Medicare B Connection

A Newsletter for MAC Jurisdiction 9 Providers

December 2012

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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 Medicare administrative contractors (A/B MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8052 which informs Medicare contractors about the changes needed to update the claim processing system with the new calendar year (CY) 2013 Medicare rates. 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

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for health insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for twp years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

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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/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44.*

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html*.

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 (wavier 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.

April 2013 update to correct coding initiative edits

Provider types affected

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

Provider action needed

Change request (CR) 8147 provides a reminder for physicians to take note of the quarterly updates to correct coding initiative (CCI) edits. The last quarterly release of the edit module was issued in January 2013.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The coding policies developed are based on coding conventions defined in the:

- American Medical Association's (AMA's) *Current Procedural Terminology (CPT) Manual*
- National and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice, and by
- Review of current coding practice.

The latest package of CCI edits, version 19.1, is effective April 1, 2013, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in two tables:

- Column I/Column 2 correct coding edits
- Mutually exclusive code (MEC) edits

Additional information about the CCI, including the current CCI and mutually exclusive code (MEC) edits, is available at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, (Chapter 23, Section 20.9) which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

The official instruction, CR 8147, issued to your carrier or and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2609CP.pdf*.

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

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Implementation Date: April 1, 2013

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October 2012 update to correct coding initiative edits

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8006, which provides a reminder for physicians to take note of the quarterly updates to correct coding initiative (CCI) edits. The last quarterly release of the edit module was issued in July, 2012.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The coding policies developed are based on coding conventions defined in the:

- American Medical Association's (AMA's) *Current Procedural Terminology®* (CPT®) Manual
- National and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice, and by
- Review of current coding practice.

The latest package of CCI edits, version 18.3, is effective October 1, 2012, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in two tables:

- Column I/Column 2 Correct Coding edits, and
- Mutually exclusive code (MEC) edits.

Additional information about the CCI, including the current CCI and mutually exclusive code (MEC) edits, is available at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, (Chapter 23, Section 20.9) which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

The official instruction, CR 8006, issued to your carrier or and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2498CP.pdf*.

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

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Implementation Date: October 1, 2012

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Update to claim processing instructions for non-physician practitioners

Provider types affected

This *MLN Matters*® article affects non-physician practitioners (NPPs), i.e., physicians assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), clinical psychologists (CPs), and clinical social workers (CSWs) submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8010 deletes and/or corrects obsolete and erroneous billing information in Chapter 12 of the *Medicare Claims Processing Manual* as it relates to claim processing instructions for PAs, NPs, CNSs, CPs, and CSWs. Make sure that your billing staffs are aware of these changes.

Background

Key manual revisions/updates conveyed in CR 8010 are as follows:

- NPP assistant-at-surgery services should be billed with the AS modifier only.
- The health professional shortage area (HPSA) payment modifiers, QB and QU have been eliminated because they are no longer valid.
- The AH modifier for CPs and, the AJ modifier for CSWs have been eliminated because they are no longer necessary for identification purposes.
- The correct payment amount for the professional services of PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of what a physician is paid under the Medicare physician fee schedule (MPFS).
- Additionally, the correct payment amount for assistant-at-surgery services furnished by PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of 16 percent of what a physician is paid under the MPFS for surgical services.
- Procedures billed with the assistant-at-surgery physician modifiers 80, 81, 82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the assistant-at-surgery policy. Accordingly, Medicare will pay claims for procedures with these modifiers only if the services of an assistant-at-surgery are authorized.
- Medicare's policies on billing patients in excess of the Medicare allowed amount apply to assistant-at-surgery services.
- When a PA, NP, or CNS furnishes services to a patient during a global surgical period, Medicare contractors shall determine the level of PA, NP, or CNS involvement in furnishing part of the surgeon's global surgical package consistent with their current practice for processing such claims.
- Billing requirements and adjudication of claims requirements for global surgeries are under Chapter 12, Sections 40.2 and 40.4 of the *Medicare Claims Processing Manual.*
- PAs must have their own "nonphysician practitioner" national provider identification (NPI) number. This NPI is used for identification purposes only when billing for PA services, because only an appropriate PA employer or a provider/supplier for whom the PA furnishes services as an independent contractor can bill for PA services.
- Specialty code 97 applies for PAs enrolled in Medicare. NPs enrolling in Medicare use specialty code 50 and CNSs use specialty code 89.

Additional information

The official instruction, CR 8010 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/R2610CP.pdf*.

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

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Durable Medical Equipment

2013 update for durable medical equipment, prosthetics, orthotics, and supplies fee schedule

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), or regional home health intermediaries (RHHIs) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8133 to advise providers of the calendar year (CY) 2013 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Be sure your staffs are aware of these updates.

Background and key points of CR 8133

The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR 414.102 for parenteral and enteral nutrition (PEN) on the CMS website.

Fee schedule files

The DMEPOS fee schedule file will also be available for state Medicaid agencies, managed care organizations, and other interested parties at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html*.

Healthcare Common Procedure Coding System (HCPCS) codes added/deleted

The following new codes are effective as of January 1, 2013:

- A4435 in the ostomy, tracheostomy, and urological supplies (OS) payment category
- E0670 and E2378 in the inexpensive/routinely purchased (IN) payment category
- L5859, L7902 and L8605 in the prosthetics and orthotics (PO) payment category, and
- V5281 – V5290 (67).

The fee schedule amounts for codes E2378, L5859, L7902 will be established as part of the July 2013 DMEPOS fee schedule update, when applicable. Also when applicable, DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2013, through June 30, 2013. The new codes are not to be used for billing purposes until they are effective on January 1, 2013.

For gap-filling purposes, the 2012 deflation factors by payment category are listed in the following table:

Factor	Category
0.477	Oxygen
0.480	Capped Rental
0.482	Prosthetics and Orthotics
0.611	Surgical Dressings
0.665	Parenteral and Enteral Nutrition

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DMEPOS *(continued)*

Specific coding and pricing issues

1. The fee schedule amounts for shoe modification codes A5503 through A5507 are adjusted to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2013, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 are weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2011. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2013.
2. Effective January 1, 2013, new code L8605 Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ML is being added to the HCPCS code set. This code falls under the claim processing jurisdiction of local carriers rather than the DME MACs. Fee schedule amounts for this code are added as part of this update.

CY 2013 fee schedule update factor

For CY 2013, the update factor of 0.8 percent is applied to the applicable CY 2012 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2013 by the percentage increase in the consumer price index (CPI) for all urban (U) consumers (United States city average), CPI-U, for the 12-month period ending with June of 2012, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP).

The MFP adjustment is 0.9 percent and the CPI-U percentage increase is 1.7 percent. Thus, the 1.7 percentage increase in the CPI-U is reduced by the 0.9 percent MFP adjustment resulting in a net increase of 0.8 percent for the 2013 MFP-adjusted update factor.

2013 update to labor payment rates

2013 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.7 percent effective for dates of service on or after January 1, 2013, through December 31, 2013, and those rates are as follows:

State	K0739	L4205	L7520	State	K0739	L4205	L7520
AK	$26.92	$30.67	$36.08	NJ	$19.28	$21.28	$28.91
AL	$14.29	$21.30	$28.91	NM	$14.29	$21.30	$28.91
AR	$14.29	$21.30	$28.91	NV	$22.77	$21.28	$39.41
AZ	$17.67	$21.28	$35.57	NY	$26.32	$21.30	$28.91
CA	$21.93	$34.96	$40.75	OH	$14.29	$21.28	$28.91
CO	$14.29	$21.30	$28.91	OK	$14.29	$21.30	$28.91
CT	$23.87	$21.77	$28.91	OR	$14.29	$21.28	$41.57
DC	$14.29	$21.28	$28.91	PA	$15.34	$21.91	$28.91
DE	$26.32	$21.28	$28.91	PR	$14.29	$21.30	$28.91
FL	$14.29	$21.30	$28.91	RI	$17.03	$21.93	$28.91
GA	$14.29	$21.30	$28.91	SC	$14.29	$21.30	$28.91
HI	$17.67	$30.67	$36.08	SD	$15.97	$21.28	$38.65
IA	$14.29	$21.28	$34.61	TN	$14.29	$21.30	$28.91
ID	$14.29	$21.28	$28.91	TX	$14.29	$21.30	$28.91
IL	$14.29	$21.28	$28.91	UT	$14.33	$21.28	$45.02
IN	$14.29	$21.28	$28.91	VA	$14.29	$21.28	$28.91
KS	$14.29	$21.28	$36.08	VI	$14.29	$21.30	$28.91
KY	$14.29	$27.27	$36.97	VT	$15.34	$21.28	$28.91
LA	$14.29	$21.30	$28.91	WA	$22.77	$31.21	$37.07
MA	$23.87	$21.28	$28.91	WI	$14.29	$21.28	$28.91

(continued on next page)

DMEPOS *(continued)*

State	K0739	L4205	L7520	State	K0739	L4205	L7520
MD	$14.29	$21.28	$28.91	WV	$14.29	$21.28	$28.91
ME	$23.87	$21.28	$28.91	WY	$19.92	$28.38	$40.31
MI	$14.29	$21.28	$28.91	MN	$14.29	$21.28	$28.91
MO	$14.29	$21.28	$28.91	MS	$14.29	$21.30	$28.91
MT	$14.29	$21.28	$36.08	NC	$14.29	$21.30	$28.91
ND	$17.81	$30.61	$36.08	NE	$14.29	$21.28	$40.31
NH	$15.34	$21.28	$28.91				

2013 national monthly payment amounts for stationary oxygen equipment

CR 8133 implements the 2013 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2013. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the payment class for oxygen generating portable equipment (OGPE).

The updated 2013 monthly payment amount of $177.36 includes the 0.8 percent update factor for the 2013 DMEPOS fee schedule.

Please note that when the stationary oxygen equipment fees are updated, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2013 maintenance and servicing payment for certain oxygen equipment

CR 8133 also updates the 2013 payment amount for maintenance and servicing for certain oxygen equipment.

You can read more about payment for claims for maintenance and servicing of oxygen equipment in *MLN Matters*® articles, MM6792, which is at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf* and MM6990, which is at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf*.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR Section 414.210(5) (iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section1834(a)(14) of the Act. Thus, the 2012 maintenance and servicing fee is adjusted by the 0.8 percent MFP-adjusted covered item update factor to yield CY 2013 maintenance and servicing fee of $68.05 for oxygen concentrators and transfilling equipment.

Additional information

You can find the official instruction, CR 8133, issued to your FI, carrier, RHHI, or A/B MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2608CP.pdf*.

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

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Medicare DMEPOS Competitive Bidding Program – quick reference article

Provider types affected

This *MLN Matters*® special edition article is informational in nature. It is intended to be a quick reference tool for all health care professionals who order or refer patients for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in a competitive bidding area (CBA).

Background

The Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program (The Program) was successfully implemented in nine areas on January 1, 2011. Round 2 of The Program is targeted to go into effect in 91 Metropolitan Statistical Areas (MSAs) on July 1, 2013. Medicare will also be implementing a national mail-order program for diabetic testing supplies at the same time as Round 2. The national mail-order program will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

When a round of The Program becomes effective, beneficiaries with Original Medicare who obtain competitively bid items in CBAs must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. Referral agents located in CBAs who prescribe DMEPOS for Medicare beneficiaries or refer beneficiaries to specific suppliers should be aware of which suppliers in the area are contract suppliers. The Centers for Medicare & Medicaid Services (CMS) plans to announce the contract suppliers for Round 2 and the national mail order program in the spring of 2013.

About this article

This article is designed as a quick reference tool that provides referral agents with a list of important web links and phone numbers to find information on The Program. The information found at these sources will greatly assist referral agents in locating information that will assist them in obtaining DMEPOS items and services for Medicare beneficiaries. For purposes of The Program, referral agents include such entities as Medicare enrolled providers, physicians, treating practitioners, discharge planners, social workers, disability/disease-based organizations, and pharmacists who refer beneficiaries for services in a CBA.

Referral agents play a critical role in helping beneficiaries select DMEPOS suppliers that can meet the beneficiaries' needs and meet the requirements of the program. A beneficiary's first contact with The Program may be at the point when he or she receives a prescription for a competitively bid item. If the beneficiary resides in a CBA or is visiting a CBA in which he or she needs to obtain a competitively bid item, he or she may need to be directed to a contract supplier.

Where do I go to learn more about the Medicare DMEPOS Competitive Bidding Program?

The CMS Web page on The Program (*http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html*) provides links to the latest news, press releases, announcements and fact sheets. A link to the Round 2/National Mail Order timeline can also be found on this Web page.

Partnering with CMS is a key to helping people with Medicare maximize their benefits. Beyond extending the reach of these important benefits to people who need them, a partnership helps you leverage resources by fostering relationships with other CMS partners, keeps you informed, and provides you with expert training, educational materials, tools such as this toolkit at *http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS_Toolkit.html*, research, and a connection to CMS' 10 regional offices, where you may access personalized local assistance.

Email updates for referral agents

In the coming months leading up to the start of The Program, CMS will send out more information that will be helpful for referral agents and guide them through the changes that the new program brings.

(continued on next page)

Competitive *(continued)*

In light of the important role that referral agents serve, CMS has adopted the use of a new email update to better communicate the various aspects of The Program and to ensure that official information is released and received by referral agents as quickly as possible. CMS encourages all referral agents to sign up for this new email update to ensure they receive the most accurate and timely information regarding The Program.

To ensure you give Medicare patients correct DMEPOS information, sign up for the email updates for referral agents (*https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7814*)

How do I know if a Medicare beneficiary resides in a competitive bidding area?

The Competitive Bidding Implementation Contactor (CBIC) provides a tool at *http://www.dmecompetitivebid.com* to find a CBA on its website. To determine if a beneficiary resides in a CBA, click on the "Find a CBA" tab and enter the ZIP code of the beneficiary's permanent residence on file with the Social Security Administration (SSA).

The tool will indicate whether the ZIP code is within a CBA or not.

How do I find a Medicare contract supplier for a Medicare beneficiary in a CBA?

The Medicare.gov website (*http://www.medicare.gov/default.aspx*) provides a supplier directory tool under the "Resource Locator" tab for finding a Medicare contract supplier to provide certain durable medical equipment in the Medicare DMEPOS Competitive Bidding Program where the beneficiary resides. Once the contract suppliers have been announced, the supplier directory tool will indicate whether the beneficiary is affected by the Medicare Competitive Bidding program based on the beneficiary's ZIP code and the particular DMEPOS needed.

Customer service representatives at 1-800-MEDICARE (1-800-633-4227) can also assist beneficiaries in finding a contract supplier. TTY users should call 1-877-486-2048.

How do I know what DMEPOS items and services are competitively bid items in the program?

Product categories are groupings of related items that are used to treat a similar medical condition. A list of the product categories for Round 2 can be found by visiting *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Product_Categories_and_Items.html*.

The CBIC provides a tool to identify specific items within a product category by Healthcare Common Procedure Coding System (HCPCS) code at *http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Product%20 Categories*.

