Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers March 2013

In this issue

Getting prepared for ordering and referring denial edits

Effective May 1, Medicare will deny claims for all covered Medicare Part B, durable medical equipment, orthotics, and supplies (DMEPOS), and Part A home health agency (HHA) services when the ordering or referring provider is not enrolled in Medicare or the claim does not list the national provider identification (NPI) number for the ordering or referring provider.

Preventing Medicare fraud

Providers who routinely order or refer such services or supplies on behalf of Medicare beneficiaries should take proactive steps now to ensure their claims and those of billing suppliers are not denied payment once ordering and referring edits are implemented May 1. On that day, Medicare contractors and fiscal intermediaries will turn on claim edits to review each of the respective types of claims.

The purpose of the ordering and referring edits is to safeguard the Medicare trust fund as the system seeks to eliminate fraudulent Medicare claims by reviewing three important criteria:

- First, the system will check to see if the physician or other provider is enrolled in Medicare, either in an approved or an opt-out status.
- Second, the system will verify that the ordering or referring NPI matches that of the individual provider. Billing providers should ensure that referring or ordering provider names are spelled correctly and match the NPI database, otherwise the claim will be denied.
- Finally, the system edits will check the claim to determine if the physician or provider listed on the claim is of a specialty type that is eligible to order and refer.

If any claim fails to meet any of the three criteria, payment will be denied. Providers will have the opportunity to appeal denied claims through normal processes.

Medicare Part B and DMEPOS providers will record the ordering or referring information on the line, "Name of Referring Provider or Other Source," along with the referring provider's NPI (lines 17 and 17b of Form CMS-1500). For Medicare Part A HHAs, enter the ordering or referring information on the line, "Attending," along with the attending provider's NPI (line 76 of Form CMS-1450). The ordering/referring provider's name must match the name found in the provider's Internet-based PECOS enrollment record.

In both instances, providers should check the spelling of provider names closely to ensure they match PECOS and NPI databases.

Ways to avoid denied claims

To avoid denied claims, CMS advises providers to check online to determine their current status with Medicare through the Internet-based PECOS and ensure their enrollment record includes their NPI. Providers uncertain of their NPI status may verify it by *visiting the NPI registry website*.

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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.

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.

Quarterly update to Correct Coding Initiative edits, version 19.1, effective April 1, 2013

Note: This article was revised on March 13, 2013, to update website information. The transmittal release date, transmittal number, and Web address for the transmittal was also changed. This information was previously published in the December 2012 *Medicare B Connection*, Page 5.

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) 8147 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 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/R2669CP.pdf*.

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

MLN Matters® Number: MM8147
Related Change Request (CR) #: CR 8147
Related CR Release Date: March 11, 2013
Effective Date: April 1, 2013
Related CR Transmittal #: R2669CP
Implementation Date: April 1, 2013

Update to claim processing instructions for non-physician practitioners

Note: This article was revised February 11, 2013, to reflect a revised change request (CR) 8010 issued February 7. The CR was modified to clarify that modifier AH and AJ are not being eliminated, but will no longer be required to be submitted. The article was adjusted accordingly. In addition, the CR release date, Transmittal number, and the Web address for accessing the CR have been revised. This information was previously published in the February 2013 *Medicare B Connection*, Pages 7-8.

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

CR 8010 deletes and/or corrects obsolete and erroneous billing information in Chapter 12 of the *Medicare Claims Processing Manual* as it relates 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 will no longer need to be submitted 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/R2656CP.pdf*.

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

MLN Matters® Number: MM8010 *Revised*
Related Change Request (CR) #: CR 8010
Related CR Release Date: February 7, 2013
Effective Date: February 19, 2013
Related CR Transmittal #: R2656CP
Implementation Date: February 19, 2013

Ambulatory Surgical Center

April 2013 ambulatory surgical center payment system update

Provider types affected

This *MLN Matters*® article is intended for ambulatory surgical centers (ASCs) submitting claims to Medicare contractors (carriers or Part B Medicare administrative contractors (Part B MACs)) for ASC payment system-paid services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8237 describes changes to and billing instructions for various payment policies implemented in the April 2013 ASC payment system update and it applies to the *Medicare Claims Processing Manual*, Chapter 14, Section 10. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 8237 describes changes to and billing instructions for various payment policies implemented in the April 2013 ASC payment system update. Key changes to and billing instructions for various payment policies implemented in the April 2013 ASC payment system update are as follows:

New Healthcare Common Procedure Coding System (HCPCS) procedure codes

The new HCPCS procedure code listed in Table 1 (also included as Attachment A of CR 8237) is assigned for payment under the ASC payment system, effective April 1, 2013.

Table 1 – New HCPCS procedure code

HCPCS	Effective date	Short descriptor	Long descriptor	ASC PI
C9735	04-01-13	Anoscopy, submucosal inj	Anoscopy; with directed submucosal injection(s), any substance	G2

Billing for drugs, biologicals, and radiopharmaceuticals

Drugs and biologicals with payments based on average sales price (ASP), effective April 1, 2013

Payments for separately payable drugs and biologicals based on ASPs are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, the Centers for Medicare & Medicaid Services (CMS) will incorporate changes to the payment rates in the April 2013 ASC DRUG FILE. The updated payment rates, effective April 1, 2013, will be included in the April 2013 update of the ASC Addendum BB, which will be posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html*.

Drugs and biologicals with OPPS pass-through status, effective April 1, 2013

Five drugs and biologicals have been granted ASC payment status effective April 1, 2013. These items, along with their descriptors and APC assignments, are identified in Table 2 (also included as Attachment A, CR 8237).

Table 2 – New HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals, effective April 1, 2013

HCPCS code	Long descriptor	ASC PI
C9130*	Injection, immune globulin (Bivigam), 500 mg	K2
C9297*	Injection, omacetaxine mepesuccinate, 0.01 mg	K2
C9298*	Injection, ocriplasmin, 0.125 mg	K2
J7315	Mitomycin, ophthalmic, 0.2 mg	K2
Q4127	Talymed, per square centimeter	K2

Note: The HCPCS codes identified with an "*" indicate that these are new codes, effective April 1, 2013.

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ASC *(continued)*

Additional information on HCPCS code C9298 (Injection, Ocriplasmin, 0.125 mg)

Jetrea (ocriplasmin) is packaged in a sterile, single-use vial containing 0.5 mg ocriplasmin in a 0.2 mL solution for intravitreal injection (2.5 mg/mL). As approved by the U.S. Food and Drug Administration (FDA), the recommended dose for Jetrea (NDC 24856-0001-00) is 0.125 mg. Use of the contents of an entire single-use vial to obtain one recommended dose for one eye of one patient per the FDA-approved label would result in reporting 4 units of C9298 on a claim.

In addition, as indicated in the *Code of Federal Regulations*, Title 42 (Public Health), Part 414 (Payment for Part B Medical and Other Health Services), Subpart K (Payment for Drugs and Biologicals Under Part K), CMS calculates an average sales price (ASP) payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label, and any additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit. In addition, no payment is made for amounts of product in excess of that reflected on the FDA-approved label. See 42 CFR 414.904 at *http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=95a35802cef2dd89565a03c3542c5b18&rgn=div5&view=text&node=42:3.0.1.1.1&idno=42*.

Additional information related to HCPCS code J7315 (Mitomycin, ophthalmic, 0.2 mg)

HCPCS Code J7315 should only be used for Mitosol and should not be used for compounded mitomycin or other forms of mitomycin.

Flucelvax (influenza virus vaccine)

Flucelvax (influenza virus vaccine) was approved by the FDA November 20, 2012. Although this vaccine recently received FDA approval, *CPT*® code *90661*, which was established by the *CPT*® editorial panel effective January 1, 2008, describes Flucelvax. Since January 1, 2008, *CPT*® code *90661* (Flu vacc cell cult prsv free) has been assigned to ASC payment indicator "Y5" (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) because the product associated with this code had not received FDA approval until recently. CMS is revising the ASC payment indicator for *CPT*® code *90661* from "Y5" to "L1" (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.), effective November 20, 2012. This change will be reflected in the April 2013 ASC PI file.

