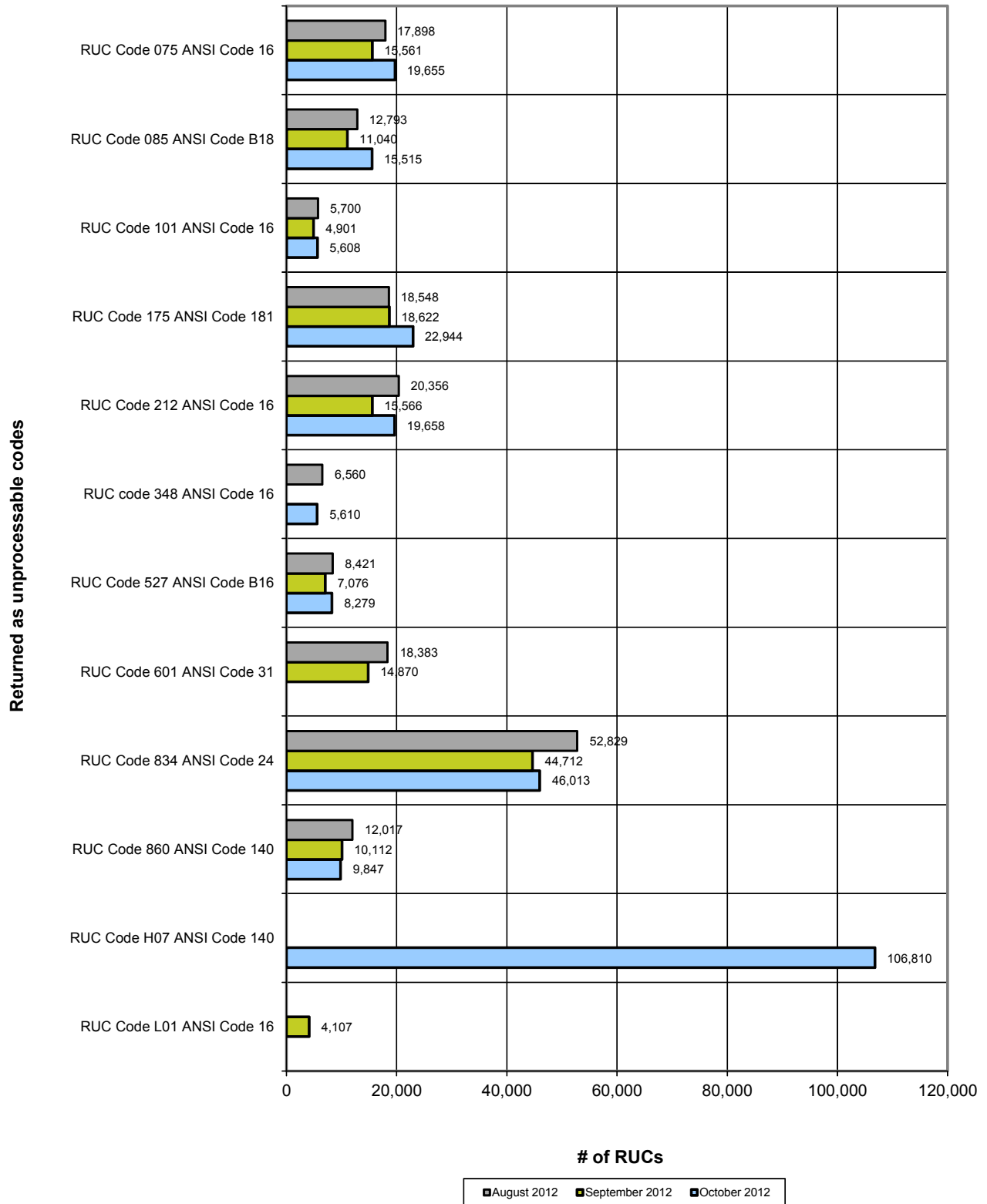
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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 August-October 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

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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

BOTULINUM TOXINS: Botulinum toxins – revision to the LCD

LCD ID number: L29088 (Florida)

LCD ID number: L29103 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was most recently revised March 29, 2012. Since that time, the “Documentation Requirements” section of the LCD has been revised to clarify the third bullet related to unsuccessful conventional methods of treatment.

Effective date

This LCD revision is effective for claims processed **on or after October 18, 2012**. First Coast Service Options Inc. (First Coast) 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](#).

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

LCD ID number: L29266 (Florida)

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

The local coverage determination (LCD) for ranibizumab (Lucentis®) was most recently revised August 10, 2012. Since that time, it has been determined that a revision to the “ICD-9 Codes that Support Medical Necessity” section of the LCD and the “Coding Guidelines” attachment was also necessary related to the addition of the new Food and Drug Administration (FDA) label indication diabetic macular edema (DME) (ICD-9-CM code 362.07). Therefore, a separate bullet was added for diabetic macular edema with language requiring a dual diagnosis (Diagnosis 362.07 must be submitted with a code for diabetic retinopathy [ICD-9-CM codes 362.01-362.06]).

In addition, ICD-9-CM code 362.07 was removed from the first bullet listed under “Macular edema following retinal vein occlusion (RVO),” since the FDA label only indicates macular edema for RVO indication. The appropriate ICD-9-CM coding should be supported by the documentation in the medical record for the service provided.

Effective date

This LCD revision is effective for claims processed **on or after November 30, 2012**, for services rendered **on or after August 10, 2012**. First Coast Service Options Inc. (First Coast) 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](#).