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Evaluation and Management

Expansion of Medicare telehealth services for calendar year 2013

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7900 which updates the list of Medicare telehealth services in the *Medicare Benefit Policy Manual* and the *Medicare Claims Processing Manual*.

(continued on next page)

Telehealth *(continued)*

Caution – what you need to know

In the calendar year (CY) 2013 physician fee schedule proposed rule with comment period, the Centers for Medicare & Medicaid Services (CMS) is proposing to add eight codes to the list of Medicare distant site telehealth services. Additionally, the 2013 Healthcare Procedural Coding System (HCPCS) update will replace several *Current Procedural Terminology®* (*CPT®*) codes related to psychotherapy services and a number of these services are on the list of approved telehealth services. Therefore, CR 7900 updates the list of approved telehealth services to reflect these code changes and it replaces several *CPT®* codes related to psychotherapy services.

Go – what you need to do

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

Background

Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation *CPT®* codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners were instructed to bill a new or established patient office/outpatient visit *CPT®* code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits.

CMS has approved the use of a telecommunications system to substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. The conditions of payment for Medicare telehealth services, including qualifying originating sites and the types of telecommunications systems recognized by Medicare, are subject to the provisions of 42 CFR 410.78 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr410_main_02.tpl*). Payment for these services is subject to the provisions of 42 CFR 414.65 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl*).

In the calendar year 2013 PFS proposed rule with comment period, CMS is proposing to add eight codes to the list of Medicare distant site telehealth services. Additionally, the 2013 HCPCS update will replace several *CPT®* procedure codes related to psychotherapy services, and a number of these services are on the list of approved telehealth services. The established policy for these telehealth services has not changed.

CMS is proposing to add the eight services contained in the following table to the List of Medicare Telehealth Services for CY 2013. CR 7900 instructs that the HCPCS codes for these services should be added to the List of Medicare Telehealth Services:

HCPCS code	Descriptor
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and brief intervention, 15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and intervention greater than 30 minutes
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes.
G0444	Annual Depression Screening, 15 minutes.
G0445	High-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes.
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes.
G0447	Face-to-face behavioral counseling for obesity, 15 minutes.

CR 7900 also adds relevant policy instructions to the manuals regarding the addition of these codes.

The following *CPT®* codes should be added to the List of Telehealth Services to replace codes that will be deleted for CY 2013:

- *CPT®* codes *90832, 90833, 90834, 90836, 90837, 90838* to report individual psychotherapy services, reported with *CPT®* codes *90804–90809* prior to CY 2013, and
- *CPT®* codes *90791, 90792* to report psychiatric diagnostic interview examination, reported with *CPT®* code *90801* prior to CY 2013.

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Telehealth *(continued)*

CR 7900 revises the *Medicare Claims Processing Manual* (Chapter 12, Section 190.3 (List of Medicare Telehealth Services)) and the *Medicare Benefit Policy Manual* (Chapter 15, Section 270.2 (List of Medicare Telehealth Services)) which are included as attachments to CR 7900.

Additional information

Further information regarding telehealth services is available at *http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html*.

You can also find information about submitting requests for adding services to the list of Medicare telehealth services at *https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Criteria.html*.

The official instruction, CR 7900, was issued to your FI, carrier, or A/B MAC via two transmittals. The first updates the *Medicare Benefit Policy Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R164BP.pdf*. The second transmittal updates the *Medicare Claims Processing Manual*, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2606CP.pdf*.

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

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Implementation Date: January 7, 2013

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Prepayment edit of evaluation and management code *99215*

The Office of the Inspector General (OIG) recently reviewed current coding trends and discovered a growing frequency of Medicare providers billing higher level evaluation and management (E/M) codes. From 2001 to 2010, providers increased their billing for *Current Procedural Terminology*® (*CPT*®) codes *99214* and *99215* by 17 percent. The Centers for Medicare & Medicaid Services (CMS) concurred with the OIG recommendations that Medicare administrative contractors (MACs) continue to educate physicians on proper billing for E/M services and to review physicians' billing for these services.

Following these recommendations, First Coast Service Options, Inc. (First Coast) completed an analysis that indicates there is a high risk of improper claim payment for certain specialties billing E/M code *99215* in Florida. Therefore, a 100 percent prepayment review of code *99215* will be applied to claims submitted on or after January 18, 2013, for the following provider specialties in the Florida segment of First Coast's jurisdiction:

- General practice
- Optometry
- Osteopathic manipulative medicine
- Pediatric medicine
- Podiatry

The *CPT*® manual defines code *99215* as follows:

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- A comprehensive history
- A comprehensive examination
- Medical decision making of high complexity.

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Prepayment *(continued)*

Usually the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

Furthermore, claims submitted with E/M code *99215* must be supported by documentation indicating the medical necessity for this level of service.

First Coast and CMS offer multiple resources addressing the documentation guidelines for E/M service levels at:

- First Coast's *Evaluation and Management (E/M) services page*, offering links to tools, FAQs, online learning, and additional resources.
- CMS *Internet-only manual (IOM)* guidelines addressing multiple types and settings pertaining to E/M services.

In addition, in recent years First Coast has offered multiple webcasts addressing E/M issues, which have been recorded and can be accessed at *http://www.fcsouniversity.com*. E/M will continue to be a point of focus in upcoming months – please check our *events calendar* to be aware of E/M education being offered.

Laboratory/Pathology

Annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

Provider types affected

This *MLN Matters®* article is intended for clinical diagnostic laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8132 which provides instructions to Medicare contractors for the calendar year (CY) 2013 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Be sure your billing staffs are aware of these updates.

Background

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Patient Protection and Affordable Care Act (ACA) of 2010 and the Middle Class Tax Relief and Job Creation Act of 2012, the annual update to the local clinical laboratory fees for CY 2013 is -2.95 percent. The annual update to local clinical laboratory fees for CY 2013 reflects the consumer price index for urban areas (CPI-U) of 1.70 percent less a multi-factor productivity adjustment of 0.9 percentage points and a -1.75 percentage point reduction as described by the ACA legislation, plus a -2.0 percentage point reduction as described by the MCTRJCA. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2013 is 1.7 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA).

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

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Laboratory *(continued)*

Key points of CR 8132

National minimum payment amounts

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2013 national minimum payment amount is $14.53 ($14.97 plus (-2.95) percent update for CY 2013). The affected codes for the national minimum payment amount are shown in the following table:

88142	*88143*	*88147*	*88148*	*88150*
88152	*88153*	*88154*	*88164*	*88165*
88166	*88167*	*88174*	*88175*	G0123
GO143	G0144	G0145	G0147	G0148
P3000				

National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

Access to data file

Internet access to the CY 2013 clinical laboratory fee schedule data file will be available after November 21, 2012, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, may use the Internet to retrieve the CY 2013 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public comments

On July 16, 2012, CMS hosted a public meeting to solicit input on the payment relationship between CY 2012 codes and new CY 2013 *CPT*® codes. Notice of the meeting was published in the *Federal Register* on May 29, 2012, and on the CMS website approximately June 15, 2012. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Additional written comments from the public were accepted until September 28, 2012. CMS has posted a summary of the public comments and the rationale for the final payment determinations on the CMS website.

Pricing information

The CY 2013 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes *36415*, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2013, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2013 clinical laboratory fee schedule also includes codes that have a “QW” modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

As in prior years, the CY 2013 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping information

New code *86386*QW is priced at the same rate as code *86386*, effective January 1, 2012.

New code *83861*QW is priced at the same rate as code *83861*, effective July 1, 2012.

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Laboratory *(continued)*

New code *86803*QW is priced at the same rate as code *86803*.

The following are new codes to be gap filled:

81201 81202 81203 81235 81252 81253 81254 81321 81322 81323 81324 81325
81326 81200 81205 81206 81207 81208 81209 81210 81211 81212 81213 81214
81215 81216 81217 81220 81221 81222 81223 81224 81225 81226 81227 81228
81229 81240 81241 81242 81243 81244 81245 81250 81251 81255 81256 81257
81260 81261 81262 81263 81264 81265 81266 81267 81268 81270 81275 81280
81281 81282 81290 81291 81292 81293 81294 81295 81296 81297 81298 81299
81300 81301 81302 81303 81304 81310 81315 81316 81317 81318 81319 81330
81331 81332 81340 81341 81342 81350 81355 81370 81371 81372 81373 81374
81375 81376 81377 81378 81379 81380 81381 81382 81383 81400 81401 81402
81403 81404 81405 81406 81407 81408 86152

The following are existing codes that are deleted:

83890 83891 83892 83893 83894 83896 83897 83898 83900 83901 83902
83903 83904 83905 83906 83907 83908 83909 83912 83913 83914

New code *82777* is priced at the same rate as code *83520*.

New code *86711* is priced at the same rate as code *86789*.

New code *86828* is priced at the same rate as code *86807*.

New code *86829* is priced at the same rate as code *86808*.

New code *86830* is priced at 7 times the rate of code *83516*.

New code *86831* is priced at 6 times the rate of code *83516*.

New code *86832* is priced at 11 times the rate of code *83516*.

New code *86833* is priced at 10 times the rate of code *83516*.

New code *86834* is priced at 31 times the rate of code *83516*.

New code *86835* is priced at 28 times the rate of code *83516*.

New code *87631* is priced at the same rate as code *87502* plus 2 times the rate of code 87503.

New code *87632* is priced at the same rate as code *87502* plus 6 times the rate of code 87503.

New code *87633* is priced at the same rate as code *87502* plus 16 times the rate of code 87503.

New code *87910* is priced at the same rate as code *87902*.

New code *87912* is priced at the same rate as code *87902*.

Laboratory costs subject to reasonable charge payment in CY 2011

For outpatients, the following codes are paid under a reasonable charge basis. The reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2013 is 1.7 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, Sections 80 through 80.8. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. **Note**: The Medicare manuals noted in this article are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html*.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, *Medicare Claims Processing Manual*, Chapter 8, Section 60.3, instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

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Laboratory *(continued)*

Blood product codes

These blood codes are:

P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9044	P9050	P9051	P9052
P9053	P9054	P9055	P9056	P9057	P9058
P9059	P9060				

Also, payment for the following codes are applied to the blood deductible as instructed in the "Medicare General Information, Eligibility and Entitlement Manual", Chapter 3, Sections 20.5 through 20.5.4:\

P9010	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine costs

These codes are:

86850	*86860*	*86870*	*86880*	*86885*	*86886*
86890	*86891*	*86900*	*86901*	*86902*	*86904*
86905	*86906*	*86920*	*86921*	*86922*	*86923*
86927	*86930*	*86931*	*86932*	*86945*	*86950*
86960	*86965*	*86970*	*86971*	*86972*	*86975*
86976	*86977*	*86978*	*86985*		

Reproductive medicine procedure codes

These codes are:

89250	*89251*	*89253*	*89254*	*89255*	*89257*
89258	*89259*	*89260*	*89261*	*89264*	*89268*
89272	*89280*	*89281*	*89290*	*89291*	*89335*
89342	*89343*	*89344*	*89346*	*89352*	*89353*
89354	*89356*				

Additional information

You can find the official instruction, CR 8132, issued to your FI, carrier, or A/B MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2612CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Related Change Request (CR) #: CR 8132
Related CR Release Date: December 14, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2612CP
Implementation Date: January 7, 2013

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Medicare Physician Fee Schedule Database

Application of the multiple procedure payment reduction on imaging services to physicians in the same group practice

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7747 which informs Medicare contractors about changes to the multiple procedure payment reduction (MPPR).

The MPPR on diagnostic imaging applies when multiple services are furnished by the same physician, to the same patient, in the same session, on the same day. The MPPR on certain diagnostic imaging services applies to professional component (PC) and technical component (TC) services. It applies to both PC-only services, TC-only services, and to the PC and TC of global services. Full payment is made for each PC and TC service with the highest payment under the Medicare physician fee schedule (MPFS). Payment is made at 75 percent for subsequent PC services furnished by the same physician, to the same patient, in the same session, on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician, to the same patient, in the same session, on the same day. The individual PC and TC services with the highest payments under the MPFS of globally billed services must be determined in order to calculate the reduction.

Currently, the MPPR applies only when an individual physician furnishes multiple services to the same patient, in the same session, on the say day. The Centers for Medicare & Medicaid Services (CMS) is expanding the MPPR on the PC and TC of imaging services by applying it to physicians in the same group practice (same group national provider identifier (NPI)) who furnish multiple services to the same patient, in the same session, on the same day.

The complete list of codes subject to the MPPR on diagnostic imaging can be found in Attachment 1 of CR 7747, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1104OTN.pdf*.

Background

Section 3134 of the Affordable Care Act added Section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed

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MPPR *(continued)*

in conjunction with furnishing a single service. As a further step in implementing this provision, Medicare is making a change to the MPPR on the PC and TC of certain diagnostic imaging procedures. Specifically, Medicare is applying the MPPR to physicians in the same group practice who furnish multiple services to the same patient, in the same session, on the same day. Medicare will assume procedures furnished on the same date of service were furnished in the same session unless the provider uses modifier 59 to indicate multiple sessions, in which case the reduction does not apply.

Additional information

The official instruction, CR 7747 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/R1104OTN.pdf*.

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

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Implementation Date: January 7, 2013

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Therapeutic Services

Transcutaneous electrical nerve stimulation for chronic low back pain

Note: This article was revised December 4, 2012, to reflect a revised change request (CR) 7836, issued November 30, 2012. In this article, the CR transmittal numbers, release date, and the Web address for accessing CR 7836 have been revised. All other information remains the same. This information was previously published in the August 2012 *Medicare B Connection*, Pages 11-12.

Provider types affected

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

What you need to know

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

Background

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

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Transcutaneous *(continued)*

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

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

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

Key points

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

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

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

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

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

Medicare contractors will deny TENS line items on claims when billed with a TENS code and at least one of the ICD-9 or ICD-10 codes for CLBP (see attachments to transmittal R2605CP of CR 7836 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2605CP.pdf*), if the conditions of requirement listed above are not met. When Medicare denies such claims for not containing the requisite ICD-9 (or later ICD-10) code, your remittance advice will reflect the following messages:

- Group code CO
- Claim adjustment reason code B5 (Coverage/program guidelines were not met or were exceeded.), and
- Remittance advice remark code N386 (This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have Web access, you may contact the contractor to request a copy of the NCD.

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

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

CLBP is defined as:

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

(continued on next page)

Transcutaneous *(continued)*

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

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

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

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

The study must also adhere to standards of scientific integrity and relevance to the Medicare population and those standards are part of Section 160.27. You may read the entire set of parameters in the official instruction attached to transmittal R149NCD of CR 7836. That transmittal is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R149NCD.pdf*.

Additional information

The official instruction, CR 7836, issued to your Medicare carrier, RHHI or DME MAC regarding this change via two transmittals. The first updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R149NCD.pdf*. The other transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2605CP.pdf*.