Updated payment rates for certain drug, bological, and radiopharmaceutical HCPCS codes, effective January 1, 2013, through March 31, 2013

The payment rates for two HCPCS codes: J9263 and Q4106 were incorrect in the January 2013 ASC drug file. The corrected payment rates are listed in Table 3 (also included as Attachment A of CR 8237), and they have been installed in the revised January 2013 ASC drug file, effective for services furnished January 1, 2013, through March 31, 2013. Suppliers who received an incorrect payment for dates of service between January 1, 2013, and March 31, 2013, may request contractor adjustment of the previously processed claims.

Table 3: Updated payment rates for certain drugs, biologicals, and radiopharmaceuticals HCPCS codes, effective January 1, 2013, through March 31, 2013

HCPCS code	Short descriptor	Corrected payment rate	ASC PI
J9263	Oxaliplatin	$3.95	K2
Q4106	Dermagraft	$42.55	K2

Additional information

The official instruction, CR 8237 issued to your carrier and Part B MAC, regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2662CP.pdf*.

If you have any questions, please contact your carrier or Part 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: MM8237
Related Change Request (CR) #: CR 8237
Related CR Release Date: March 1, 2013
Effective Date: April 1, 2013
Related CR Transmittal #: R2662CP
Implementation Date: April 1, 2013

Consolidated Billing

Home health consolidated billing codes updated

Provider types affected

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

What you need to know

This article is based on change request (CR) 8246 which provides the annual update to home health (HH) consolidated billing effective July 1, 2013. CR 8246 adds the following HCPCS codes to the HH consolidated billing therapy code list: G0456 (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters) and G0457 (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm).

Background

The Social Security Act (Section 1842(b)(6); see *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm*) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see *http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=e49c86165ce00a5c3e044053adf4c2d0&rgn=div5&view=text&node=42:2.0.1.2.9&idno=42*) and in the *Medicare Claims Processing Manual* (Chapter 10, Section 20; see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf*).

CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS).

Services appearing on this list (that are submitted on claims to Medicare contractors) will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA), with the exception of the following:

- Therapies performed by physicians
- Supplies incidental to physician services, and
- Supplies used in institutional settings.

Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods.

The following are not subject to HH consolidated billing:

- Therapies performed by physicians
- Supplies incidental to physician services
- Supplies used in institutional settings

The HH consolidated billing code lists are updated annually to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year.

These new codes were effective January 1, 2013, but were overlooked in the annual HH consolidated billing update published in CR 8043 (see the related article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8043.pdf*.

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Consolidated *(continued)*

The following HCPCS codes are added to the HH consolidated billing therapy code list effective for claims with dates of service on or after July 1, 2013:

- **G0456:** Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
- **G0457:** Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm

Additional information

The official instruction, CR 8246 issued to your DME MACs, FIs, RHHIs, and A/B MACs regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2672CP.pdf*.

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

MLN Matters® Number: MM8246
Related Change Request (CR) #: CR 8246
Related CR Release Date: March 15, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2672CP
Implementation Date: July 1, 2013

Drugs and Biologicals

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

Provider types affected

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

Provider action needed

Stop – impact to you

Medicare will use the July 2013 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 1, 2013, with dates of service July 1, 2013, through September 30, 2013.

Caution – what you need to know

Also, change request (CR) 8247, from which this article is taken, instructs your Medicare contractors to download and implement the July 2013 ASP Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised April 2013, January 2013, October 2012, and July 2012 files.

(continued on next page)

ASP *(continued)*

Go – what you need to do

Make sure that your billing staffs are aware of the release of these July 2013 ASP Medicare Part B drug files.

Background

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

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

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

Additional information

The official instruction, CR 8247 issued to your FI, carrier, A/B MAC, RHHI or DME/MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2676CP.pdf*.

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

MLN Matters® Number: MM8247
Related Change Request (CR) #: CR 8247
Related CR Release Date: March 15, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2676CP
Implementation Date: July 1, 2013

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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.

Durable Medical Equipment

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

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (A/B Medicare administrative contractors (MACs), carriers, and durable medical equipment MACs (DME MACs) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider action needed

This article is based on change request (CR) 8204 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

Key points of CR 8204

- The coverage indicators for Healthcare Common Procedure Coding System (HCPCS) codes L8680, L8682, L8683, L8684, L8685, L8686, L8687, and L8688 have changed from invalid for Medicare ("I") to special coverage instructions apply ("D"), effective January 1, 2013. This change to the coverage indicators for codes L8680 and L8682 through L8688 are noted in the 2013 HCPCS Correction file, posted at *http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html*.
- The CY 2013 fee schedule amounts for HCPCS codes L8680 and L8682 through L8688 are in the following table. The fee schedule amounts for these codes were updated for 2013 by applying the 2013 0.8 percent update factor to the 2012 fee schedule amounts.

Note: These codes are all categorized as "prosthetic/orthotic" and fall under the claim processing jurisdiction of local carriers rather than the DME MACs.

State	L8680	L8682	L8683	L8684	L8685	L8686	L8687	L8688
AL	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
AR	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
AZ	$440.40	$5,715.74	$5,031.17	$732.55	$12,537.39	$7,999.88	$16,316.14	$10,411.02
CA	$440.40	$5,715.74	$5,031.17	$732.55	$12,537.39	$7,999.88	$16,316.14	$10,411.02
CO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
CT	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
DC	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
DE	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
FL	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
GA	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
IA	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
ID	$435.71	$5,654.72	$4,977.44	$736.69	$12,403.49	$7,914.43	$16,141.88	$10,299.82
IL	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
IN	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93

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DME *(continued)*

State	L8680	L8682	L8683	L8684	L8685	L8686	L8687	L8688
KS	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
KY	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
LA	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
MA	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
MD	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
ME	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
MI	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
MN	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
MO	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
MS	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
MT	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
NC	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
ND	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
NE	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
NH	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
NJ	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
NM	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
NV	$440.40	$5,715.74	$5,031.17	$732.55	$12,537.39	$7,999.88	$16,316.14	$10,411.02
NY	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
OH	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
OK	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
OR	$435.71	$5,654.72	$4,977.44	$736.69	$12,403.49	$7,914.43	$16,141.88	$10,299.82
PA	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
RI	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
SC	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
SD	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
TN	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
TX	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
UT	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
VA	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
VT	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
WA	$435.71	$5,654.72	$4,977.44	$736.69	$12,403.49	$7,914.43	$16,141.88	$10,299.82
WI	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
WV	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
WY	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
AK	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HI	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PR	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
VI	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

- Take note that the 2013 fee schedule amounts for HCPCS codes L8680 and L8682 through L8688 will not appear on the 2013 DMEPOS fee schedule files. A separate public use file containing only the 2013 fee schedule amounts for codes L8680, and L8682 through L8688 is available for download on the CMS DMEPOS fee schedule website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html*.

Diabetic testing supplies

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DME *(continued)*

Diabetic testing supplies

- In accordance with Section 636(b) of the American Taxpayer Relief Act of 2012 (ATRA), effective for claims with dates of service on or after April 1, 2013, the 2009 fee schedule covered item update for non-mail order diabetic supplies is revised from 5 percent to -9.5 percent. Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as listed with the HCPCS codes below. As part of this update, the fee schedule amounts for these codes have been revised to reflect the change in the 2009 covered item update.
  - A4233 Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each
  - A4234 Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each
  - A4235 Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each
  - A4236 Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each
  - A4253 Blood glucose test or reagent strips for home glucose monitor, per 50 strips
  - A4256 Normal, low and high calibration solution/chips
  - A4258 Spring-powered device for lancet, each
  - A4259 Lancets, per box of 100

Also, effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the ATRA, the fee schedule amounts for non-mail order diabetic supplies will be further adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established in implementing the national mail order competitive bidding program under Section 1847 of the Social Security Act. The national competitive bidding program for mail order diabetic supplies is scheduled to take effect July 1, 2013. The definitions of mail order item and non-mail order item set forth in 42 CFR 414.402 is:

- Mail order item (KL HCPCS modifier) – any item shipped or delivered to the beneficiary's home, regardless of the method of delivery
- Non-mail order item (KL modifier not applicable) – any item that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront

A change request instruction and data file will be released for the July quarterly update to the 2013 DMEPOS fee schedule file to incorporate the new national payment amounts, and these amounts will be updated each time the amounts established in accordance with Section 1847 of the Act are updated. The single payment amount public use file for the national mail order competitive bidding program will be available at *www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*.