Find fees faster: Try First Coast’s fee schedule lookup

Now you can find the fee schedule information you need faster than ever before with First Coast’s redesigned fee schedule lookup, located at http://medicare.fcso.com/Fee_lookup/fee_schedule.asp. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

77301: Intensity modulated radiation therapy (IMRT) – revision to the LCD

LCD ID number: L29200 (Florida)

LCD ID number: L29352 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for intensity modulated radiation therapy (IMRT) was most recently revised October 5, 2009. Since that time, a revision was made under the “ICD-9 Codes that Support Medical Necessity” section of the LCD to add ICD-9-CM diagnosis code 198.5 (Secondary malignant neoplasm of bone and bone marrow).

Effective date

This LCD revision is effective for services rendered **on or after November 29, 2012**. First Coast Service Options Inc. (First Coast) 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](#).

77371: Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – revision to the LCD

LCD ID number: L30366 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) was effective October 5, 2009. Since that time, a revision was made under the “ICD-9 Codes that Support Medical Necessity” section of the LCD to add ICD-9-CM diagnosis code 198.5 (Secondary malignant neoplasm of bone and bone marrow) for procedure codes 77373, G0339, and G0340 for SBRT.

Effective date

This LCD revision is effective for services rendered **on or after November 29, 2012**. First Coast Service Options Inc. (First Coast) 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](#).



Find out first: Subscribe to First Coast eNews

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

Educational Events

Upcoming provider outreach and educational events December 2012

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.fcsso.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 has extended it until further notice. The following are links to the latest e-News:
- 'CMS Medicare FFS Provider e-News': October 25, 2012 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-25-e-News.pdf>
- 'CMS Medicare FFS Provider e-News': November 1, 2012 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-01-e-News.pdf>
- CMS e-News for Wednesday, November 8, 2012 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-08-Enews.pdf>
- 'CMS Medicare FFS Provider e-News': November 15, 2012 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-15-e-News.pdf>
- 'CMS Medicare FFS Provider e-News': November 21, 2012 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-21-e-News.pdf>

Source: CMS PERL 201210-07, 201210-09, 201211-04, 201211-05, 201211-06

New look for the CMS Medicare FFS Provider e-News

You'll notice some changes to the weekly CMS Medicare fee-for-service (FFS) Provider e-News. It has the same great content, but with a new look as the Centers for Medicare & Medicaid Services transitioned to a new delivery system.

What's new?

- Refreshed, cleaner design with new header graphic
- Email body is a preview of the week's e-News issue table of contents, with a link to the full text version of the newsletter.
- New link to [subscribe](#) or manage your subscription. Refer your colleagues.

If you did not receive the e-News on November 8, please subscribe using the link above.

Thank you for your continued interest in Medicare FFS news.

Source: CMS PERL 201211-02

Medical identity theft Web-based training course for providers

In April 2012, the Centers for Medicare & Medicaid Services (CMS) produced a medical identity theft Web-based training course that is currently available on the CMS *Medicare Learning Network* website. The *Safeguarding Your Medical Identity* course is designed to educate Medicare providers on how to recognize the risks of medical identity theft and the resources available to protect their medical identity.

The training course features Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity. It discusses the scope and definition of medical identity theft, common schemes using stolen identities, consequences for victims, mitigation strategies, and appropriate actions for potential victims of medical identity theft. Health care professionals can earn a total of 1.0 hour of continuing medical education (CME) credit, after completing a post-assessment with three questions. Registration is required to earn CME credit, and instructions for registration can be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SafeMed-ID-Products.pdf>.

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
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education

Educational purposes and review of customary/prevaling 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

and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

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/prevaling 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

Addresses

Claims

Additional documentation

General mailing

Congressional mailing

First Coast Service Options Inc.
P.O. Box 45036
Jacksonville, FL 32232-5036

Redeterminations

First Coast Service Options Inc.
P.O. Box 45056
Jacksonville, FL 32232-5056

Redeterminations on overpayment

First Coast Service Options Inc.
P.O. Box 45015
Jacksonville, FL 32232-5015

Post-payment medical exams

First Coast Service Options Inc.
P.O. Box 44159
Jacksonville, FL 32231-4159

Freedom of Information Act (FOIA) related requests

First Coast Service Options Inc.
P.O. Box 45092
Jacksonville, FL 32232-5092

Medicare fraud and abuse

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

Provider enrollment

Mailing address changes

First Coast Service Options Inc.
Provider Enrollment
Post Office Box 44021
Jacksonville, FL 32231-4021

Electronic Data Interchange (EDI)

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

Flu vaccinated list

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

Local coverage determinations

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

Debt collection

Overpayments, questions about Medicare as a secondary payer, cash management
First Coast Service Options Inc.
P.O. Box 45040
Jacksonville, FL 32232-5040

Overnight mail and other special handling postal services

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

Other Medicare contractors and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)

CIGNA Government Services
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary

Palmetto Government Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare

Palmetto Government Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Phone numbers

Providers

Customer service – free of charge

Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-715-1921

For the hearing and speech impaired (TDD)

1-888-216-8261

Interactive voice response (IVR)

1-877-847-4992

Beneficiary

Customer service – free of charge

1-800-MEDICARE
1-800-633-4227

Hearing and speech impaired (TDD)

1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number

1-904-361-0407

Website for Medicare

Providers

First Coast – MAC J9

medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services

www.medicare.gov

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 []				
<i>Please write legibly</i>			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