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

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Therapy Services

Therapy cap values for calendar year 2013

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 therapy services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8129, which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for calendar year (CY) 2013. The therapy caps for 2013 will be $1900 for physical therapy and speech-language therapy combined and $1900 for occupational therapy. Make sure that your billing staffs are aware of this update.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare patients. These limits change annually. The Deficit Reduction Act of 2005 directed the Secretary to implement a process for exceptions to therapy caps for medically necessary services. The Affordable Care Act extended the exceptions to therapy caps through December 31, 2010; the Medicare and Medicaid Extenders Act (MMEA) of 2010 extended the therapy caps exceptions through December 31, 2011; and Section 3005 (g) of the Middle Class Tax Relief And Job Creation Act (MCTRJCA) of 2012 extended the therapy caps exceptions through December 31, 2012.

Additional information

The official instruction, CR 8129, 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/R2600CP.pdf*.

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*.

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2013 annual update to the therapy code list

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8126 which updates the therapy code list for calendar year (CY) 2013 by adding two "sometimes therapy" codes. CR 8126 also adds forty two "always therapy" codes, which are non-payable and for use only in functional reporting. The additions to the therapy code list reflect those made in the CY 2013 Healthcare Common Procedure Coding System and *Current Procedural Terminology, Fourth Edition* (HCPCS/*CPT-4*). Please make sure your billing and coding staff are aware of these changes.

Background

The Social Security Act (Section 1834(k)(5); see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/*Current Procedural Terminology*®, 2013 Edition (HCPCS/*CPT-4*) is the coding system used for the reporting of these services.

CR 8126 provides the calendar year (CY) 2013 annual updates to the list of codes that sometimes or always describe therapy services. The additions to the therapy code list reflect those made in the 2013 HCPCS/*CPT-4*. The therapy code listing can be found at *http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html*.

CR 8126 updates the therapy code list by adding two "sometimes therapy" codes and forty two "always therapy" codes for CY 2013 as shown in the following tables:

Always therapy codes added for CY 2013

	HCPCS code	Short descriptor		HCPCS code	Short descriptor (Cont'd)		HCPCS code	Short descriptor (Cont'd)
1	G8978	Mobility current status	15	G8992	Other PT/OT D/C status	29	G9164	Lang express D/C status
2	G8979	Mobility goal status	16	G8993	Sub PT/OT current status	30	G9165	Atten current status
3	G8980	Mobility D/C status	17	G8994	Sub PT/OT goal status	31	G9166	Atten goal status
4	G8981	Body pos current status	18	G8995	Sub PT/OT D/C status	32	G9167	Atten D/C status
5	G8982	Body pos goal status	19	G8996	Swallow current status	33	G9168	Memory current status
6	G8983	Body pos D/C status	20	G8997	Swallow goal status	34	G9169	Memory goal status
7	G8984	Carry current status	21	G8998	Swallow D/C status	35	G9170	Memory D/C status
8	G8985	Carry goal status	22	G8999	Motor speech current status	36	G9171	Voice current status

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List *(continued)*

	HCPCS code	Short descriptor		HCPCS code	Short descriptor (Cont'd)		HCPCS code	Short descriptor (Cont'd)
9	G8986	Carry D/C status	23	G9158	Motor speech D/C status	37	G9172	Voice goal status
10	G8987	Self care current status	24	G9159	Lang comp current status	38	G9173	Voice D/C status
11	G8988	Self care goal status	25	G9160	Lang comp goal status	39	G9174	Speech lang current status
12	G8989	Self care D/C status	26	G9161	Lang comp D/C status	40	G9175	Speech lang goal status
13	G8990	Other PT/OT current status	27	G9162	Lang express current status	41	G9176	Speech lang D/C status
14	G8991	Other PT/OT goal status	28	G9163	Lang express goal status	42	G9186	Motor speech goal status

Sometimes therapy codes added for CY 2013

	HCPCS code	Short descriptor
1	G0456	Neg pres wound < 50 sq cm
2	G0457	Neg pres wound > 50 sq cm

Additional information

CR 8036 alerts providers that all requests for therapy services above $3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance. This applies to: Part B skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies (outpatient rehabilitation facilities (ORFs), private practices, home health agencies (TOB 34x), and hospital outpatient departments. You can find CR 8036 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1124OTN.pdf*. The *MLN Matters*® article corresponding to CR 8036 is at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8036.pdf*.

The official instruction, CR 8126 issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2596CP.pdf*.

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

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Implementing the claims-based data collection requirement for outpatient therapy services

Provider types affected

This *MLN Matters*® article for change request (CR) 8005 is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8005, which implements a new claims-based data collection requirement for outpatient therapy services by requiring reporting with 42 new non-payable functional G-codes and seven new modifiers on claims for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. Be sure your billing staff knows of these new requirements.

Background

The Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA; Section 3005(g); see *http://www.gpo.gov/fdsys/pkg/CRPT-112hrpt399/pdf/CRPT-112hrpt399.pdf*) states that “The Secretary of Health and Human Services shall implement, beginning on January 1, 2013, a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)). Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes.”

This claims-based data collection system is being implemented to include both 1) the reporting of data by therapy providers and practitioners furnishing therapy services, and 2) the collection of data by the contractors. This reporting and collection system requires claims for therapy services to include nonpayable G-codes and related modifiers. These non-payable G-codes and severity/complexity modifiers provide information about the beneficiary’s functional status at:

- The outset of the therapy episode of care
- Specified points during treatment, and
- The time of discharge.

These G-codes and related modifiers are required on specified claims for outpatient therapy services – not just those over the therapy caps.

Application of new coding requirements

This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013. However, a testing period will be in effect from January 1, 2013, through June 30, 2013, to allow providers to use the new coding requirements in order to assure that their systems work. During this time period claims without G-codes and modifiers will be processed.

Note: A separate CR (and related *MLN Matters*® article) will be issued regarding the editing required for claims with therapy services on and after July 1, 2013, at which time Medicare will begin returning and rejecting claims, as applicable, that do not contain the required functional G-code/modifier information.

In order to implement use of these G-codes for reporting function data on January 1, 2013, a new status indicator of “Q” has been created for the Medicare physician fee schedule database (MPFSDB). This new status indicator will identify codes being used exclusively for functional reporting of therapy services. These functional G-codes will be added to the MPFSDB with the new “Q” status indicator. Because these are nonpayable G-codes, there will be no relative value units or payment amounts for these codes. The new “Q” status code indicator reads, as follows:

- Status code indicator “Q” –“Therapy functional information code, used for required reporting purposes only.”

A separate instruction/article (see *MLN Matters*® article MM8126 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8126.pdf*) was issued to alert providers/suppliers and contractors that these nonpayable functional G-codes will be added as “always therapy” codes to the new 2013 therapy code list.

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Collection *(continued)*

Services affected

The reporting and collection requirements of beneficiary functional data apply to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the PT, OT, and SLP services furnished under the comprehensive outpatient rehabilitation facility (CORF) benefit. They also apply to the therapy services furnished incident to the service of a physician and certain non-physician practitioners (NPPs), including, as applicable, nurse practitioners (NPs), certified nurse specialists (CNSs), and physician assistants (PAs).

Providers and practitioners affected

These reporting requirements apply to the therapy services furnished by the following providers: hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and home health agencies (HHAs) (when the beneficiary is not under a home health plan of care). It also applies to the following practitioners: therapists in private practice (TPPs), physicians, and NPPs as noted above.

Function-related G-codes

The following Healthcare Common Procedure Coding System (HCPCS) G-codes are used to report the status of a beneficiary's functional limitations:

Mobility G-code set

- *G8978, Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals.*
  - Short descriptor: Mobility current status
- *G8979, Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.*
  - Short descriptor: Mobility goal status
- *G8980, Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting.*
  - Short descriptor: Mobility D/C status

Changing & maintaining body position G-code set

- *G8981, Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals.*
  - Short descriptor: Body pos current status
- *G8982, Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
  - Short descriptor: Body pos goal status
- *G8983, Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting.*
  - Short descriptor: Body pos D/C status

Carrying, Moving & Handling Objects G-code set

- *G8984, Carrying, moving & handling objects functional limitation, current status, at therapy episode outset and at reporting intervals*
  - Short descriptor: Carry current status
- *G8985, Carrying, moving & handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
  - Short descriptor: Carry goal status
- *G8986, Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting*
  - Short descriptor: Carry D/C status

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Collection *(continued)*

Self care G-code set

- *G8987, Self care functional limitation, current status, at therapy episode outset and at reporting intervals*
  - Short descriptor: Self care current status
- *G8988, Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
  - Short descriptor: Self care goal status
- *G8989, Self care functional limitation, discharge status, at discharge from therapy or to end reporting*
  - Short descriptor: Self care D/C status

Other PT/OT Primary G-code set

- *G8990, Other physical or occupational primary functional limitation, current status, at therapy episode outset and at reporting intervals*
  - Short descriptor: Other PT/OT current status
- *G8991, Other physical or occupational primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
  - Short descriptor: Other PT/OT goal status
- *G8992, Other physical or occupational primary functional limitation, discharge status, at discharge from therapy or to end reporting*
  - Short descriptor: Other PT/OT D/C status

Other PT/OT subsequent G-code set

- *G8993, Other physical or occupational subsequent functional limitation, current status, at therapy episode outset and at reporting intervals*
  - Short descriptor: Sub PT/OT current status
- *G8994, Other physical or occupational subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
  - Short descriptor: Sub PT/OT goal status
- *G8995, Other physical or occupational subsequent functional limitation, discharge status, at discharge from therapy or to end reporting*
  - Short descriptor: Sub PT/OT D/C status

Swallowing G-code set

- *G8996, Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor: Swallow current status
- *G8997, Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy*
  - Short descriptor: Swallow goal status
- *G8998, Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation*
  - Short descriptor: Swallow D/C status

Motor Speech G-code Set: (Note: These codes are not sequentially numbered)

- *G8999, Motor speech functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor Motor speech current status
- *G9186, Motor speech functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*

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Collection *(continued)*

- Short descriptor Motor speech goal status

- *G9158, Motor speech functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
  - Short descriptor: Motor speech D/C status

Spoken language comprehension G-code set

- *G9159, Spoken language comprehension functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor: Lang comp current status
- *G9160, Spoken language comprehension functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
  - Short descriptor: Lang comp goal status
- *G9161, Spoken language comprehension functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
  - Short descriptor: Lang comp D/C status

Spoken Language Expressive G-code set

- *G9162, Spoken language expression functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor: Lang express current status
- *G9163, Spoken language expression functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
  - Short descriptor: Lang express goal status
- *G9164, Spoken language expression functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
  - Short descriptor: Lang express D/C status

Attention G-code set

- *G9165, Attention functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor: Atten current status
- *G9166, Attention functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
  - Short descriptor Atten goal status
- *G9167, Attention functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
  - Short descriptor: Atten D/C status

Memory G-code set

- *G9168, Memory functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor: Memory current status
- *G9169, Memory functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*

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Collection *(continued)*

- Short descriptor: Memory goal status

- *G9170, Memory functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
  - Short descriptor: Memory D/C status

Voice G-code set

- *G9171, Voice functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor Voice current status
- *G9172, Voice functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
  - Short descriptor Voice goal status
- *G9173, Voice functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
  - Short descriptor: Voice D/C status

Other speech-language pathology G-code set

- *G9174, Other speech language pathology functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor: Speech lang current status
- *G9175, Other speech language pathology functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
  - Short descriptor: speech lang goal status
- *G9176, Other speech language pathology functional limitation, discharge status at discharge from therapy/ end of reporting on limitation*
  - Short descriptor: speech lang D/C status

Severity/complexity modifiers

For each non-payable G-code shown above, a modifier must be used to report the severity/complexity for that functional measure. The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the therapist, physician, or NPP furnishing the therapy services. The beneficiary's current status, the anticipated goal status, and the discharge status are reported via the appropriate severity modifiers. The seven modifiers are defined in the following table below:

Modifier	Impairment limitation restriction
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

Required reporting of functional G-codes and severity modifiers

The functional G-codes and corresponding severity modifiers listed above are used in the required reporting on specified therapy claims for certain dates of service (DOS). Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC). However, functional reporting is required on claims throughout the entire episode of care; so, there will be instances where two or more functional limitations will be reported for one beneficiary's POC, just not during the same time frame. In these situations, where reporting on the first reported functional limitation is complete and the need for treatment continues, reporting is required for a second functional limitation using another set of G-codes. Thus, reporting on more than one functional limitation may be required for some beneficiaries, but not simultaneously.

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Collection *(continued)*

Specifically, functional reporting, using the G-codes and modifiers, is required on therapy claims for certain DOS as described below:

- At the outset of a therapy episode of care, i.e., on the DOS for the initial therapy service;
- At least once every 10 treatment days – which is the same as the newly-revised progress reporting period – the functional reporting is required on the claim for services on same DOS that the services related to the progress report are furnished;
- The same DOS that an evaluative procedure, including a re-evaluative one, is submitted on the claim (see below for applicable HCPCS/*CPT*® codes);
- At the time of discharge from the therapy episode of care, if data is available; and,
- On the same DOS the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary.

As noted above, this functional reporting coincides with the progress reporting frequency, which is being changed through this instruction. Previously, the progress reporting was due every 10th treatment day or 30 calendar days, whichever was less. The new requirement is for the services related to the progress reports to be furnished on or before every 10th treatment day. In the example below, the G-codes for the mobility functional limitation (G8978 - 8980) are used to illustrate the timing of the functional reporting.

- **At the outset of therapy** – the DOS the evaluative procedure is billed or the initial therapy services are furnished:
  - G8978 and G8979, along with the related severity modifiers, are used to report the current status and projected goal status of the mobility functional limitation.
- **At the end of each progress reporting period** – the DOS when the progress report services are furnished:
  - G8978 and G8979, along with the related severity modifiers, are used to report the current status and projected goal status of the mobility functional limitation.
  - This step is repeated as clinically appropriate

At the time the beneficiary is discharged from the therapy episode – the DOS the discharge progress report services are furnished:

- G8979 and G8980, along with the related severity modifiers, are used to report the projected goal and discharge status of the mobility functional limitation.

In the above example, if further therapy is medically necessary once reporting for the mobility functional limitation has ended, the therapist begins reporting on another functional limitation using a different set of G-codes. Reporting of the next functional limitation is required on the DOS of the first treatment day after the reporting was ended for the mobility functional limitation.

Evaluative procedures

The presence of an HCPCS/*CPT* code on a claim for an evaluation or re-evaluation service listed below requires reporting of functional G-code(s) and corresponding modifier(s) for the same date of service:

HCPCS/*CPT*® codes requiring functional G-code(s) and corresponding modifier(s)

92506	*92597*	*92607*	*92608*	*92610*	*92611*	*92612*
92614	*92616*	*96105*	*97001*	*97002*	*97003*	*97004*

The number of functional G-codes required on a particular claim when functional reporting is required for therapy services under one POC will be two. However, it is possible for a claim to contain four or more non-payable G-codes in cases where a beneficiary receives therapy services under multiple POCs – PT, OT, and/or SLP – from the same therapy provider. Each reported functional G-code must also contain the following essential line of service information:

- Functional severity modifier in the range CH - CN
- Therapy modifier indicating the discipline of the POC – GP, GO or GN – for PT, OT, and SLP services, respectively
- Date of the corresponding billable service

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Collection *(continued)*

- Nominal charge, e.g., a penny, for institutional claims submitted to the FIs and A/MACs. For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.