Additional information

The official instruction, CR 8204 issued to your carrier, DME/MAC, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2661CP.pdf*. Current and past DMEPOS fee schedules can be viewed at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html*.

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

MLN Matters® Number: MM8204
Related Change Request (CR) #: CR 8204
Related CR Release Date: February 22, 2013
Effective Date: January 1, 2013, for fee schedule amounts for codes in effect on January 1, 2013; April 1, 2013, for all other changes
Related CR Transmittal #: R2661CP
Implementation Date: April 1, 2013

Laboratory/Pathology

New waived tests

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 8212 which informs Medicare contractors of the nine newly added waived tests under the Clinical Laboratory Improvement Amendments of 1998 (CLIA).

Caution – what you need to know

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *Current Procedural Terminology* (*CPT*®) codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 8212, from which this article is taken, informs carriers and MACs about the latest new *CPT*® codes that are subject to CLIA edits.

Go – what you need to do

Make sure that your billing staffs are aware of these CLIA-related changes for 2012 and 2013 and that you remain current with certification requirements. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The *CPT*® codes for the following new tests must have the modifier QW to be recognized as a waived test.

Waived tests (QW modifier required)

CPT® code	Effective date	Description
82055QW	April 30, 2012	Germaine Laboratories AimStrip Alcohol Saliva
G0434QW	November 29, 2012	Chemtron Biotech, Inc. Chemtrue Single/Multi-Panel Drug Screen Cassette Tests
G0434QW	November 29, 2012	Chemtron Biotech, Inc. Chemtrue Single/Multi-Panel Drug Screen Dip Card Tests
G0434QW	January 4, 2013	American Screening Corporation, Inc., Multi-Drug Testing Cards
G0434QW	January 4, 2013	American Screening Corporation, Inc., Multi-Drug Testing Cups
G0434QW	January 10, 2013	UCP Biosciences, Inc. UCP Compact Drug Test Cards
G0434QW	January 10, 2013	UCP Biosciences, Inc. UCP Compact Drug Test Cups
85610QW	January 16, 2013	Coag-Sense Prothrombin Time (PT/INR) Monitoring System (Professional use)
81003QW	January 23, 2013	CLIA waived Inc. Automated Urinalysis Test System

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Waived *(continued)*

Note that the tests mentioned on the first page of the list attached to CR 8212 (*CPT*® codes: *81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.

Note: Medicare contractors will not search files to either retract payment or retroactively pay claims based on the changes in CR 8212; however, claims should be adjusted if you bring them to your contractor's attention.

Additional information

The official instruction, CR 8212, 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/R2671CP.pdf*.

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

MLN Matters® Number: MM8212
Related Change Request (CR) #: CR 8212
Related CR Release Date: March 15, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2671CP
Implementation Date: July 1, 2013

Clinical laboratory fee schedule – Medicare travel allowance fees for collection of specimens

Provider types affected

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

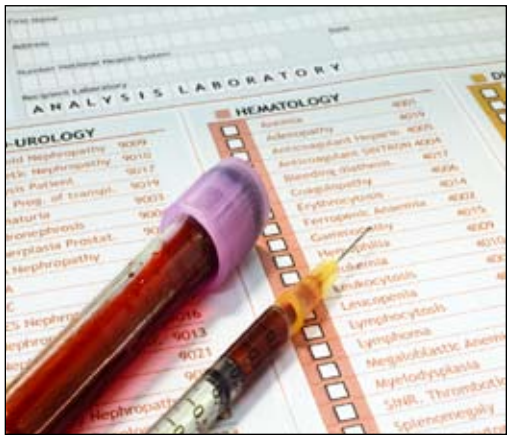
Provider action needed

Stop – impact to you

This article is based on change request (CR) 8203 which informs Medicare contractors and providers about changes to the clinical lab fee schedule related to travel allowances and specimen collection fees.

Caution – what you need to know

CR 8203 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat rate basis using HCPCS code P9604 for CY 2013.



Go – what you need to do

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

Background

Travel codes allow for payment either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. Medicare contractor discretion allows Medicare contractors to choose either a mileage basis or a flat rate, and how to set each type of allowance. Because of audit evidence that some laboratories abused the per mileage fee basis by claiming travel mileage in excess of the minimum distance necessary for a laboratory technician to travel for specimen collection, many Medicare contractors established local policy to pay on a flat rate basis only.

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CLFS *(continued)*

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the contractor.

Medicare Part B, allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Act. Payment for these services is made based on the clinical laboratory fee schedule.

New mileage rates

The new rate for HCPCS code P9603, where the average trip to patients' homes exceeds 20 miles round trip, is $0.565 per mile, plus an additional $0.45 per mile to cover the technician's time and travel costs, for a total of $1.015 per mile. The actual total of $1.015 is then rounded up to $1.02 due to processing systems capabilities. Higher rates may be established if local conditions warrant it.

The new rate for HCPCS code P9604 is paid on a flat-rate trip basis travel allowance of $10.15.

Note: Claims for these services will not be automatically adjusted. Providers must bring any previously paid claims to their contractors' attention.

Additional information

The official instruction, CR 8203, 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/R2675CP.pdf*.

More information may be found in Chapter 16, Section 60.2 of the *Medicare Claims Processing Manual* at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf*.

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

MLN Matters® Number: MM8203
Related Change Request (CR) #: CR 8203
Related CR Release Date: March 15, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2675CP
Implementation Date: June 17, 2013

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our new "time limit" calculators on our Appeals of claim decisions page. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Medicare Physician Fee Schedule Database

Mandatory payment reductions in the Medicare fee-for-service (FFS) program – Sequestration

The Budget Control Act of 2011 requires, among other things, mandatory across-the-board reductions in federal spending, also known as sequestration. The American Taxpayer Relief Act of 2012 postponed sequestration for two months. As required by law, President Obama issued a sequestration order March 1, 2013. The administration continues to urge Congress to take prompt action to address the current budget uncertainty and the economic hardships imposed by sequestration.

This listserv message is directed at the Medicare fee-for-service (FFS) program (i.e., Part A and Part B). In general, Medicare FFS claims with dates of service or dates of discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME competitive bidding program, will be reduced by 2 percent based upon whether the date of service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

The claims payment adjustment shall be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare secondary payment adjustments.

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The Centers for Medicare & Medicaid Services (CMS) encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare's reimbursement.

Questions about reimbursement should be directed to your Medicare claims administration contractor. As indicated above, CMS is hopeful that Congress will take action to eliminate the mandatory payment reductions.

Source: CMS PERL 201303-02

Federal sequestration payment reductions FAQs

Question: Does the 2 percent payment reduction under sequestration apply to the payment rates reflected in Medicare fee-for-service fee schedules or does it only apply to the final payment amounts?

Answer: Payment adjustments required under sequestration are applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible, and any applicable Medicare secondary payment adjustments. All fee schedules, Pricers, etc., are unchanged by sequestration; it's only the final payment amount that is reduced.

Question: How is the 2 percent payment reduction under sequestration identified on the electronic remittance advice (ERA) and the standard paper remittance (SPR)?

Answer: Claim adjustment reason code (CARC) 223 is used to report the sequestration reduction on the ERA and SPR.

Question: What is the verbiage for CARC 223?

Answer: "Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created."

Question: Will the 2 percent reduction be reported on the remittance advice in a separate field?

Answer: For institutional Part A claims, the adjustment is reported on the remittance advice at the claim level. For Part B physician/practitioner, supplier, and institutional provider outpatient claims, the adjustment is reported at the line level.

Question: How will the payments be calculated on the claims?

Answer: The reduction is taken from the calculated payment amount, after the approved amount is determined and the deductible and coinsurance are applied.