In addition, claims containing any of these functional G-codes must also contain another billable and separately payable (non-bundled) service.

Required tracking and documentation of functional G-codes and severity modifiers

The reported functional information is derived from the beneficiary's functional limitations set forth in the therapy goals, a requirement of the POC, that are established by a therapist, including – an occupational therapist, a speech-language pathologist or a physical therapist – or a physician/NPP, as applicable. The therapist or physician/NPP furnishing the therapy services must not only report the functional information on the therapy claim, but, he/she must track and document the G-codes and modifiers used for this reporting in the beneficiary's medical record of therapy services.

Remittance advice messages

Medicare will return a claim adjustment reason code 246 (This non-payable code is for required reporting only.) and a group code of CO (contractual obligation) assigning financial liability to the provider. In addition, beneficiaries will be informed via Medicare summary notice 36.7 that they are not responsible for any charge amount associated with one of these G-codes.

Additional information

CR 8005 will be reissued in the future with revisions to the *Medicare Benefit Policy Manual* and the *Medicare Claims Processing Manual*. At this point, CR 8005 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2603CP.pdf*.

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

The following provides additional information and related links for therapy providers and practitioners:

- **CMS Therapy Services Web Page**: The CMS Therapy Services home page is located at *http://www.cms.gov/Medicare/Billing/TherapyServices/index.html*.
- **Therapy services transmittals**: The following CMS Web page lists transmittals that are directed to the therapy services provider community: *http://www.cms.gov/Medicare/Billing/TherapyServices/Therapy-Services-Transmittals.html*

  Note that this list may not include all instructions for which therapy service providers are responsible. For a list of all instructions, view the CMS transmittals Web page under Regulations and Guidance at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals.html*.
- **Annual therapy update**: You can find and download the Therapy Code List and Dispositions for 2009, 2010, 2011, and 2012 at *http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html*. The additions, changes, and deletions to the therapy code list reflect those made in the applicable year for the Healthcare Common Procedure Coding System and *Current Procedural Terminology®, Fourth Edition* (HCPCS/*CPT*-4).
- **Studies and reports**: Studies and reports (report to Congress, CMS contracted, and other government) relating to utilization and policy for outpatient Part B therapy can be found at *http://www.cms.gov/Medicare/Billing/TherapyServices/Studies-and-Reports.html*.

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Revisions of the financial limitation for outpatient therapy services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012

Note: This article was revised on December 18, 2012, to reflect a revised change request (CR) 7785 issued on December 14. In this article, the CR release date, transmittal number and the Web address for accessing CR 7785 have been revised. All other information remains the same. This information was previously published in the May 2012 *Medicare B Connection*, Pages 18-20.

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on CR 7785, which extends the therapy cap exceptions process through December 31, 2012, adds therapy services provided in outpatient hospital settings other than critical access hospitals (CAHs) to the therapy cap effective October 1, 2012, requires the national provider identifier (NPI) of the physician certifying therapy plan of care on the claim, and addresses new thresholds for mandatory medical review.

Caution – what you need to know

The therapy cap amounts for 2012 are $1880 for occupational therapy services, and $1880 for the combined services for physical therapy and speech-language pathology. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy caps on claims that are over these amounts. The use of the KX modifier indicates that the services are reasonable and necessary, and there is documentation of medical necessity in the patient's medical record. For services provided on or after October 1, 2012 and before January 1, 2013, there will be two new therapy services thresholds of $3700 per year: one annual threshold each for 1) occupational therapy (OT) services, and 2) physical therapy (PT) services and speech-language pathology (SLP) services combined. Per-beneficiary services above these thresholds will require mandatory medical review.

Go – what you need to do

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

Background

The Balanced Budget Act of 1997 (see *http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf*) enacted financial limitations on outpatient PT, OT, and SLP services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act (see *http://www.gpo.gov/fdsys/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf*), and have been extended by legislation several times.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, Section 3005; see *http://www.gpo.gov/fdsys/pkg/BILLS-112hr3630enr/pdf/BILLS-112hr3630enr.pdf*) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services.

The therapy cap amounts for 2012 are:

- $1880 for OT services, and
- $1880 for the combined services for PT and SL P.

CR 7785 instructs Medicare suppliers and providers to continue to use the KX modifier to request an exception to the therapy cap on claims that are over these amounts. Note that use of the KX modifier is an attestation from the provider or supplier that:

1. The services are reasonable and necessary, and
2. There is documentation of medical necessity in the patient's medical record.

Therapy services furnished in an outpatient hospital setting have been exempt from the application of the therapy caps. However, MCTRJCA requires original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital between October 1, 2012, and December 31, 2012.

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Financial *(continued)*

Although the therapy caps are only applicable to hospitals for services provided on or after October 1, 2012, in applying the caps after October 1, 2012, claims paid for outpatient therapy services since January 1, 2012, will be included in the caps accrual totals.

In addition, MCTRJCA contains two requirements that become effective on October 1, 2012.

- The first of these requires that suppliers and providers report on the beneficiary's claim for therapy services the national provider identifier (NPI) of the physician (or non-physician practitioner (NPP) where applicable) who is responsible for reviewing the therapy plan of care. For implementation purposes, the physician (or NPP as applicable) certifying the therapy plan of care is reported. NPPs who can certify the therapy plan of care include nurse practitioners, physician assistants and clinical nurse specialists.
- The second requires a manual medical review process for those exceptions where the beneficiary therapy services for the year reach a threshold of $3,700. The two separate thresholds triggering manual medical reviews build upon the separate therapy caps as follows:
  - One for OT services, and
  - One for PT and SLP services combined.

Although PT and SLP services are combined for triggering the threshold, medical review is conducted separately by discipline.

Claims with the KX modifier requesting exceptions for services above either threshold are subject to a manual medical review process. The count of services to which these thresholds apply begins on January 1, 2012. Absent congressional action, manual medical review expires when the exceptions process expires on December 31, 2012.

Claims for services at or above the therapy caps or thresholds for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Although Medicare suppliers and providers are not required to issue an advance beneficiary notice (ABN) for these benefit category denials, they are encouraged to issue the voluntary ABN as a courtesy to their patients requiring services over the therapy cap amounts ($1,880 for each cap in CY 2012) to alert them of their possible financial liability.

Key billing points

Remember the caps will apply to outpatient hospitals as detected via:

- Types of bill (TOB) 12x (excluding CAHs with CMS certification numbers (CCNs) in the range of 1300-1399) or 13x;
- A revenue code of 042x, 043x, or 044x;
- Modifier GN, GO, or GP; and
- Date of service on or after October 1, 2012.

Other important points are as follows:

- The new thresholds will accrue for claims with dates of service from January 1, 2012, through December 31, 2012. Medicare will display the total amount applied toward the therapy caps and thresholds on all applicable inquiry screens and mechanisms.
- Providers should report the NPI of the physician/NPP certifying the therapy plan of care in the attending physician field on institutional claims for outpatient therapy services, for dates of service on or after October 1, 2012.
- In cases where different physicians/NPPs certify the OT, PT, or SLP plan of care, report the additional NPI in the referring physician field (loop 2310F) on institutional claims for outpatient therapy services for dates of service on or after October 1, 2012.
- On professional claims, providers are to report the physician/NPP certifying the therapy plan of care, including his/her NPI, for outpatient therapy services on or after October 1, 2012.
- For claim processing purposes, the certifying physician/NPP is considered a referring provider and such providers must follow the instructions in Chapter 15, Section 220.1.1 of the *Medicare Benefit Policy Manual* (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*) for reporting the referring provider on a claim.

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Financial *(continued)*

- On electronic professional claims, report the referring provider, including NPI, per the instructions in the appropriate ASC X12 837 Technical Report 3 (TR3).
- For paper claims, report the referring provider, including NPI, per the instructions in Chapter 26, Section 10 of the *Medicare Claims Processing Manual* at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf*.

Claims without at least one referring provider, including his/her NPI, will be returned as unprocessable with the following codes:

- Claim adjustment reason code 165 (Referral absent or exceeded).
- Remittance advice remark code of N285 (Missing/incomplete/invalid referring provider name) and/or N286 (Missing/incomplete/invalid referring provider number).

Additional information

The official instruction, CR 7785, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2615CP.pdf*.

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

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General Coverage

New place of service code for place of employment/worksite

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Medicare carriers, Medicare administrative contractors (A/B MACs), or durable medical equipment Medicare administrative contractors (DME MACs)) for occupational-related medical, therapeutic, or rehabilitative services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 8125, from which this article is taken, updates the current place of service (POS) code set to add a new code: 18 – Place of employment/worksite.

Background

CR 8125, from which this article is taken, updates the current Medicare POS code set to add a new code: 18 – Place of employment/worksite; described as: “a location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic, or rehabilitative services to the individual.”

The Centers for Medicare & Medicaid Services (CMS) is establishing this POS code because:

1. Industry entities (other than Medicare) have identified a need to establish the delivery of occupational-related medical and rehabilitation services in the work place in order to: A) reduce employee time lost from work; and B) enable therapists to evaluate the work environment and provide rehabilitation services that are focused on

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Employment *(continued)*

returning the individual to their pre-injury state in a way that maximizes function in the workplace environment and reduces employee time lost.

2. As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with its standards and their implementation guides that are adopted by regulation. Specifically, the currently adopted professional implementation guide for the Accredited Standards Committee (ASC) X12 837 (Professional Health Care Claim) standards requires that each electronic claim transaction include a place of service (POS) code from the POS code set that CMS maintains.

Therefore, while it has not identified an inherent need for this new code; as a payer, Medicare must be able to recognize any code from the POS code set that appears on the HIPAA standard claim transaction.

Additional information

The official instruction, CR 8125, issued to your carrier, A/B MAC, or DME MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2602CP.pdf*.

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

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Revised and clarified place of service coding instructions

Note: This article was revised on December 18, 2012, to reflect a revised change request (CR) 7631 issued on December 14. The CR release date, transmittal number, and the Web address for accessing CR 7631 were revised. All other information is the same. This information was previously published in the October 2012 *Medicare B Connection*, Pages 24-28.

Provider types affected

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

What you need to know

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

Background

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

At the time a POS code is developed, CMS determines whether a MPFS facility or non-facility payment rate is appropriate for that setting and Medicare contractors are required to make payment at the MPFS rate designated

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Coding *(continued)*

for each POS code. Under the MPFS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to beneficiaries. While Medicare contractors cannot create new POS codes, they are instructed to develop local policies that develop or clarify POS setting definitions in situations where national POS policy is lacking or unclear.

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

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

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

CR 7631 establishes that for all services – with two exceptions – paid under the MPFS, that the POS code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule will apply to the overwhelming majority of MPFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician /practitioner will be the setting in which the beneficiary received the technical component (TC) of the service. For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary's MRI from his/her office location – POS code 22 will be used on the physician's claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

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

Facility and non-facility payment assignments

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

- Inpatient hospital (POS code 21)

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Coding *(continued)*

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

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

- Pharmacy (POS code 01)
- School (POS code 03)
- Homeless shelter (POS code 04)
- Prison/correctional facility (POS code 09)
- Office (POS code 11)
- Home or private residence of patient (POS code 12)
- Assisted-living facility (POS code 13)
- Group home (POS code 14)
- Mobile unit (POS code 15)
- Temporary lodging (POS code 16)
- Walk-in retail health clinic (POS code 17)
- Urgent-care facility (POS code 20)
- Birthing center (POS code 25)
- Nursing facility and skilled nursing facilities (SNFs) to Part B residents - (POS code 32)
- Custodial-care facility (POS code 33)
- Independent clinic (POS code 49)
- Federally qualified health center (POS code 50)
- Intermediate health care facility/mentally retarded (POS code 54)
- Residential substance abuse treatment facility (POS code 55)
- Non-residential substance abuse treatment facility (POS code 57)
- Mass immunization center (POS code 60)
- Comprehensive outpatient rehabilitation facility (POS code 62)
- End-stage renal disease treatment facility (POS code 65)

(continued on next page)

Coding *(continued)*

- State or local health clinic (POS code 71)
- Rural health clinic (POS code 72)
- Independent laboratory (POS code 81)
- Other place of service (POS code 99)

Special guidance for selected POS codes

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

Special considerations for mobile unit settings (code 15)

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

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

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

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

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

Special considerations for services furnished to registered inpatients

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

Special considerations for outpatient hospital departments

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

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Coding *(continued)*

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

Special consideration for ambulatory surgical centers (code 24)

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

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

Special considerations for hospice (code 34)

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

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

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

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

Clarifications regarding global services

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

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

Clarification regarding determination of payment locality

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

(continued on next page)

Coding *(continued)*

Global service code

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

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

Separate billing of professional interpretation

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

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

Additional information

The official instruction, CR 7631 issued to your carrier and/or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2613CP.pdf*.

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

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Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

Importance of preparing/maintaining legible medical records

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and other providers who document treatment for Medicare beneficiaries and/or submit claims for Medicare fee-for-service (FFS) reimbursement.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is publishing this article to highlight the importance of legible documentation in avoiding claim denials. **This article is informational only and does not alter existing Medicare policy, and does not introduce new policy**.

Background

Many claim denials occur because the providers or suppliers do not submit sufficient documentation to support the service or supply billed. Frequently, this documentation is insufficient to demonstrate medical necessity. In accordance with Section 1862(a)(1)(A) of the Social Security Act, CMS must deny an item or service if it is not reasonable and necessary.(See item 1 in the "References" section). When determining the medical necessity of the item or service billed, Medicare's review contractors must rely on the medical documentation submitted by the provider in support of a given claim. Therefore, legibility of clinical notes and other supporting documentation is critical to avoid Medicare FFS claim payment denials. (See item 2 in the "References" section)

Key points

General principles of medical record documentation (See items 3, 4, 5 in the "References" section) – be aware

The general principles of medical record documentation to support a service or supply billed for Medicare payment includes the following (as applicable to the specific setting/encounter):

1. Medical records should be complete and legible; and
2. Medical records should include the legible identity of the provider and the date of service.

Amendments, corrections and delayed entries in medical documentation (See item 6 in the "References" section)

Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles:

1. Clearly and permanently identify any amendments, corrections or addenda.
2. Clearly indicate the date and author of any amendments, corrections, or addenda.
3. Clearly identify all original content (do not delete).

Medicare signature requirements (See item 7 in the "References" section)

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature.

- If the signature is illegible or missing from the medical documentation (other than an order), the review contractor shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, the review contractor shall disregard the order during the review of the claim (i.e., the reviewer will proceed as if the order was not received). Signature attestations are not allowable for orders.

References

1. See the testimony of Thursday, July 15, 2010, to the United States Senate Committee on Homeland Security and Government Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and Internet. "Preventing and Recovering Medicare Payment Errors" at *http://www.hhs.gov/asl/testify/2010/07/t20100715a.html*.
2. See the CMS *Medicare Program Integrity Manual*, Section 3.6.2.1 - Coverage Determinations at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf*.
3. See the *Medicare Benefit Policy Manual*, Chapter 2, Section 30, at *http://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/Downloads/bp102c02.pdf*.

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Records *(continued)*

4. See change request (CR) 2520, provider education article, at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/AB03037.pdf*.
5. See the *MLN Matters*® special edition article, SE1027, entitles "Recovery Audit Contractor (RAC) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1027.pdf*.
6. See the *Medicare Program Integrity Manual*, Section 3.3.2.5 – Amendments, Corrections and Delayed Entries in Medical Documentation at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf*.
7. See the *Medicare Program Integrity Manua*l. Section 3.3.2.4 - Signature Requirements *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf*.

Additional information

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

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

To review specific rules for signature guidelines for medical review purposes and language for e-Prescribing you may go to *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf*.

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Quarterly provider update

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

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

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

Implementation of the PWK segment for X12N version 5010

Note: This article was updated on December 7, 2012, to reflect current Web addresses. This article was previously revised on April 21, 2011, to reflect a revised change request (CR) 7041 issued on April 20, 2011. In the previous revision, the CR release date, transmittal number, and the Web address for accessing CR 7041 were revised. Also, a reference to *MLN Matters*® article SE1106 was added in the Additional information section to give important reminders about the implementation of HIPAA 5010 and D.O., including fee-for-service implementation schedule and readiness assessments. All other information remains unchanged. This information was previously published in the April 2011 *Medicare B Connection*, Pages 13-14.

Provider types affected

This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare administrative contractors (MACs), durable medical equipment (DME) MACs, and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs)).

Provider action needed

This article is based on CR 7041 which announces the implementation of the PWK (paperwork) segment for X12N version 5010. Be sure your billing staff is aware of these changes.

Background

Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

Key points for Medicare billers

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at *http:/www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html*.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send **all** relevant PWK data at the same time for the same claim.

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PWK *(continued)*

- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the coordination of benefits contractor.

Additional information

If you have questions, please contact your MAC and/or FI/carrier 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*.

The official instruction (CR 7041) issued to your MAC and/or FI/carrier is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R874OTN.pdf*.

You may also want to review *MLN Matters*® article MM7306 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7306.pdf*.

You may also want to review *MLN Matters*® article SE1106 available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1106.pdf* for important reminders about the implementation of HIPAA 5010 and D.O., including fee-for-service implementation schedule and readiness assessments.

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Related CR Release Date: April 20, 2011
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Related CR Transmittal #: R874OTN
Implementation Date: July 5, 2011

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Calculate the possibililtes ...

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

Deductible *(continued from cover)*

The following deductible and coinsurance rates apply for 2013.

2013 Part A – Hospital insurance (HI)

- Deductible – $1,184.00
- Coinsurance:

  $296.00 a day for 61st-90th day

  $592.00 a day for 91st-150th day (lifetime reserve days)

  $148.00 a day for 21st-100th day (skilled nursing facility coinsurance)
- Base premium (BP) – $441.00 per month
- BP with 10 percent surcharge – $485.10 a month
- BP with 45 percent reduction – $243.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45 percent reduction and 10 percent surcharge - $267.30 a month

2013 Part B – Supplementary medical insurance (SMI)

- Standard premium – $104.90 a month
- Deductible – $147.00 a year
- Coinsurance – 20 percent

MLN Matters® Number: MM8052
Related Change Request (CR) #: CR 8052
Related CR Release Date: December 7, 2012
Effective Date: January 1, 2013
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Implementation Date: January 7, 2013

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HIPAA Eligibility Transaction System to replace common working file eligibility queries

Provider types affected

This *MLN Matters*® special edition article is intended for health care providers, suppliers and their billing agents, software vendors and clearinghouses that use Medicare's common working file (CWF) queries to obtain their patient's Medicare health insurance eligibility information from Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME MACs), and/or Part A/B Medicare administrative contractors (A/B MACs)).

Provider action needed

If you currently use CWF queries to obtain Medicare health insurance eligibility information for Medicare fee-for service patients, you should immediately begin transitioning to the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS).

What you need to know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that the Centers for Medicare & Medicaid Services (CMS) will implement in the coming months. By April 2013, access to CWF eligibility query functions implemented in the multi-carrier system (MCS) and ViPS Medicare system (VMS), also referred to as PPTN and VPIQ, will be terminated. CMS intends to terminate access to the other CWF eligibility queries implemented in the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE), often referred to the HIQA, HIQH, ELGA and ELGH screens and HUQA, soon thereafter. This will not affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare contractor's interactive voice response (IVR) units and/or Internet portals.

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HETS *(continued)*

Background

In 2005, CMS began offering HETS in a real-time environment to Medicare health care providers, suppliers and their billing agents, software vendors and clearinghouses. HETS is Medicare's health care eligibility benefit inquiry and response electronic transaction, ASCX12 270/271 version 5010, adopted under HIPAA. HETS replaces the CWF queries, and is to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

Key points

General information

In the coming months, CMS plans to discontinue access to the CWF queries through the shared systems: MCS PPTN, VMS VPIQ and FISS DDE. Medicare providers and their agents that currently access the CWF queries through the shared system screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS

HETS allows Medicare providers and their agents to submit and receive X12N 270/271 eligibility request and response files over a secure connection. Many Medicare providers and their agents are already receiving eligibility information from HETS. For more information about HETS and how to obtain access to the system, refer to the CMS HETS Help Web page at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html*.

Frequently asked questions

Are Medicare providers that currently use CWF to obtain beneficiary eligibility information required to switch to HETS?

No, but it is recommended. Providers may also choose to use a Medicare contractor's IVR or Internet portal.

What are the minimum data elements required in order to complete an eligibility search in HETS?

HETS applies search logic that uses a combination of four data elements: health insurance claim number (HICN), Medicare beneficiary's date of birth, Medicare beneficiary's full last name (including suffix, if applicable), and Medicare beneficiary's full first name. The date of birth and first name are optional, but at least one must be present.

Does HETS return the same eligibility information that is currently provided by the CWF eligibility queries?

HETS returns all of the information provided by the CWF eligibility queries that is needed to process Medicare claims with the exception of psychiatric information. HETS returns additional information that CWF does not return. For example, HETS returns:

- Part D plan number, address and enrollment dates, and
- Medicare Advantage organization name, address, website and phone number.

HETS returns some information in a format that differs from the CWF format. In addition, there is a change underway to allow HETS to return hospice information in the same format as CWF. The HETS 270/271 Companion Guide provides specific details about the eligibility information that is returned in the HETS 271 response. The guide is available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf*.

Additional information

If you use a software vendor or clearinghouse to access Medicare beneficiary health insurance eligibility information, you should direct questions to your vendor or clearinghouse. If you have any questions about HETS, please contact the MCARE Help Desk at 1-866-324-7315.

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Prescription Drug Monitoring Programs: A resource to help address prescription drug abuse and diversion

Provider types affected

This *MLN Matters®* special edition article about Prescription Drug Monitoring Programs (PDMPs) is intended for physicians, pharmacists, nurses, and other health care providers that prescribe or dispense scheduled drugs.

What you need to know

Prescription drug abuse and diversion are acute problems in the area of pain management. Efforts to improve the management of pain create a dilemma for physicians and other providers, who have to balance legitimate patient therapeutic needs against what may be potential abuse or drug diversion activities due to the drug-seeking behavior of their patients.

Most states have operational PDMPs that collect data on prescriptions of controlled substances in order to provide resources to reduce prescription drug abuse and diversion. If you enroll in your state's PDMP, you may get reports to help you identify patients who are obtaining prescriptions from other doctors or from multiple pharmacies, or who may be at risk for prescription drug abuse. A PDMP report may be particularly useful before prescribing controlled substances for new patients. Visit *http://www.pmpalliance.org/content/prescription-monitoring-frequently-asked-questions-faq* for more information and links to your state's PDMP.

Background

PDMPs are statewide electronic databases that collect prescription dispensing data of controlled substances. Legislation authorizing collection of data is currently in place in 49 states with 41 states having a functional PDMP[1].

Despite the proliferation of PDMPs, not all of them function in the same manner. The agencies that are responsible for housing and monitoring these programs vary across states but are typically located in either the

Average sales of opioids per person have increased from 74 milligrams to 369 milligrams between 1997 and 2007, a 402 percent increase.

state's Board of Pharmacy, Department of Health and Human Services, or law enforcement agencies. States have a say on what type of controlled substances are tracked (CII-V) and may include other prescription drugs such as tramadol, carisoprodol, or butalbital. These databases were originally implemented as an effort to address controlled substance abuse and reduce diversion.

Many PDMPs provide secure online access to authorized users including physicians and pharmacists. These monitoring programs can report dispensing dates, prescriber, pharmacy, drug name, quantity, and strength of controlled substance prescriptions, including opioids.

Although the focus of PDMPs was originally intended to help reduce drug diversion and abuse, they can also be used for improving medical care and ensuring safe use of controlled substances. Improving the prescribing of controlled substances can reduce their diversion and abuse. Identifying abusers for treatment can improve the public's health.

Need for action

Abuse of prescription drugs is considered the nation's fastest growing drug-problem. Average sales of opioids per person have increased from 74 milligrams to 369 milligrams between 1997 and 2007, a 402 percent increase. The Centers for Disease Control and Prevention (CDC) reported that the estimated number of emergency department visits for non-medical use of opioid analgesics increased 111 percent during 2004-2008 (from 144,600 to 305,900 visits). In addition, drug overdoses, including those from prescription drugs, were the second leading cause of deaths from unintentional injuries in the United States during 2007, exceeded only by motor vehicle fatalities[2].

Movements to improve pain assessment and control have increased the awareness among physicians and patients on the need for analgesics, fueling the nation's consumption, which ranks among the highest in the world. This increased attention to better managing pain creates a dilemma for prescribers who must appropriately prescribe potent opioids for the treatment of pain while being mindful of the possibility that certain individuals may be seeking prescriptions for non-medical purposes or to satisfy an addiction.

Don't be duped into believing "not my Medicare patient." A recent U.S. Government Accountability Office (GAO) report titled "Medicare Part D: Instances of Questionable Access to Prescription Drugs," identified 170,000

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PDMP *(continued)*

Medicare beneficiaries who received prescriptions from five or more prescribers and often receiving 2-4 times a normal year's supply. The most frequently prescribed drugs were hydrocodone with acetaminophen and oxycodone alone or in combination. When samples of these cases were reviewed with the prescribing physicians, none were aware of the other prescribers. In many cases, the beneficiary had signed a pain management agreement but continued to 'doctor shop.' Beginning in 2013, due to the risks of adverse effects from misuse of opioid analgesics, the Centers for Medicare and Medicaid Services (CMS) will require Medicare Part D plans to contact prescribers to ascertain the medical necessity of potentially unsafe, high opioid dosages used for chronic, non-cancer pain. For more information about the requirements for Medicare Part D sponsors to manage the use of opioids in their prescription drug plans, go to *http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html*.

With added involvement and interventions from prescribers and pharmacists, PDMPs are one step towards resolving inappropriate or unsafe controlled substance prescription use by the identification of 'doctor shoppers' and detecting therapeutic duplication. Most states require pharmacies to report controlled substance prescription data at least biweekly to their PDMP. This consistent and up-to-date monitoring could prevent the dispensing of unnecessarily high amounts of controlled substance prescriptions at either the physician visit or dispensing pharmacy - a more direct and time efficient method.

A recent report assessing the best practices of PDMPs identified six areas for further development[3].One area of special note was increasing medical provider education and encouraging the use of PDMPs as a clinical tool. This second area is the natural extension of PDMP data into the broader areas of improving public health and safety.

Provider action

PDMP records may help you determine if a patient is obtaining prescriptions from other doctors or from multiple pharmacies. CMS encourages you to actively participate in your state's PDMP:

- Determine if your state has a PDMP and how you can access the data by visiting *http://www.pmpalliance.org/content/state-pmp-websites*.
- Consider developing an office protocol to request a PDMP report for all new patients receiving a controlled substance. Additionally, a periodic PDMP report could be requested if pain control is for a chronic condition to assure that the patient is properly managing their medications.

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1 Clark T, Eadie J, Kreiner P, Strickler G. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices. The PDMP Center of Excellence, Heller School for Social Policy and Management, Brandeis University. September 20, 2012.

2 Unintentional drug poisoning in the United States [July 2010]. National Center for Injury Prevention and Control. Centers for Disease Control and Prevention. http://www.cdc.gov/HomeandRecreationalSafety/pdf/poison-issue-brief.pdf.

3 Clark T, Eadie J, Kreiner P, Strickler G. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices. The PDMP Center of Excellence, Heller School for Social Policy and Management, Brandeis University. September 20, 2012.

Redesign of the MSN – final implementation – and major update to Chapter 21 of the *Medicare Claims Process Manual*

Provider types affected

Physicians, providers, and suppliers who bill Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B/ MACs), regional home health intermediaries (RHHIs), or durable medical equipment MACs for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The content and format of the Medicare summary notice (MSN) are redesigned, effective January 3, 2013.

(continued on next page)

MSN *(continued)*

Caution – what you need to know

In change request (CR) 7676, CMS announces that (effective January 3, 2013) the content and format of the MSN have been redesigned. It also announces relevant manual changes that Medicare contractors will use to implement the newly designed document. Note that MACs will begin phasing the new MSN beginning January 3, 2013.

Go – what you need to do

You should make sure that your billing staffs are aware of these MSN changes.

Background

Section 1806(a) of the Social Security Act (the Act) requires the Centers for Medicare & Medicaid Services (CMS) to provide a Part A, Part B, and/or DME MSN to each Medicare beneficiary. The MSN content and format are impacted by statute, legislation, and court decisions including:

- The Plain Writing Act of 2010, which requires all government communications to be written in plain language that is easily understood by the target audience
- Sections 1806(b), 1816(j), 1842(h)(7), 1848(g), 1869(a)(4), and 1869(a)(4)(C) of the Act
- 42 C.F.R. Section 405.921
- Section 925 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173); and
- Court decisions Gray Panthers v. Schweiker, 652 F. 2d 146, 168 (D.C. Cir. 1980); David v. Heckler, 591 F.Supp. 1033 (E.D.N.Y 1984); Vorster v. Bowen, 709 F.Supp 934 (C.D. Cal. 1989); and Connecticut Department of Social Services v. Leavitt

CR 7676, from which this article is taken, announces that CMS has undertaken a redesign of the MSN, in order to: 1) make the document current and consistent with all applicable statutes and laws, and 2) to render it more easily and widely understood by the beneficiary population that it serves., 428 F.3d 138 (2d Cir. 2005).

In addition, CR 7676 announces that of the *Medicare Claims Processing Manual* Chapter 21 (Medicare Summary Notices), Sections 10.3-31 (MSN Redesign) has been updated to reflect the new MSN designs. This update is effective with the final implementation of the new designs January 3, 2013, and will be used to provide guidance on the implementation of these new MSN designs.