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Questions *(continued)*

Example: A provider bills a service with an approved amount of $100.00, and $50.00 is applied to the deductible. A balance of $50.00 remains. We normally would pay 80 percent of the approved amount after the deductible is met, which is $40.00 ($50.00 x 80 percent = $40.00).

The patient is responsible for the remaining 20 percent coinsurance amount of $10.00 ($50.00 - $40.00 = $10.00). However, due to the sequestration reduction, 2 percent of the $40.00 calculated payment amount is not paid, resulting in a payment of $39.20 instead of $40.00 ($40.00 x 2 percent = $0.80).

Question: How are unassigned claims affected by the 2 percent reduction under sequestration?

Answer: Though beneficiary payments toward deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The non-participating physician who bills on an unassigned basis collects his/her full payment from the beneficiary, and Medicare reimburses the beneficiary the Medicare portion (e.g., 80 percent of the reduced fee schedule amount.

Note: The "reduced fee schedule" refers to the fact that Medicare's approved amount for claims from non-participating physicians/practitioners is 95 percent of the full fee schedule amount). This reimbursed amount to the beneficiary would be subject to the 2 percent sequester reduction just like payments to physicians on assigned claims. Both are claims payments, but to different parties. If the limiting charge applies to the service rendered, providers cannot collect more than the limiting charge amount from the beneficiary.

Example: A non-participating provider bills an unassigned claim for a service with a limiting charge of $109.25. The beneficiary remains responsible to the provider for this full amount. However, sequestration affects how much Medicare reimburses the beneficiary. The non-participating fee schedule approved amount is $95.00, and $50.00 is applied to the deductible. A balance of $45.00 remains. Medicare normally would reimburse the beneficiary for 80 percent of the approved amount after the deductible is met, which is $36.00 ($45.00 x 80 percent = $36.00). However, due to the sequestration reduction, 2 percent of the $36.00 calculated payment amount is not paid to the beneficiary, resulting in a payment of $35.28 instead of $36.00 ($36.00 x 2 percent = $0.72).

We encourage physicians, practitioners, and suppliers who bill unassigned claims to discuss with their Medicare patients the impact of the sequestration reductions to Medicare payments.

Question: Is this reduction based on the date of service or date of receipt?

Answer: In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME competitive bidding program, will be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

Payment reductions specified by sequestration – clarification

A sequestration order was issued March 1, 2013, that provides for a 2 percent reduction in Medicare fee-for-service (FFS) payments for dates of service or dates of discharge on or after April 1, 2013. The Medicare Part B physician fee schedule (MPFS) allowances posted to the First Coast Service Options (First Coast) Medicare provider websites do not reflect the payment adjustment required under sequestration.

Payment adjustments required under sequestration shall be applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible, and any applicable Medicare secondary payment adjustments.

April update to the 2013 Medicare physician fee schedule database

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FI), A/B Medicare administrative contractors (A/B MAC), and/or regional home health intermediaries (RHHI)) for services that are paid under the Medicare physician fee schedule (MPFS).

What you need to know

This article is based on change request (CR) 8169 and instructs Medicare contractors to download and implement a new Medicare physician fee schedule database (MPFSDB), effective January 1, 2013.

Background

Section 1848 (c) (4) of the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the U.S. Secretary of Health and Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians' services.

CR 8169, from which this article is taken announces that the MPFSDB has been updated effective January 1, 2013; and new payment files have been created in order to reflect appropriate payment policy in line with the CY 2013 MPFS final rule, published in the *Federal Register* November 16, 2012, as modified by the final rule correction notice, published in the *Federal Register* January 2, 2013, and relevant statutory changes applicable January 1, 2013.

The summary of changes in the April 2013 update consists of the following (all other indicators remain the same):

- *0309T* global indicator is being corrected to "ZZZ" (add-on). This change is effective January 1, 2013.
- *36222-36228* bilateral indicators are being corrected to "1" = 150 percent payment adjustment applies if billed with modifier 50. This change is effective January 1, 2013.
- *90785* global indicator is being corrected to "ZZZ" (add-on). This change is effective January 1, 2013.
- The codes in the following table are having their short descriptors corrected or adjusted as shown below. These changes are effective January 1, 2013.

HCPCS code	Old short description	Revised short description
19301	Partical mastectomy	Partial mastectomy
31648	Bronchial valve addl insert	Bronchial valve remov init
31649	Bronchial valve remov init	Bronchial valve remov addl
31651	Bronchial valve remov addl	Bronchial valve addl insert
87631	Resp virus 3-11 targets	Resp virus 3-5 targets
95907	Motor&/sens 1-2 nrv cndj tst	Nvr cndj tst 1-2 studies
95908	Motor&/sens 3-4 nrv cndj tst	Nrv cndj tst 3-4 studies
95909	Motor&/sens 5-6 nrv cndj tst	Nrv cndj tst 5-6 studies
95910	Motor&sens 7-8 nrv cndj test	Nrv cndj test 7-8 studies
95911	Motor&sen 9-10 nrv cndj test	Nrv cndj test 9-10 studies
95912	Motor&sen 11-12 nrv cnd test	Nrv cndj test 11-12 studies
95913	Motor&sens 13/> nrv cnd test	Nrv cndj test 13/> studies
95907-26	Motor&/sens 1-2 nrv cndj tst	Nvr cndj tst 1-2 studies
95908-26	Motor&/sens 3-4 nrv cndj tst	Nrv cndj tst 3-4 studies
95909-26	Motor&/sens 5-6 nrv cndj tst	Nrv cndj tst 5-6 studies
95910-26	Motor&sens 7-8 nrv cndj test	Nrv cndj test 7-8 studies
95911-26	Motor&sen 9-10 nrv cndj test	Nrv cndj test 9-10 studies
95912-26	Motor&sen 11-12 nrv cnd test	Nrv cndj test 11-12 studies

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MPFSDB *(continued)*

HCPCS code	Old short description	Revised short description
95913-26	Motor&sens 13/> nrv cnd test	Nrv cndj test 13/> studies
95907-TC	Motor&/sens 1-2 nrv cndj tst	Nvr cndj tst 1-2 studies
95908-TC	Motor&/sens 3-4 nrv cndj tst	Nrv cndj tst 3-4 studies
95909-TC	Motor&/sens 5-6 nrv cndj tst	Nrv cndj tst 5-6 studies
95910-TC	Motor&sens 7-8 nrv cndj test	Nrv cndj test 7-8 studies
95911-TC	Motor&sen 9-10 nrv cndj test	Nrv cndj test 9-10 studies
95912-TC	Motor&sen 11-12 nrv cnd test	Nrv cndj test 11-12 studies
95913-TC	Motor&sens 13/> nrv cnd test	Nrv cndj test 13/> studies
0195T	Arthrod presac interbody	Prescrl fuse w/o instr L5/S1
0196T	Arthrod presac interbody eac	Prescrl fuse w/o instr L4/L5
0206T	Pptr dbs alys car elec dta	Cptr dbs alys car elec dta
90700	Dtap vaccine > 7 yrs im	Dtap vaccine < 7 yrs im
90702	Dt vaccine > 7 yrs im	Dt vaccine < 7 yrs im

- G9157 will become an active code with a Procstat of “A” and a PC/TC indicator of “2” = professional component only. Payment amounts are being included. All other indicators remain the same. This change is effective January 1, 2013.
- *33961* global indicator is being corrected to “XXX”. This change is effective January 1, 2013.
- The TC components of the following nerve conduction tests: *95907, 95908, 95909, 95910*, *95911, 95912*, and *95913*, are having the physician supervision of diagnostic procedures indicators adjusted to “7A” = “Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.” (“77” = “Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under general supervision of a physician (TC only; PC always physician)”). These changes are effective January 1, 2013.
- *81161* is being added to the fee schedule with a Procstat of “X” = statutory exclusion. This change is effective January 1, 2013.
- Q0507, Q0508, Q0509 are being added to the fee schedule with Procstat indicators of “E” = excluded from physician fee schedule by regulation. These codes are effective April 1, 2013.
- The Procstat indicator of 3750F, 4142F, 6150F, 3517F is changing to “M” effective April 1, 2013.
- The Procstat indicator of G8559, G8560, G8561, G8562, G8563, G8564, G8565, G8566, G8567, G8568, Q0505 is changing to “I” effective April 1, 2013.
- For *23000, 32997, 32998*, the bilateral indicators are being corrected to “1” = 150 percent payment adjustment applies if billed with modifier 50. These changes are effective April 1, 2013.