Additional information

You can find the official instruction, CR 7676, issued to your carrier, FI, A/B MAC, RHHI, or DME MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2522CP.pdf*. You will find the updated *Medicare Claims Processing Manual* Chapter 21 (Medicare Summary Notices), Sections 10.3-31 (MSN Redesign), and including all of the new (and final) MSN designs as attachments to that CR.

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

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Implementation Date: January 3, 2013

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Further details on the revalidation of provider enrollment information

Note: This article was revised on December 3, 2012, to provide the calendar year 2013 fee amount of $532.00. All other information remains the same. This information was previously published in the November 2011 *Medicare B Connection*, pages 38-39.

Provider types affected

This *Medicare Learning Network (MLN) Matters*® special edition article is intended for all providers and suppliers who enrolled in Medicare prior to March 25, 2011, via Medicare's contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider action needed

Stop – impact to you

In change request (CR) 7350, the Centers for Medicare & Medicaid Services (CMS) discussed the final rule with comment period, titled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the "Federal Register." A related *MLN Matters*® article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf*. This article provides no new policy, but only provides further information regarding the revalidation requirements based on Section 6401 (a) of the Affordable Care Act.

Caution – what you need to know

All providers and suppliers enrolled with Medicare prior to March 25, 2011, must revalidate their enrollment information, but only after receiving notification from their MAC.

Special note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers should continue to submit routine changes – address updates, reassignments, additions to practices, changes in authorized officials, information updates, etc – as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

Go – what you need to do

When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based PECOS or complete the 855
- Sign the certification statement on the application
- If applicable, pay your fee by going to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*, and
- Mail your supporting documents and certification statement to your MAC.

See the *Background* and *Additional information* sections of this article for further details about these changes.

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are generally not impacted.

CMS has reevaluated the revalidation requirement in the Affordable Care Act, and believes it affords the flexibility to extend the revalidation period for another two years. This will allow for a smoother process for providers and contractors. Revalidation notices will now be sent through March of 2015. Important: This does not affect those providers which have already received a revalidation notice. If you have received a revalidation notice from your contractor respond to the request by completing the application either through Internet-based PECOS or by completing the appropriate 855 application form.

Therefore, between now and 2015, MACs will send out revalidation notices on an intermittent, but regular basis to begin the revalidation process for each -provider and supplier. Providers and suppliers must submit the revalidation application only after being asked by their MAC to do so. Please note that 42 CFR 424.515(d) provides CMS the authority to conduct these off-cycle revalidations.

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Revalidation *(continued)*

The first set of revalidation notices went to providers who are billing, but are not currently in PECOS. To identify these providers, contractors searched their local systems and if a provider transaction access number (PTAN) for a physician was not in PECOS, a revalidation request for that physician was sent. CMS asks all providers who receive a request for revalidation to respond to that request.

- For providers **not** in PECOS – the revalidation letter will be sent to the special payments or primary practice address because CMS does not have a correspondence address.
- For providers in PECOS – the revalidation letter will be sent to the special payments and correspondence addresses simultaneously. If these are the same, it will also be mailed to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your Medicare contractor. Contact information may be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

Note: CMS has structured the revalidation processes to reduce the burden on the providers by implementing innovative technologies and streamlining the enrollment and revalidation processes. CMS will continue to provide updates as progress is made on these efforts.

The most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to *https://pecos.cms.hhs.gov/pecos/login.do*. PECOS allows you to review information currently on file, update and submit your revalidation via the Internet. Once submitted, YOU MUST print, sign, date, and mail the certification statement along with all required supporting documentation to the appropriate MAC immediately.

Section 6401(a) of the Affordable Care Act also requires the Secretary to impose a fee on each “institutional provider of medical or other items or services and suppliers.” The application fee is $505 for calendar year (CY) 2011. For CY 2012, the fee is $523.00 and for CY 2013, the fee is $532.00. CMS has defined “institutional provider” to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

All institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit an enrollment fee (reference 42 CFR 424.514) with their revalidation. In mid-September, CMS revised the revalidation letter that contractors sent to providers to clarify who must pay the fee. You may submit your fee by ACH debit, or credit card. Revalidations are processed only when fees have cleared. To pay your application fee, go to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do* and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you mail this receipt to the Medicare contractor along with the certification statement for the enrollment application. CMS will notify the Medicare contractor that the application fee has been paid.

Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges.

Additional information

For more information about the enrollment process and required fees, refer to *MLN Matters®* article MM7350, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf*.

For more information about the application fee payment process, refer to *MLN Matters®* article SE1130, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf*.

The *MLN* fact sheet titled “The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations” is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and can be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf*.

To access PECOS, your authorized official must register with the PECOS Identification and Authentication system. To register for the first time go to *https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin* to create an account.

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Revalidation *(continued)*

A sample letter requesting providers to review, update, and certify their enrollment information is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf*.

For additional information about the enrollment process and Internet-based PECOS, please visit the "Medicare Provider-Supplier Enrollment" Web page at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*.

If you have questions, contact your Medicare contractor. 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*.

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Phase 2 of ordering/referring requirement

Note: This article was revised on December 10, 2012, to delete language relating to portable X-ray services. All other information remains the same. This information was previously published in the November 2012 *Medicare B Connection*, Pages 42-45.

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 and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A home health agency (HHA) services who submit claims to RHHIs, fiscal intermediaries (who still maintain an HHA workload), and Part A/B MACs.

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

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Phase *(continued)*

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

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

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

N264 Missing/incomplete/invalid ordering physician provider name

N265 Missing/incomplete/invalid ordering physician primary identifier

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

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

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

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

N272 Missing/incomplete/invalid other payer attending provider identifier

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

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

Phase 2: CMS has not announced a date when the edits for phase 2 will become active. CMS will give the provider community at least 60 days' 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

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Phase *(continued)*
not of a specialty that is eligible to order and refer, the claim will not be paid. Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D Referring/Ordering Provider Not Allowed To Refer

255D Referring/Ordering Provider Mismatch

289D Referring/Ordering Provider NPI Required

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

37236 – This reason code will assign when:

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

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

37237 – This reason code will assign when:

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

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

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

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

Additional information

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

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

The *Medicare Learning Network®* (*MLN®*) 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*.

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Phase *(continued)*

- *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*.
- *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*.

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Related Change Request (CR) #: N/A
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Implementation Date: N/A

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Implementation of provider enrollment provisions in CMS-6028-FC

Note: This article was revised December 3, 2012, to provide the application fee amount of $532.00 for calendar year 2013. All other information remains the same. This information was previously published in the November 2011 *Medicare B Connection*, Pages 40-42.

Provider types affected

All providers and suppliers submitting enrollment applications to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse (NSC) are affected by this article.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the *Federal Register*.

(continued on next page)

CMS-6028-FC *(continued)*

Caution – what you need to know

This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories
- Submission of application fees as part of the provider enrollment process
- Suspensions of payment based on credible allegations of fraud, and
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

Go – what you need to do

This article is based on change request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria. (Payment suspensions will be addressed via separate CMS guidance.). Please ensure that your staffs are aware of these new provisions.

Background

CR 7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new Sections 19 through 19.4 of Chapter 15 in the *Medicare Program Integrity Manual*. Those manual sections are attached to CR 7350 and are summarized as follows:

Screening processes

Beginning March 25, 2011, Medicare will place newly-enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the *Program Integrity Manual* (*PIM*) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new Section of the *PIM* is attached to CR 7350.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the "high" category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

Application fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011. Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee.

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011, through December 31, 2011, is $505.00. The fee for January 1, 2012, through December 31, 2012, is $523.00 and for **January 1, 2013, through December 31, 2013, the fee is $532.00**. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved
- An application that was rejected prior to the Medicare contractor's initiation of the screening process, or
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR 424.570.

(continued on next page)

CMS-6028-FC *(continued)*

The provider or supplier must pay the application fee electronically by going to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do* and paying their fee via credit card, debit card, or check. Providers and suppliers are strongly encouraged to submit with their application a copy of their receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

Hardship exception

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter must accompany the application. If the application is submitted via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the hardship exception letter must accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. During this review period, the contractor will not begin processing the provider's application. CMS will communicate its decision to the institutional provider and the contractor via letter.

Important: In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the application will be processed in the order in which it was received.

Review of hardship exception request

As already stated, the application fee for CY 2011 is $505. This generally should not represent a significant burden for an adequately capitalized provider or supplier. It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

a) Considerable bad debt expenses

b) Significant amount of charity care/financial assistance furnished to patients

c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population

d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note that if the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

Appeal of the denial of hardship exception decision

If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the procedures outlined in Chapter 15, Section 19 of the *Program Integrity Manual* (*PIM*), which is attached to CR 7350.

Temporary moratoria

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the *Federal Register*. For initial and new location applications involving the affected provider and supplier type, the moratorium:

(continued on next page)

CMS-6028-FC *(continued)*

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.
- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the "high" level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within six months after the applicable moratorium was lifted, the contractor will process the application using the "high" level of categorical screening.

Additional information

The official instruction, CR 7350, 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/R371PI.pdf*.

Complete details regarding this issue, as defined in the PIM revisions, are attached to CR 7350.

MLN Matters® article SE1126, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf*, has further details on the Affordable Care Act-required revalidation of provider enrollment information for all providers and suppliers who enrolled in the Medicare program prior to March 25, 2011.

For more information about the application fee payment process, refer to *MLN Matters*® article SE1130, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf*.

A sample letter requesting providers to review, update, and certify their enrollment information is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf*.

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: MM7350 *Revised*
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Related CR Release Date: March 23, 2011
Effective Date: March 25, 2011
Related CR Transmittal #: R371PI
Implementation Date: March 25, 2011

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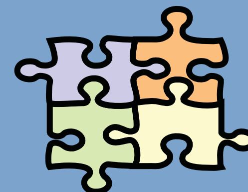
Puzzled about your enrollment status?

Put the pieces together using the enrollment status lookup. View all active applications, specific applications, and confirm if you have been sent a revalidation request at *http://medicare.fcso.com/Enrollment/PEStatus.asp*

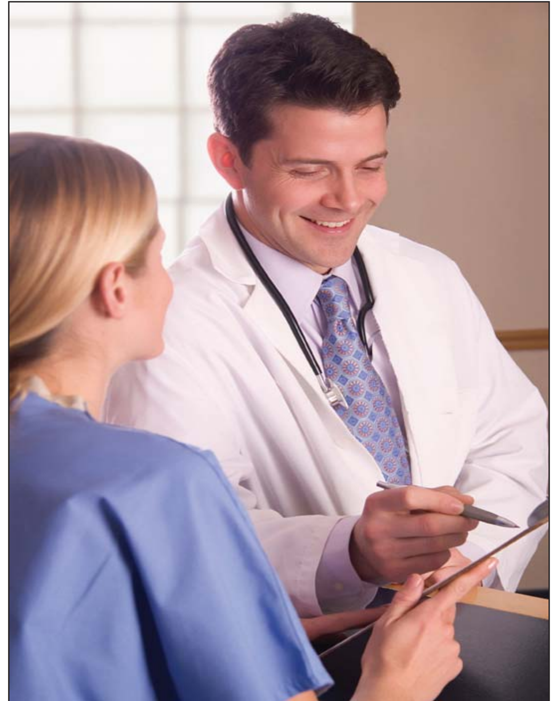


Revision to Chapter 15 of the *Medicare Program Integrity Manual*

Note: This article was revised on December 18, 2012, to reflect the revised change request (CR) 7864 issued on December 14. In the article, the effective and implementation dates have been revised. Also, an incorrect Web address has been updated for 42 CFR 424.80. The CR release date, transmittal number, and Web address for accessing the CR have been revised. All other information remains the same. This information was previously published in the May 2012 *Medicare B Connection*, Pages 40-41.

Provider types affected

This *MLN Matters*® article for 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.

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://www.gpo.gov/fdsys/pkg/CFR-2005-title42-vol2/pdf/CFR-2005-title42-vol2-sec424-82.pdf* 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

(continued on next page)

Manual *(continued)*

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/R445PI.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 *Revised*
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Related CR Transmittal #: R445PI
Implementation Date: January 1, 2014

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

Note: This article was revised on December 13, 2012, to add clarifying language to the bullet point related to optometrists. All other information remains the same. This information was previously published in the September 2012 *Medicare B Connection*, Pages 41-42.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

Background

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not

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Ordered *(continued)*

authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home health agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.

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

Additional information

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

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

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

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

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

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

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

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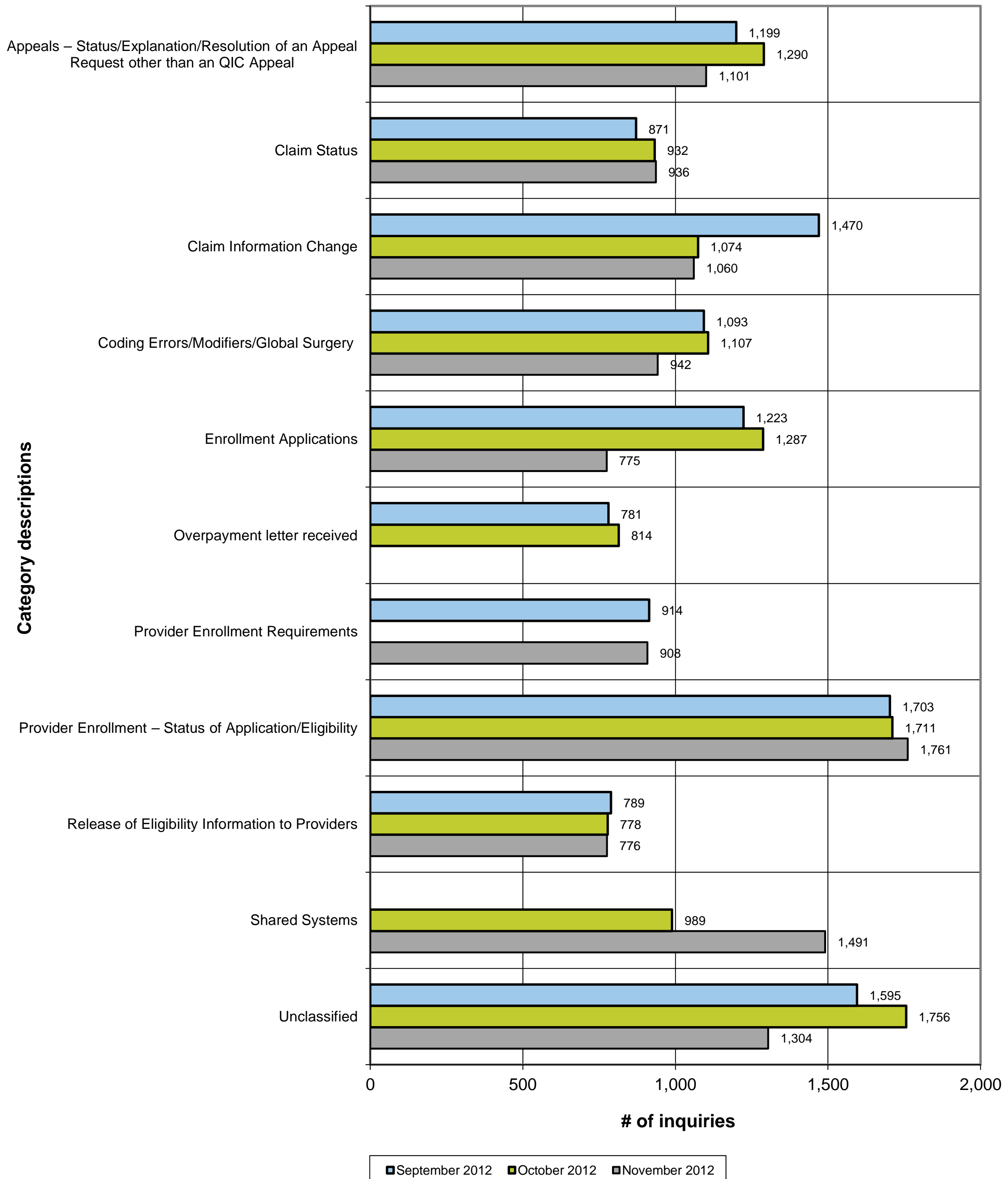
Top inquiries, denials, and return unprocessable claims

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 September-November 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 September-November 2012



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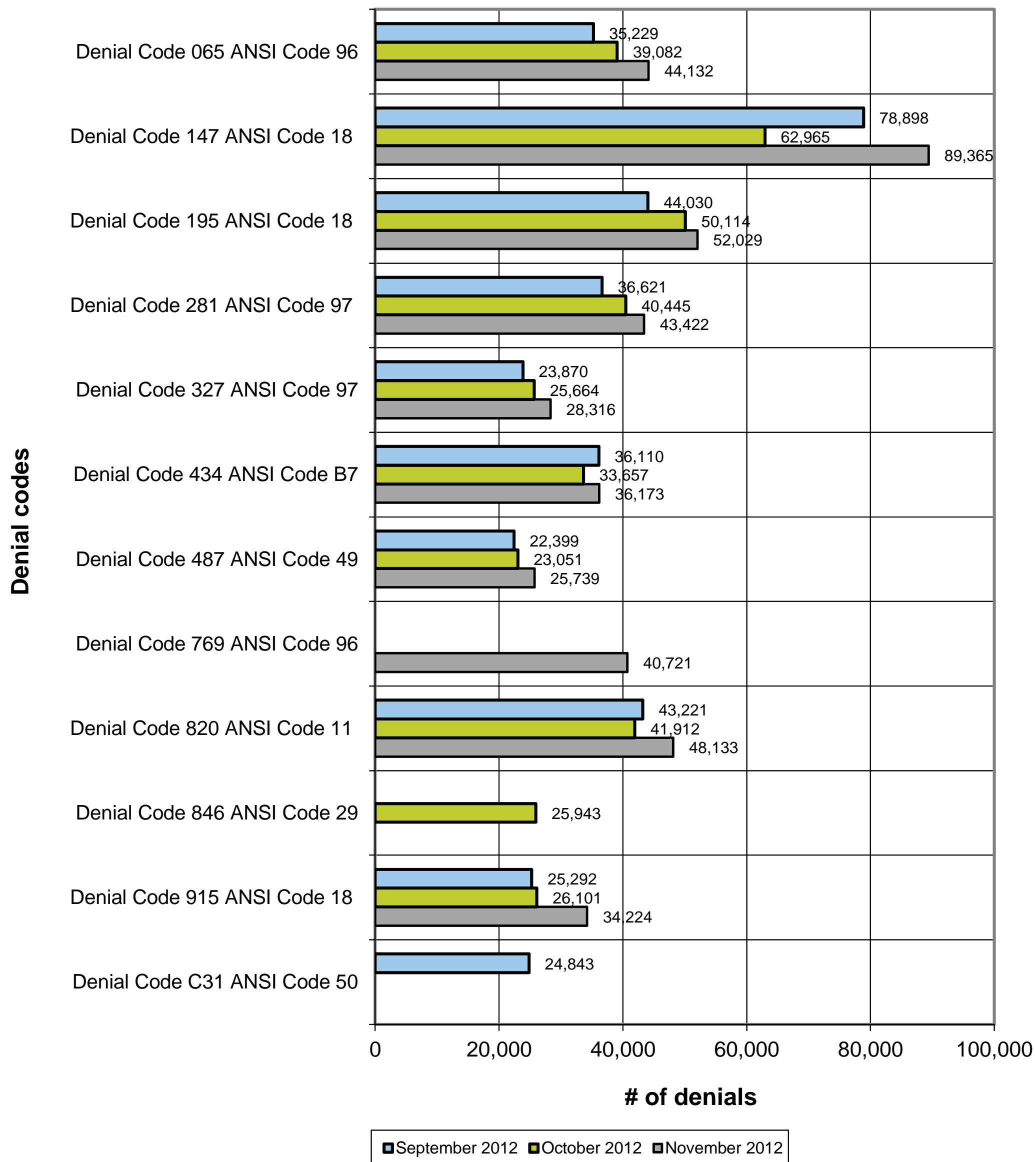


What to do when your claim is denied

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

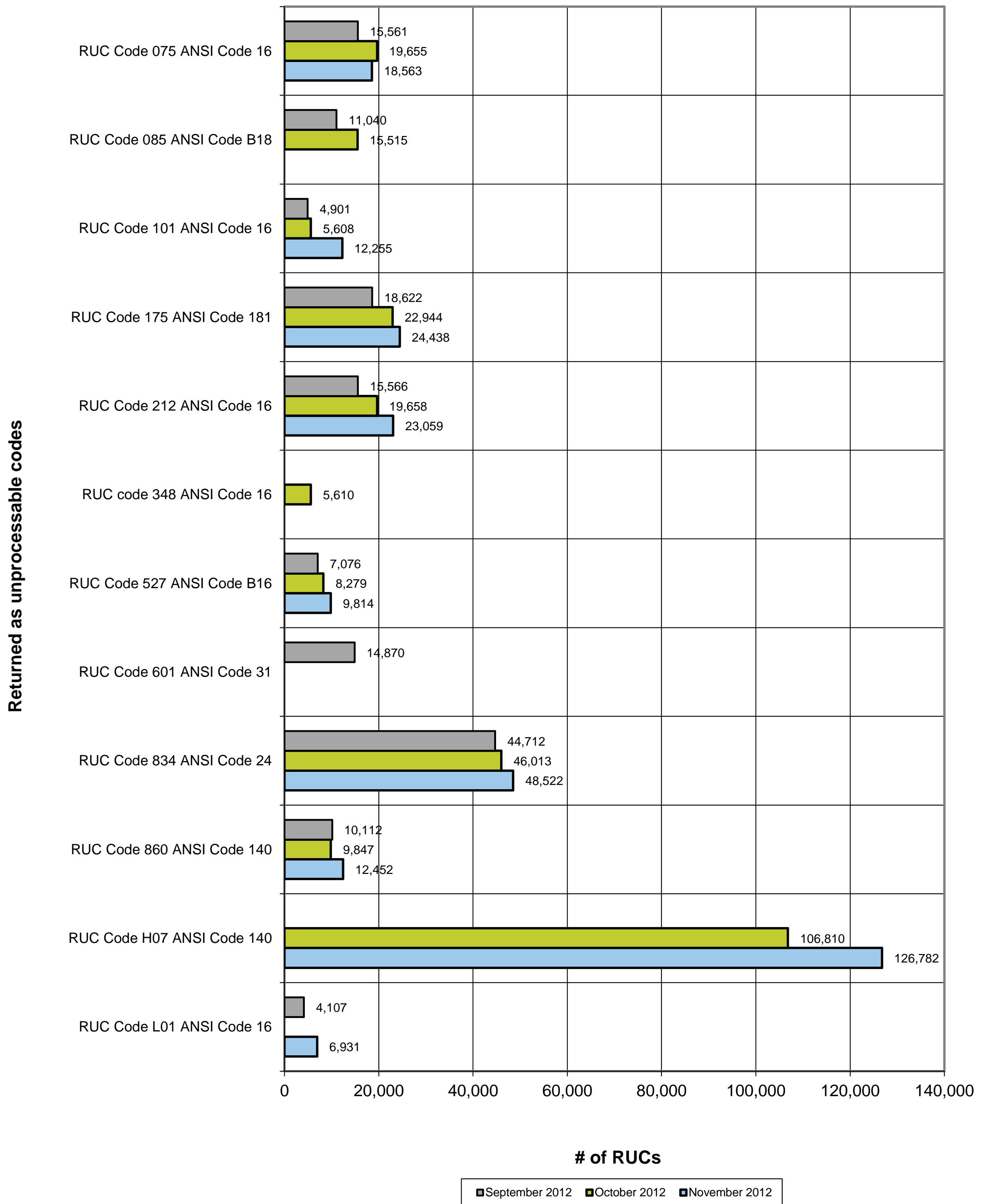
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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

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

Top *(continued)*

Part B top return as unprocessable claims for September-November 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.

New LCDs

TESTOPEL: Testosterone pellets (Testopel®) – new LCD

LCD ID number: L33002 (Florida/Puerto Rico/U.S. Virgin Islands)

Testosterone pellets (Testopel®) have been approved by the Food and Drug Administration (FDA) for the treatment of primary hypogonadism (congenital or acquired) and hypogonadotropic hypogonadism (congenital or acquired). Primary hypogonadism includes such conditions as testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome, or orchidectomy. Hypogonadotropic hypogonadism (secondary hypogonadism) includes conditions such as idiopathic or gonadotropic luteinizing hormone releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors.

This new local coverage determination (LCD) was developed to outline indications and limitations of coverage and/or medical necessity, ICD-9-CM codes that support medical necessity, documentation requirements and utilization guidelines for testosterone pellets (Testopel®). A "coding guidelines" LCD attachment was also developed which provides instructions to bill Testopel® with the Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) code J3490 (Unclassified drugs) and the Current Procedural Terminology (*CPT*®) code *11980* (*Subcutaneous hormone pellet implantation [implantation of estradiol and/or testosterone pellets beneath the skin]*) on the same claim. If HCPCS code J3490 and *CPT*® code *11980* are not billed on the same claim, the claim will be subject to prepayment review.

Effective date

This new LCD is effective for services rendered **on or after January 29, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

36516: Low density lipoprotein (LDL) apheresis – new LCD

LCD ID number: L32998 (Florida/Puerto Rico/U.S. Virgin Islands)

Low density lipoprotein (LDL) apheresis describes the process of acutely removing LDL-cholesterol (LDL-C) from the plasma of high risk patient populations. LDL-apheresis (LDL-A) is not routinely used for the treatment of hypercholesterolemia, as hypercholesterolemia usually responds to medical management. LDL-A is indicated for the treatment of hypercholesterolemia for patients with selected inherited conditions who have failed to respond to maximum medical management and diet therapy.

Currently, there is a Medicare national coverage determination (NCD) for apheresis (therapeutic pheresis – NCD 110.14). However, it does not specifically address coverage requirements for LDL apheresis.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage and/or medical necessity, *CPT*® code *36516*, ICD-9-CM diagnosis code 272.0, documentation guidelines, and utilization guidelines for low density lipoprotein (LDL) apheresis.

Effective date

This new LCD is effective for services rendered **on or after February 4, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

86352: Transplantation immune cell function assay (ImmuKnow®) – new LCD

LCD ID number: L33015 (Florida/Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) was developed as a non-coverage LCD based on review of the current published available literature for transplantation immune cell function assay (ImmuKnow®) (*CPT*® code *86352*). This assay addresses recipient cell-mediated immunity in the course of evaluation of possible immunologic graft rejection. It was determined that this service does not meet the reasonable and necessary criteria as defined in Section 1862 (a)(1)(A) of the Social Security Act and is therefore a non-covered service.

Effective date

This new LCD is effective for services rendered **on or after January 29, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

Retired LCD

90862: Pharmacologic medication management for psychiatry services – retired LCD

LCD ID number: L30351 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pharmacologic medication management for psychiatry services was most recently revised October 1, 2011. Since that time, a decision was made to retire the LCD based on the annual 2013 HCPCS update and data analysis.

Effective date

This LCD retirement is effective for services rendered **on or after January 1, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

Revisions to LCDs

J9263: Oxaliplatin (Eloxatin®) – revision to the LCD

LCD ID number: L29248 (Florida)
LCD ID number: L29459 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for oxaliplatin (Eloxatin®) was most recently revised January 13, 2012. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to include the off-labeled indications of hepatobiliary cancers and multiple specific non-Hodgkin Lymphomas based on the Centers for Medicare & Medicaid Services (CMS)-approved compendia. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis codes 155.1, 156.0, 156.1, 156.2, 156.8, 156.9, 200.30-200.38, 200.40-200.48, 200.60-200.68, 200.70-200.78, 202.00-202.08, and 202.10-202.18 were added. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

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J9263 *(continued)*

Effective date

This LCD revision is effective for services rendered **on or after December 10, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

NCSVCS: Noncovered services – revision to the LCD

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

The local coverage determination (LCD) for noncovered services was most recently revised on January 1, 2013. Since that time a revision was made to the LCD. The following codes were evaluated and determined not to be medically reasonable and necessary at this time based on the current published evidence (e.g., peer-reviewed medical literature, published studies): *CPT*® code *84999* (CancerType ID) was added to the "*CPT*/HCPCS Codes, Local Noncoverage Decisions-Laboratory Procedures" section of the LCD. *CPT*® codes *78999* (Intraoperative nuclear mapping during parathyroidectomy [Gamma probe]), *92700* (Vestibular evoked myogenic potentials [VEMP]), *97039* (Cold laser therapy [low level laser therapy]) and Category III *CPT*® codes *0302T, 0303T, 0304T, 0305T, 0306T*, and *0307T* were added to the "*CPT*/HCPCS Codes, Local Noncoverage Decisions – Procedures section of the LCD. In addition under the "Related Documents section of the LCD a reference page is included.

Effective date

This LCD revision is effective for services rendered **on or after January 29, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

NCSVCS: Noncovered services (0191T) – revision to the LCD

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

The local coverage determination (LCD) for noncovered services was most recently revised October 9, 2012. Since that time, the LCD was revised to remove Category III *CPT*® code *0191T* from the "*CPT*/HCPCS Codes, Local Noncoverage Decisions-Procedures" section of the LCD. When a service or procedure is removed from the Noncovered Services LCD, this does not imply a positive coverage statement, since there is no coverage statement in any LCD. Therefore, claims billed for Category III *CPT*® code *0191T* (assuming all other requirements of the program are met) would always need to meet the medically reasonable and necessary threshold for coverage in a prepayment or post payment audit of the official medical record. Therefore, at this time *CPT*® code *0191T* will be medically reviewed on an individual consideration basis.