Additional information

The official instruction, CR 8169, issued to your carrier, FI, A/B MAC, or RHHI regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2663CP.pdf*.

If you have any questions, please contact your carrier, FI, A/B MAC, or RHHI 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: MM8169
Related Change Request (CR) #: CR 8169
Related CR Release Date: March 1, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2663CP
Implementation Date: April 1, 2013

Preventive Services

Recovery of annual wellness visit overpayments

Provider types affected

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

What you need to know

This article is based on change request (CR) 8153, which provides instructions to Medicare contractors for recovering annual wellness visit (AWV) overpayments that have been made.

- For claims with dates of service on and after January 1, 2011, that were processed by Medicare processed on and after April 4, 2011, through March 31, 2013, Medicare systems allowed for an AWV visit (Healthcare Common Procedure Coding System (HCPCS) G0438 or G0439) on an institutional claim and a professional claim for the same patient on the same day. In some cases, this has resulted in overpayments.
- CR 8107 has updated those business requirements in order to prevent future overpayments.
- CR 8153 instructs contractors on recovering those overpayments.

Make sure that your billing staffs are aware of these changes.

Background

CR 7079 provided billing instructions for AWV services, which informed providers that they may provide an initial AWV visit (HCPCS code G0438) to a beneficiary once in a lifetime. In addition, providers may provide a subsequent AWV (HCPCS code G0439) if the beneficiary has not received an initial preventive physical examination (IPPE) or an AWV within the past 12 months.

For claims with dates of service on and after January 1, 2011, and processed on and after April 4, 2011, through March 31, 2013, the business requirements of CR 7079 allowed an AWV visit (HCPCS G0438 and G0439) on an institutional claim and a professional claim for the same patient on the same day. In some cases, this resulted in double billing of the same service, since institutional and professional claims may be submitted for the same service. In other instances, both a professional and an institutional claim have been received for the same patient with different dates of service exceeding the allowed services under coverage guidelines. As a response to double billing of AWV services, the Centers for Medicare & Medicaid Services (CMS) issued CR 8107 to provide instructions for edits to be modified to only allow payment for either the practitioner or the facility for furnishing the AWV. CR 8107 will be implemented April 1, 2013. In the interim period from April 4, 2011, through March 31, 2013, double billings have occurred and may continue to occur. CR 8153 provides instructions to contractors to initiate a recovery process for these overpayments of AWV services.

Section 4103(c)(3)(A) of the Affordable Care Act specifically excludes the AWV from payment under the outpatient prospective payment system (OPPS) and establishes payment for the AWV when performed in a hospital outpatient department under the Medicare physician fee schedule (MPFS). CMS will accept claims for payment from facilities furnishing the AWV in a facility setting if no physician claim for professional services has been submitted to CMS for payment. That is, Medicare will pay either the practitioner or the facility for furnishing the AWV providing personalized prevention plan services (PPPS) in a facility setting, and only a single payment under the MPFS will be allowed. Where an AWV payment for a beneficiary has been made, this is an overpayment that must be recovered. Where these overpayments are recovered from providers, the beneficiaries will be notified that they are not responsible for reimbursing the providers for the recovered amount.

Additional information

The official instruction, CR 8153, 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/R1190OTN.pdf*.

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

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AWV *(continued)*

To review the *MLN Matters*® article, MM8107, that describes the modified billing instructions for an AMW visit, go to *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8107.pdf*.

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

MLN Matters® Number: MM8153
Related Change Request (CR) #: CR 8153
Related CR Release Date: February 15, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1190OTN
Implementation Date: July 1, 2013

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Reminder: Coverage of a one-time ultrasound screening for abdominal aortic aneurysms

Note: This article was updated March 8, 2013, to update statements regarding the coinsurance and deductible payments for AAA and the IPPE. There is no coinsurance or Part B deductible for AAA screening or the IPPE. For updated information regarding payment for preventive care services under the Affordable Care Act, please go to *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7012.pdf*. All other information remains unchanged. This information was previously published in the April 2007 *Medicare B Update!*, Pages 34-35.

Provider types affected

All Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for the initial preventive physical examination (IPPE) and the ultrasound screening for abdominal aortic aneurysms (AAA).

Provider action needed

This article conveys no new policy information. This article is for informational purposes only and serves as a reminder that Medicare provides coverage of a one-time initial preventive physical examination and a one-time preventive ultrasound screening for abdominal aortic aneurysms subject to certain coverage, frequency, and payment limitations. The Centers for Medicare & Medicaid Services (CMS) needs your help to get the word out and to encourage eligible beneficiaries to take full advantage of these benefits and all preventive services and screenings covered by Medicare.

Background

In January 2005, the Medicare program expanded the number of preventive services available to Medicare beneficiaries, as a result of Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, to include coverage under Medicare Part B of a one-time IPPE, also referred to as the “Welcome to Medicare” physical exam, for all Medicare beneficiaries whose Medicare Part B effective date began on or after January 1, 2005.

On January 1, 2007, Medicare further expanded the number of preventive benefits, as provided for in Section 5112 of the Deficit Reduction Act (DRA) of 2005, to include coverage under Medicare Part B of a one-time preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at risk beneficiaries as part of the IPPE. Both benefits (the IPPE and AAA) are subject to certain eligibility and other limitations.

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AAA *(continued)*

The information in this special edition *MLN Matters*® article reminds health care professionals that Medicare now pays for these benefits as well as a broad range of other preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their "Welcome to Medicare" physical exam within the first six months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the preventive ultrasound screening as part of their "Welcome to Medicare" physical exam.

The initial preventive physical examination ("Welcome to Medicare" physical exam)

Effective for dates of service on or after January 1, 2005: Medicare beneficiaries whose Medicare Part B effective date is on or after January 1, 2005, are covered for a one-time IPPE visit. The IPPE must be received by the beneficiary within the first six months of their Medicare Part B effective date. The IPPE is a preventive evaluation and management (E/M) service that includes the following seven components:

1. A review of an individual's medical and social history with attention to modifiable risk factors.
2. A review of an individual's individual's potential (risk factors) for depression.
3. A review of the individual's functional ability and level of safety.
4. An examination to include an individual's height, weight, blood pressure measurement, and visual acuity screen.
5. Performance of an electrocardiogram (EKG) and interpretation of the EKG.
6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements.
7. Education, counseling, and referral (including a brief written plan such as a checklist provided to the individual for obtaining the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits).

The Part B deductible and coinsurance/copayment no longer apply to the IPPE benefit.

Note: The deductible does not apply for an IPPE provided in a federally qualified health center (FQHC). Only the coinsurance/copayment applies.

Important reminders about the IPPE:

1) The IPPE is a unique benefit available only for beneficiaries new to the Medicare Program and must be received within the first six months of the effective date of their Medicare Part B coverage.
2) This exam is a preventive physical exam and not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare does not provide coverage for routine physical exams.

Other preventive services and screenings covered under Medicare Part B include: Adult immunizations (flu, pneumococcal, and hepatitis B), bone mass measurements, cardiovascular screening, diabetes screening, glaucoma screening, screening mammograms, screening Pap test and pelvic exam, colorectal and prostate cancer screenings, diabetes self-management training, medical nutrition therapy for beneficiaries diagnosed with diabetes or renal disease, and smoking and tobacco-use cessation counseling. Benefits are subject to certain eligibility and other limitations.

Note: The IPPE/"Welcome to Medicare" physical exam does not include any clinical laboratory tests. The physician, qualified non-physician practitioner, or hospital may also provide and bill separately for the preventive services and screenings that are currently covered and paid for by Medicare Part B. (See the *Additional information* section for links to *MLN Matters*® articles MM3771 and MM3638, which provide detailed coverage criteria and billing information about the IPPE benefit.)