Effective date

This LCD revision is effective for services rendered **on or after December 10, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

11730: Surgical treatment of nails – revision to the LCD

LCD ID number: L29318 (Florida)
LCD ID number: L29395 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for surgical treatment of nails was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD has been revised as a result of a Zone Program Integrity Contractor (ZPIC) data analysis from the period January 2009 through April 2012, related to overutilization of nail avulsion service (*CPT*® code *11730*). Based on ZPIC data analysis, it was determined that podiatrists in Florida are billing for avulsion of the nail services more frequently than current peer review literature supports. Therefore, LCD language related to the utilization and frequency of nail avulsion services has been added to the "Indications and Limitations of Coverage and /or Medical Necessity" and "Utilization Guidelines" sections of the LCD, stating that services performed more often than every 12 weeks on the same digit are considered to be not medically reasonable and necessary and will be denied. In addition, the "Documentation Requirements" section of the LCD was also updated.

Effective date

This LCD revision is effective for services rendered **on or after February 11, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

43644: Surgical management of morbid obesity – revision to the LCD

LCD ID number: L29317 (Florida)
LCD ID number: L29477 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for surgical management of morbid obesity was most recently revised January 1, 2011. Since that time, the LCD has been revised based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8028 effective for claims processed on or after December 10, 2012, for dates of service on or after June 27, 2012. According to CR 8028 Medicare administrative contractors acting within their respective jurisdictions may determine coverage of stand-alone laparoscopic sleeve gastrectomy (LSG), *CPT*® code *43775*, for the treatment of comorbid conditions related to obesity.

This LCD was revised to clarify which bariatric procedures are currently covered and non-covered per national coverage determination (NCD) 100.1, as well as at the local level for LSG. The criteria are clarified for covered bariatric procedures in the LCD section titled "Indications and Limitations of Coverage and/or Medical Necessity". The "Documentation Requirements" section of the LCD applies to all of the covered indications and clarifies what should be included in the medical record in support of the allowed procedures.

Criteria that must be met in order to meet the covered indications include:

- The patient has a BMI ≥ 35 and comorbid conditions exist (e.g., hypertensive cardiovascular disease, pulmonary/respiratory disease, diabetes, sleep apnea or degenerative arthritis of weight-bearing joints) related to obesity. Documentation of the level of severity of the comorbid existing condition must be included in the patient's medical record; and
- The patient has been previously unsuccessful with medical treatment for obesity; and
- Treatable metabolic causes for obesity (e.g., adrenal or thyroid disorders) have been ruled out or have been clinically treated if present; and
- When performed at facilities that are (1) certified by the American College of Surgeons as a Level I Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (program standards and requirements in effect on February 15, 2006). A list of approved facilities and their approval dates will be listed and maintained on the CMS coverage website at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx* and will be published in the *Federal Register*.

A triple diagnosis combination will need to be submitted on claims for bariatric procedures. A list of comorbidity codes was added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD. The primary diagnosis (ICD-9-CM code 278.01) and then an additional secondary diagnosis for body mass index (BMI) followed by the comorbidity diagnosis as appropriate will need to be submitted.

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43644 *(continued)*

Effective date

This LCD revision is effective for services rendered **on or after January 29, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

Additional Information

Modifier *24* widespread probe results

First Coast Service Options Inc. (First Coast) implemented a pre-payment edit for Florida April 16, 2012, applicable to office evaluation and management (E/M) claims (codes *99201-99205* and *99212-99215*) billed with the *24* modifier in response to three widespread probes that identified incorrect billing of modifier *24* at least 60 percent of the time. To address this widespread improper billing, First Coast implemented a pre-payment edit on April 16, 2012, applicable to office visit E/M claims (codes *99201-99205* and *99212-99215*) billed with the *24* modifier. First Coast has completed three additional widespread probes. The findings indicate that the modifier *24* was either not supported for the encounter or was improperly applied. The following E /M codes were included in the widespread probe:

- E/M codes *99223, 99233* and *99291*, which resulted in a 66.95 percent error rate
- E/M codes *92012* and *92014*, which resulted in a 33.99 percent error rate
- E/M codes *99308*, *99309*, and *99310*, which resulted in a 65.54 percent error rate

Educational resources

Providers currently billing E/M services with the *24* modifier are encouraged to review the Medicare guidelines as outlined in the Centers for Medicare & Medicaid Services Internet-only manual, Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.6:

Contractors pay for an evaluation and management service other than inpatient hospital care before discharge from the hospital following surgery (*CPT*® codes *99221-99238*) if it was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with *CPT*® modifier *24*, and accompanied by documentation that supports that the service is not related to the postoperative care of the procedure. They do not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred unless the doctor is also treating another medical condition that is unrelated to the surgery. All care provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment.

The following Web-based training courses are available on *First Coast University* to help providers learn about the proper billing of the *24* modifier as well as the documentation requirements to support the necessity and/or validity of its use:

- “Introduction to Global Surgery”
- “Medical Documentation Errors”
- “Medical Documentation Request”
- “Modifier 24”

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.

Self-administered drug (SAD) list – Part B: J1744/J2212

The self-administered drug (SAD) list was most recently revised August 6, 2012. Since that time, based on the 2013 Healthcare Common Procedure Coding System (HCPCS) annual update, self-administered drugs icatibant (Firazyr®) and methylnatrexone bromide (Relistor®) (HCPCS codes J3490/C9399) have received new HCPCS codes.

Effective for services rendered on or after January 1, 2013, the following new HCPCS codes have been added to the Medicare administrative contractor (MAC) for jurisdiction 9 (J9) Part B SAD list to replace the unclassified codes for icatibant (Firazyr®) and methylnatrexone bromide (Relistor®).

- J1744 Injection, icatibant, 1 mg
- J2212 Injection, methylnaltrexone, 0.1 mg

The First Coast Service Options Inc. SAD lists are available through the CMS Medicare coverage database at: *http://medicare.fcso.com/Self-administered_drugs/*.

2013 HCPCS local coverage determination changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2013 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

LCD Title	Changes
BOTULINUM TOXINS Botulinum Toxins (**Coding Guidelines only**)	**Descriptor change** for *CPT®* codes *64612* and *64614* **Added** *CPT®* codes *64615* and *52287*
IDTF Independent Diagnostic Testing Facility (IDTF) (**Coding Guidelines only**)	**Deleted** *CPT®* codes *71040, 71060, 75650, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 78000, 78001, 78003, 78006, 78007, 78010, 78011, 95900, 95903, 95904, 95934*, and *95936* **Added** *CPT®* codes *78012, 78013, 78014, 78071, 78072, 95782, 95783, 95907, 95908, 95909, 95910, 95911, 95912, 95913, 95924*, and *95943*
J0881 Erythropoiesis Stimulating Agents	**Deleted** HCPCS code Q2047 **Added** HCPCS code J0890
J1459 Intravenous Immune Globulin	**Descriptor change** for HCPCS codes J1561 and J1569
J9280 MItomycin (Mutamycin®, Mitomycin-C)	**Descriptor change** for HCPCS code J9280
NCSVCS Noncovered Services	**Descriptor change** for *CPT®* codes *0195T, 0196T, 0206T, 28890, 94014*, and *94016* **Deleted** *CPT®* codes *0173T, 0242T* (replaced with *CPT®* code *91112*), *0276T* (replaced with *CPT®* code *31660*), *0277T* (replaced with *CPT®* code *31661*), *90664* and *90665* **Removed** *CPT®* code *99199* (Snap wound care system) and replaced with HCPCS codes G0456 and G0457 **Added** *CPT®* codes *0309T, 22586, 90653, 90685, 90686, 90687, 90688*, and *90739*
Q2048 Doxorubicin, Liposomal (Doxil/Lipodox))	**Deleted** HCPCS code Q2048 **Added** HCPCS code J9002 **Changed** “Contractor’s Determination Number” to J9002
SKINSUB Skin Substitutes	**Descriptor change** for HCPCS codes Q4119, Q4126, and Q4128 **Deleted** HCPCS code C9366, C9368, and C9369 **Added** HCPCS codes Q4131, Q4132, Q4133, Q4134, Q4135, and Q4136 to “The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products” section of the LCD

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HCPCS *(continued)*

LCD Title	Changes
THERSVCS Therapy and Rehabilitation Services	**Descriptor change** for *CPT*® codes *97530, 97532, 97533, 97535, 97537*, and *97755* **Changed** *CPT*® code range *29000-29590* to *CPT*® code range *29000-29584* in the "Coding Guidelines" attachment
01991 Monitored Anesthesia Care (MAC) for Certain Interventional Pain Management Services	**Descriptor change** for *CPT*® codes *01991* and *01992*
0279T Circulating Tumor Cell Testing	**Delete** *CPT*® codes *0279T* and *0280T* **Added** *CPT*® codes *86152* and *86153* **Changed** "Contractor's Determination Number" to 86152
22533 Lumbar Spinal Fusion for Instability and Degenerative Disc Disease	**Added** *CPT*® codes *0309T* and *22586*
33224 Biventricular Pacing/Cardiac Resynchronization Therapy	**Descriptor change** for *CPT*® code *33225*
43201 Noncovered Procedures-Endoscopic Treatment of Gastroesophageal Reflux Disease (GERD)	**Descriptor change** for HCPCS code C9724
64561 Sacral Neuromodulation	**Descriptor change** for *CPT*® code *64561*
76376 3D Interpretation and Reporting of Imaging Studies	**Descriptor change** for *CPT*® codes *76376* and *76377*
77055 Screening and Diagnostic Mammography	**Descriptor change** for *CPT*® codes *77051 and 77052*
77371 Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (**Coding Guidelines only**)	**Added** *CPT*® code *32701*
86003 Allergy Testing	**Descriptor change** for *CPT*® codes *95004, 95024*, and *95027* **Deleted** *CPT*® codes *95010* and *95015* **Added** *CPT*® codes *95017* and *95018*
90801 Psychatric Diagnostic Interview Examination	**Deleted** *CPT*® code *90801* **Added** *CPT*® codes *90791* and *90792* **Changed** "Contractor's Determination Number" to 90791 **Changed** "LCD Title" from "Psychiatric Diagnostic Interview Exam" to "Psychiatric Diagnostic Evaluation"
90802 Interactive Psychiatric Services	**Deleted** *CPT*® codes *90801, 90802, 90804,90810, 90811, 90812, 90813, 90814, 90815, 90823, 90824, 90826, 90827, 90828, 90829*, and *90857* **Added** *CPT*® codes *90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837*, and *90838* **Changed** "Contractor's Determination Number" to 90785 **Changed** "LCD Title" from "Interactive Psychiatric Services" to "Interactive Complexity Services

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HCPCS *(continued)*

LCD Title	Changes
90804 Individual Psychotherapy	**Deleted** *CPT®* codes *90804, 90805, 90806, 90807, 90808, 90809, 90816, 90817, 90818, 90819, 90821*, and *90822* **Added** *CPT®* codes *90832, 90833, 90834, 90836, 90837*, and *90838* **Changed** "Contractor's Determination Number" to 90832 **Changed** "LCD Title" from "Individual Psychotherapy" to "Psychotherapy"
90901 Biofeedback	**Descriptor change** for *CPT®* codes *90875* and *90876*
91110 Wireless Capsule Endoscopy	**Descriptor change** for *CPT®* codes *91110* and *91111*
92018 Ophthalmological Diagnostic Services	**Descriptor change** for *CPT®* codes *92286* and *92287*
93015 Cardiovascular Stress Testing	**Descriptor change** for *CPT®* codes *93015* and *93016*
93224 Long-Term Wearable Electrocardiographic Monitoring (WEM)	**Descriptor change** for *CPT®* codes *93224, 93227, 93228, 93229, 93268*, and *93272*
93350 Stress Echocardiography	**Descriptor change** for *CPT®* codes *93351*
95805 Polysomnography and Sleep Testing	**Descriptor change** for *CPT®* codes *95808, 95810*, and *95811* **Added** *CPT®* codes *95782* and *95783* **Changed** "Contractor's Determination Number" to 95782
95860 Electromyography and Nerve Conduction Studies	**Deleted** *CPT®* codes *95900, 95903, 95904, 95934*, and *95936* **Added** *CPT®* codes 959*07, 95908, 95909, 95910, 95911, 95912*, and *95913*
95920 Intraoperative Neurophysiology Testing	**Deleted** *CPT®* code *95920* **Added** *CPT®*/HCPCS codes *95940* and G0453 **Changed** "Contractor's Determination Number" to 95940 **Changed** "LCD Title" from "Intraoperative Neurophysiology Testing" to "Intraoperative Neurophysiology Monitoring"
95921 Autonomic Function Tests	**Added** *CPT®* codes *95924* and *95943*
95925 Somatosensory Testing (**Coding Guidelines only**)	**Deleted** *CPT®* code *95920* **Added** *CPT®*/HCPCS codes *95940* and G0453
95990 Implantable Infusion Pump for the Treatment of Chronic Intractable Pain	**Descriptor change** for *CPT®* codes *62370* and *95991*
96000 Comprehensive Motion Analysis Studies	**Descriptor change** for *CPT®* code *96004*
96150 Health and Behavior Assessment/ Intervention (**Coding Guidelines only**)	**Deleted** *CPT®* code range *90801-90862* and replaced it with "psychiatry services"
99183 Hyperbaric Oxygen Therapy (HBO Therapy)	**Descriptor** change for *CPT®* code *99183*
99324 E/M Home and Domiciliary Visits	**Descriptor** change for *CPT®* codes *99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349*, and *99350*

Source: Pub 100-04, transmittal 2529, change request 7909

Educational Events

Upcoming provider outreach and educational events January 2013

Medicare Part B changes and regulations

When: Wednesday, January 16
Time: 1:00-2:30 p.m.

Implementing the claims-based data collection requirement for outpatient therapy services

When: Thursday, January 17
Time: 11:30 a.m.-1:00 p.m.

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: ______________________________

Registrant's Title: ______________________________

Provider's Name: ______________________________

Telephone Number: ______________ Fax Number: ______________

Email Address: ______________________________

Provider Address: ______________________________

City, State, ZIP Code: ______________________________

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

Educational Resources

CMS Medicare Provider e-News

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

- CMS e-News for Wednesday, December 13, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/eNews121312.pdf*
- 'CMS Medicare FFS Provider e-News': December 6, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-12-06-e-News.pdf*
- 'CMS Medicare FFS Provider e-News': November 29, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-29-e-News.pdf*
- 'CMS Medicare FFS Provider e-News': December 20, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/eNews-12202012.pdf*

Source: CMS PERL 201211-07, 201211-08, 201212-01, 201212-04

Find out first: Subscribe to First Coast *eNews*

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

Mail directory

Claims submissions

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

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

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

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

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

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

Communication

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

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

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

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

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

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

Durable medical equipment (DME)

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

Electronic media claims (EMC)

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

Additional development

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

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

Miscellaneous

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

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
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/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

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

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

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

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

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

Phone numbers

Providers

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

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

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

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

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

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange (EDI)

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

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

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

Provider enrollment

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

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

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

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

Email address:
AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

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

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

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

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 Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare
Palmetto Goverment 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		
2013 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2013, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

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

Contact Name: ______________________________

Provider/Office Name: ______________________________

Phone: ______________________________

Mailing Address: ______________________________

City: ________________ State: ________________ ZIP: ____________

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

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

Attention Billing Manager