Preventive ultrasound screening for abdominal aortic aneurysms (AAA)

Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time preventive ultrasound screening for AAA for beneficiaries who are at risk (has a family history of AAA or is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime). Eligible beneficiaries must receive a referral for the screening as a result of their "Welcome to Medicare" physical exam. There is no Part B deductible or coinsurance/copayment applied to this benefit.

Important note: Only Medicare beneficiaries who receive a referral from their physician or other qualified non-physician practitioner for the preventive ultrasound screening, as part of their "Welcome to Medicare" physical exam, will be covered for the AAA benefit. (See the *Additional information* section for a link to *MLN Matters*® article

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AAA *(continued)*

MM5235, which provides detailed coverage criteria and billing information about the AAA benefit.)

Additional information

For more information about Medicare's coverage criteria and billing procedures for the AAA and IPPE benefits, refer to the following *MLN Matters*® articles:

- MM5235 (2006), Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination, *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5235.pdf*.
- MM3771 (2005), MMA – Clarification for Outpatient Prospective Payment system (OPPS) Hospitals Billing the Initial Preventive Physical Exam (IPPE), *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3771.pdf*.
- MM3638 (2004), MMA – Initial Preventive Physical Examination, *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3638.pdf*.

CMS has also developed a variety of educational products and resources to help health care professionals and their staff, become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- The MLN® Preventive Services Educational Products Web Page – provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html*.
- The CMS website provides information for preventive service covered by Medicare is at *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*.

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

MLN Matters® Number: SE0711
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Therapy Services

Outpatient therapy functional reporting non-compliance alerts

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who submit claims to Medicare contractors (carriers or Part B Medicare administrative contractors (B MACs)) for outpatient therapy services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 8166, from which this article is taken implements alert messaging that conveys supplemental information regarding your claims for outpatient therapy from April 1, 2013, through June 30, 2013.

For therapy claims, with dates of service on and after January 1, 2013, processed on and after April 1, 2013, through June 30, 2013, you will receive a remittance advice (RA) message to alert you to include the applicable new functional limitation G-codes (from the list of 42) and the appropriate severity/complexity modifier (from the list of 7) on future specified therapy claims.

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Functional *(continued)*

Your carrier or B MAC will continue to process and adjudicate your therapy claims without the required G-codes and severity/complexity modifier.

Please note that no changes are being made to the policy on the claims-based data collection for outpatient therapy.

Background

Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA) (see *http://www.gpo.gov/fdys/pkg/CRPT-112hrpt399/pdf/CRPT-112hrpt399.pdf*) states that "The Secretary of Health and Human Services shall implement, beginning 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."

In response, CMS issued regulations November 1, 2012, creating such a system The Centers for Medicare & Medicaid Services (CMS implemented a new claims-based data submission requirement for outpatient therapy services, effective January 1, 2013. It requires reporting with 42 new non-payable functional Healthcare Common Procedure Coding System (HCPCS) G-codes and seven new severity/complexity modifiers on claims for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. (You can find the associated *MLN Matters*® article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf*.

Dates to remember

A testing period is in effect from January 1, 2013, through June 30, 2013, during which claims without the required G-codes and severity/complexity modifier will be processed to allow providers to use the new coding requirements to assure that your systems work. During the testing period, your carrier or B MAC will continue to process and adjudicate your therapy claims without the required G-codes and severity/complexity modifier.

For therapy claims, with dates of service on and after January 1, 2013, processed on and after April 1, 2013, through June 30, 2013, contractors will send alerts reminding you to include the new functional limitation G-codes (from the list of 42) and the appropriate severity/complexity modifier (from the list of seven) on future specified therapy claims through a new RA message. The scenarios below illustrate what will be effective April 1, 2013.

Effective April 1, 2013, to June 30, 2013

1. Effective for therapy claims with dates of service on or after January 1, 2013, and processed on and after April 1, 2013, through June 30, 2013, contractors will alert providers, who submit claims containing functional G-codes (G8978-G8999, G9158-G9176, and G9186) without a severity/complexity modifier (CH-CN), that functional G-codes require a severity/complexity modifier, and effective July 1, 2013, claims that do not include required functional reporting information will be returned or rejected.

The following claim adjustment reason code (CARC) and RA remark code (RARC) will be used as the alert message:

- **CARC 246** – "This non-payable code is for required reporting only" and
- **RARC N565** – "Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed." when nonpayable HCPCS codes G8978 to G8999, G9158 to G9176, or G9186 are submitted without the appropriate modifier (CH-CN).

2. Effective for therapy claims with dates of service on or after January 1, 2013, and processed on and after April 1, 2013, through June 30, 2013, contractors will alert providers, who submit claims containing any of the following *CPT*® evaluation/re-evaluation therapy codes *92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004* without functional information, that these codes

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Functional *(continued)*

require functional G-code(s) and appropriate severity/complexity modifier (s), and effective July 1, 2013, claims that do not include required functional reporting information will be returned or rejected. The following CARC and RARC will be used as the alert message:

- **CARC 246** – "This non-payable code is for required reporting only." and
- **RARC N566** – "Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed."" when *CPT*® codes *92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003*, or *97004* are submitted without the nonpayable HCPCS codes G8978 to G8999, G9158 to G9176, or G9186 and the appropriate modifier (CH-CN).

Beginning July 1, 2013

- Beginning July 1, 2013, your claims will be returned or rejected using a new RA message when you do not comply with these reporting requirements.

Note: CR 8166 is not applicable to institutional claims. There will be no alert messaging for institutional claims between April 1, 2013, and July 1, 2013.

Additional information

You can find more information about outpatient therapy functional reporting non-compliance alerts by going to CR 8166, located at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1196OTN.pdf*.

You may want to refer to CR 8005, Publication 100-04, transmittal 2622, dated December 21, 2012, for detailed instructions on the implementation of the 42 nonpayable G-codes and 7 severity/complexity modifiers. You can find this at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2622CP.pdf*. The related *MLN Matters*® article may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf*.

For more information, please see the 2013 physician fee schedule final rule in the *Federal Register*, dated November 16, 2013, at *http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf*.

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

MLN Matters® Number: MM8166
Related Change Request (CR) #: CR 8166
Related CR Release Date: March 8, 2013
Effective Date: April 1, 2013
Related CR Transmittal #: R1196OTN
Implementation Date: April 1, 2013

Multiple procedure payment reduction for selected therapy services

Provider types affected

This *MLN Matters*® article is intended for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and Part A/B Medicare administrative contractors (A/B MACs) for therapy services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS) or paid at the physician fee schedule rate.

Provider action needed

This article is based on change request (CR) 8206, which informs Medicare contractors that Section 633 of the American Taxpayer Relief Act of 2012 increased the multiple procedure payment reduction (MPPR) on selected therapy services to 50 percent for both office and institutional settings. This is effective for claims with dates of service on or after April 1, 2013. Make sure that your billing staffs are aware of this update.

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MPPR *(continued)*

Background

Effective January 1, 2011, Medicare applied an MPPR to the practice expense (PE) payment of select therapy services paid under the physician fee schedule or paid at the physician fee schedule rate.

Currently, the reduction is 20 percent for therapy services furnished in office and other non-institutional settings, and 25 percent for therapy services furnished in institutional settings. Effective for claims with dates of service April 1, 2013, and after, Section 633 of the American Taxpayer Relief Act of 2012 revised the reduction to 50 percent for all settings.

Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. Effective for claims with dates of service on or after April 1, 2013, full payment is made for work and malpractice and 50 percent payment is made for the PE for subsequent units and procedures, furnished to the same patient on the same day.

For therapy services furnished by a group practice or "incident to" a physician's service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, e.g., physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP).

The reduction applies to the Healthcare Common Procedure Coding System (HCPCS) codes contained on the list of "always therapy" services that are paid under the physician fee schedule, regardless of the type of provider or supplier that furnishes the services (e.g., hospitals, home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs), etc.) For professional claims, the MPPR applies to the procedures with a multiple procedure (Field 21) value of "5" on the Medicare fee schedule database (MFSDB). For institutional claims, the MPPR apples to procedures with a multiple services indicator (field labeled MULTSURG) value of "5" on the therapy abstract file. Note that these services are paid with a non-facility PE. The current and revised payments are shown in the example in the following table:

Sample payment calculation						
RVU	**Procedure 1 unit 1**	**Procedure 1 unit 2**	**Procedure 2**	**Total current payment**	**Revised total payment**	**Revised payment calculation**
Work	$7.00	$7.00	$11.00	$25.00	$25.00	no reduction
PE	$10.00	$10.00	$8.00	$23.50	$19.00	$10 + (.50 x $10) + (.50 x $8)
MP	$1.00	$1.00	$1.00	$3.00	$3.00	no reduction
Total	$18.00	$18.00	$20.00	$51.50	$47.00	$18 + ($18-$10) + (.50 x $10) +($20-$8) + (.50 x $8)

Note: The total current payment reflects the 25 percent reduction for institutional services.

Additional information

The official instruction, CR 8206, issued to your carrier, FI, RHHI, or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1194OTN.pdf*.

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

MLN Matters® Number: MM8206
Related Change Request (CR) #: CR 8206
Related CR Release Date: February 22, 2013
Effective Date: April 1, 2013
Related CR Transmittal #: R1194OTN
Implementation Date: April 1, 2013

Current status of the $3,700 therapy threshold manual medical review process

For dates of service rendered October 1, 2012, through December 31, 2012

The Centers for Medicare & Medicaid Services (CMS) instructed Medicare administrative contractors (MACs) to discontinue the preapproval process for therapy services with dates of services October 1, 2012, through December 31, 2012, as of December 17, 2012.

All preapproval requests received through December 18, 2012, have been completed by First Coast and decisions mailed to providers and beneficiaries.

All therapy claims submitted without preapproval for beneficiaries who have exceeded the $3,700 therapy threshold will be subject to prepayment medical review. Claims should be submitted in the usual manner. You must respond to all additional documentation requests.

For dates of service January 1, 2013, through December 31, 2013

Until further notice from CMS, all claims for therapy services that exceed the $3,700 therapy threshold will be subject to prepayment medical review.

Once the beneficiary's claim is flagged for exceeding the $3,700 therapy threshold, an additional documentation request will be sent asking for records to support medical necessity. You must respond to all additional documentation requests.

Although CMS is encouraging contractors to complete the medical review of records within 10 business days, it is important to remember that the 10 business days do not include claims processing or finalization timeframes.

Note: Providers are encouraged to utilize PWK for faxing documentation when appropriate. You may obtain additional information regarding PWK at *http://medicare.fcso.com/EDI_news/203963.asp*.

Wound Care

Autologous platelet-rich plasma for chronic non-healing wounds

Note: This article was revised March 13, 2013, to add the full description of Healthcare Common Procedure Coding System (HCPCS) code G0460 under "Coding and payment details." All other information remains unchanged. **Note**: This article is both new and revised as the revision took place on the same day as it was released.

Provider types affected

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

Provider action needed

Stop – impact to you

If you provide Medicare beneficiaries platelet-rich plasma (PRP) for the treatment of chronic non-healing wounds, this national coverage determination (NCD) could impact your reimbursement.

Caution – what you need to know

Effective for claims with dates of service on or after August 2, 2012, CMS will cover PRP for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only when provided under a clinical research study that meets specific requirements to assess the health outcomes of PRP for the treatment of chronic non-healing diabetic, venous and/or pressure wounds.

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Wound *(continued)*

Go – what you need to do

Please refer to the *Background* section, below for details.

Background

PRP is produced by centrifuging a patient's own blood to yield a concentrate that is high in both platelets and plasma proteins; and includes whole white and red cells, fibrinogen, stem cells, macrophages, and fibroblasts. Frequently administered as a spray, or a gel; physicians have used it in clinical or surgical settings, for a variety of purposes such as an adhesive in plastic surgery and filler for acute wounds. In addition, it is being used, now, on chronic, non-healing cutaneous wounds that persist for 30 days or longer.

Since 1992, the Centers for Medicare & Medicaid Services (CMS) has issued national non-coverage determinations for platelet-derived wound healing formulas intended to treat patients with chronic, non-healing wounds. In December 2003, CMS issued a national non-coverage determination specifically for the use of autologous PRP in treating chronic non-healing cutaneous wounds except for routine costs when used in accordance with the clinical trial policy defined in Section 310.1 (Routine Costs in Clinical Trials (Effective July 9, 2007)) of the *National Coverage Determinations (NCD) Manual*. Currently, as of March 2008, CMS has non-coverage determinations for the use of autologous blood-derived products for the treatment of acute wounds where PRP is applied directly to the closed incision site, and for dehiscent wounds, as well as non-coverage for chronic, non-healing cutaneous wounds.

On October 4, 2011, CMS accepted a formal request to reopen and revise Section 270.3 of the *Medicare NCD Manual*, which addresses autologous blood-derived products for chronic non-healing wounds. The request was for a reconsideration of the coverage of autologous PRP for the treatment of the following chronic wounds: diabetic, venous, and/or pressure ulcers. It was requested that CMS cover PRP through an NCD with data collection as a condition of coverage; and requested that this would provide a practical means by which CMS could obtain the necessary data to evaluate the performance of PRP and to confirm the outcomes presented in their request.

Effective August 2, 2012, upon reconsideration, CMS determined that PRP is covered for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only when the following conditions are met:

1. The patient is enrolled in a randomized clinical trial that addresses the questions listed below using validated and reliable methods of evaluation. Clinical study applications for coverage pursuant to this national coverage determination (NCD) must be approved by August 2, 2014. Any clinical study approved by August 2, 2014, will adhere to the timeframe designated in the approved clinical study protocol.

If there are no approved clinical studies on or before August 2, 2014, CED for PRP only for the treatment of chronic non-healing diabetic, venous and/or pressure wounds will expire.

2. The clinical research study must meet the requirements specified below to assess PRP's effect on the treatment of chronic non-healing diabetic, venous and/or pressure wounds.

The clinical study must address:

- Prospectively, do Medicare beneficiaries, with chronic non-healing diabetic, venous and/or pressure wounds, who receive well-defined optimal usual care along with PRP therapy, experience clinically significant health outcomes compared to patients who receive only well-defined optimal usual care for such wounds; as indicated by addressing at least one of the following:

  a) Complete wound healing?

  b) Ability to return to previous function and resumption of normal activities?

  c) Reduction of wound size or healing trajectory which results in the patient's ability to return to previous function and resumption of normal activities?

3. The required PRP clinical trial must adhere to the following standards of scientific integrity and relevance to the Medicare population:

   - Its principal purpose is to test whether PRP improves the participants' health outcomes
   - It is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use
   - It does not unjustifiably duplicate existing studies
   - Its design is appropriate to answer the research question being asked in the study

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Wound *(continued)*

- It is sponsored by an organization or individual capable of executing the proposed study successfully
- It is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 45 CFR Part 46
- All of its aspects are conducted according to appropriate standards of scientific integrity set by the International Committee of Medical Journal Editors (*http://www.icmje.org*)
- It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with evidence development (CED)
- It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR §312.81(a) and the patient has no other viable treatment options
- It is registered on the ClinicalTrials.gov website (*http://www.clinicaltrials.gov/*) by the principal sponsor/ investigator prior to the enrollment of the first study subject
- Its study protocol:

  a) Specifies the method and timing of public release of all pre-specified outcomes to be measured, including the release of outcomes that are negative or that the study is terminated early

     The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors (*http://www.icmje.org*). However a full report of the outcomes must be made public no later than three years after the end of data collection

  b) Must explicitly discuss: 1) Subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies; 2) How the inclusion and exclusion criteria effect enrollment of these populations, and 3) A plan for the retention and reporting of said populations on the trial.

     If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.

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

Note: Consistent with Section 1142 of the Social Security Act (the Act), the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that CMS determines meet the above-listed standards and address the above-listed research questions.

Coding and payment details

Healthcare Common Procedure Coding System (HCPCS) codes

Effective for claims with dates of service on or after August 2, 2012, contractors will accept and pay PRP claims, HCPCS code G0460 – Autologous platelet rich plasma for chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment", for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only in the context of an approved clinical study, when all of the following are present:

- ICD-9/ICD-10 CM Diagnosis code from the list of diagnosis codes to be maintained by the contractors
- Diagnosis code V70.7 (secondary dx) (ICD-10 Z00.6)
- Condition code 30 (institutional claims only)
- Clinical trial modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved research study)
- Value code D4 with an 8-digit clinical trial number (optional, institutional claims only)

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Wound *(continued)*

Medicare contractors will return to provider/return as unprocessable your PRP claims that do not include **all** these diagnosis coding and additional billing requirements:

Should they return your PRP claims for the treatment of chronic non-healing diabetic, venous and/or pressure wounds only in the context of an approved clinical study, they will use the following messages:

- CARC 16 – "Claim/service lacks information which is needed for adjudication."
- RARC M16 – "Alert: See our website, mailings, or bulletins for more details concerning this policy/procedure/decision."
- RARC MA130 – "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."

Type of bill

Your contractor will pay claims for PRP services in the following settings:

- Hospital outpatient departments type of bills (TOB) 12x and 13x based on OPPS
- Skilled nursing facilities (SNF) TOBs 22x and 23x based on MPFS
- Rural health clinics (RHC) TOB 71x based on all inclusive
- Comprehensive outpatient rehabilitation facilities (CORF) TOB 75x based on MPFS
- Federally qualified health centers (FQHC) TOB 77x based on all-inclusive
- Critical access hospitals (CAH) TOB 85x based on reasonable cost, and
- CAHs TOB 85x and revenue codes 096x, 097x, or 098x based on MPFS.

They will pay for PRP services in Maryland hospitals under the jurisdiction of the Health Services Cost Review Commission (HSCRC) on an outpatient basis, TOB 13x, in accordance with the terms of the Maryland waiver.

Contractors will deny claims for PRP services (HCPCS code G0460) when provided on other than TOBs 12x, 13x, 22x, 23x, 71x, 75x, 77x, and 85x using:

- CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present";
- RARC N428 – "Service/procedure not covered when performed in this place of service"; and
- Group code: CO

Place of service (POS) professional claims

Effective for claims with dates of service on or after August 2, 2012, you should use place of service (POS) codes 11 (office), 22 (outpatient hospital), and 49 (independent clinic) for PRP services. Your contractor will deny all other POS codes using the following messages:

- CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service";
- RARC N428 – "Service/procedure not covered when performed in this place of service"; and
- Group code: CO

Note: Contractors will not retroactively adjust claims from August 2, 2012, through the implementation of this CR. However, contractors may adjust claims that are brought to their attention.

Additional information

CR 8213 is being released in two transmittals which may be found at:

- *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R152NCD.pdf*, and
- *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2666CP.pdf*.

Both transmittals (R152NCD and R2666CP) contain a listing of relevant ICD-9 and ICD-10 diagnostic codes.

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Wound *(continued)*

You can find information regarding clinical trials in the *Claims Processing Manual*, Chapter 32, Section 69 (Qualifying Clinical Trails), for information regarding clinical trials, at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf*.

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

MLN Matters® Number: MM8213 *Revised*
Related Change Request (CR) #: CR 8213
Related CR Release Date: March 8, 2013
Effective Date: August 2, 2012
Related CR Transmittal #: R152NCD, R2666CP
Implementation Date: July 1, 2013

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

General Coverage

Outstanding medical records create superior patient outcomes

Communication tool

Physicians have been taught throughout their training that the medical record is their best insurance policy to communicate the quality of their analytical skills, problem-solving ability, and as a controlling guide for the complexity of patient care.

Evidence emerging from increasing use of electronic health records confirms that, when properly applied, the medical record will,

- Reduce patient care errors,
- Reduce rates of missing clinical information,
- Advance evidence-based clinical decision-making,
- Reduce costs by preventing duplicative and contraindicated services,
- Provide for care coordination across the spectrum of providers, and
- Enhance the quality of patient outcomes (See references 1-13)

Quality of records

When the contribution of rigorously structured medical records was studied in a critical-care setting (acute coronary syndrome) in an extensive cross-section of U.S. hospitals (more than 200), the results were dramatic: substantial incremental differences in survival and discharge health status were observed when high standards of clinical records were maintained (14).

In contrast, inferior patient records produce the opposite outcomes in all of the above categories.

The American College of Medical Quality (ACMQ) has further refined concepts of quality of care and medical documentation (15).

Auditing for medical necessity

Beginning with the original statute mandated by the 1965 (Medicare) provisions of the Social Security Act, and further elaborated by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), the doctrine of **medical necessity** controls coverage and payment policy by federal healthcare payers (16). Medical necessity in turn is evidenced by a variety of criteria, including criteria for effectiveness, appropriateness to the patient's presentation, relevance to a disease process, non-provision for strictly physician convenience, etc. (17-20).

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Outstanding *(continued)*

Accordingly, a nexus was established between medical necessity documentation and the vehicle of the medical record as a tool for care coordination, evidence of services, risk minimization, and outcome enhancement.

The above considerations led to the medical record audits mandated by CMS, identified as comprehensive error rate testing, or CERT (21, 22). The CERT program requires (post-pay) audits of medical records to establish that services were 1) provided and 2) of medical necessity, with the authority to recoup payments where evidence for these services is inadequate for a medically-trained reviewer.

It is therefore accurate to consider the CERT audit as a tool to ascertain service provision and as a mechanism to improve overall patient quality outcomes.

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National Correct Coding Initiative add-on codes

The Centers for Medicare & Medicaid Services (CMS) has provided contractors with guidelines regarding the use of add-on codes, which may result in new denials not previously received.

Add-on codes may be identified in three ways:

1. The code is listed as a Type I, Type II, or Type III, add-on code.
2. An add-on code generally has a global surgery period of "ZZZ" on the Medicare physician fee schedule database.
3. An add-on code is designated by the symbol "+" in the *Current Procedural Terminology*® (*CPT*®) *Manual*.

Add-on code edits

An add-on code describes a service that, with one exception (see "Exception"), is always performed in conjunction with a primary service. An add-on code with one exception is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner on the same date of service. An add-on code with one exception is never eligible for payment if it is the only procedure reported by a practitioner.

Exception: Two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service. For the same date of service only one physician of the same specialty in the group practice may report *CPT*® code *99291* with or without *CPT*® code *99292*, and the other physician(s) must report their critical care services with *CPT*® code *99292*.

Note: Although the add-on code and primary code are normally reported for the same date of service, under unusual circumstances they may be reported for different dates of service. For example, when critical care (*CPT*® code *99291*) begins on one date of service and rolls over into the following day and the additional critical care time (*CPT*® code *99292*) is provided on that following day.

Change request (CR) 7501 details the three different edit tables:

- Type I Add-on Code Edit Table lists add-on codes for which the *CPT*® *Manual* or HCPCS tables define all acceptable primary codes.
- Type II Add-on Code Edit Table lists add-on codes for which the *CPT*® *Manual* and HCPCS tables do not define any primary codes.
- Type III Add-on Code Edit Table lists add-on codes for which the *CPT*® *Manual* or HCPCS tables define some, but not all, acceptable primary codes.

For more information about this change, refer to CR 7501 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf.*

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

Find the fee schedule information you need fast - with First Coast's 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.

Reorganization of Chapter 13

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs) for services provided in rural health clinics (RHCs) and federally qualified health centers (FQHCs) to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7824, which updates and reorganizes Chapter 13 of the *Medicare Benefit Policy Manual*. This chapter deals with Medicare RHCs and FQHCs. Chapter 13 is reorganized for easier use and updated to include more comprehensive information. There are no new policies contained in the manual.

Additional information

The official instruction, CR 7824 issued to your FI, carrier, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R166BP.pdf*.

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

MLN Matters® Number: MM7824
Related Change Request (CR) #: CR 7824
Related CR Release Date: January 31, 2013
Effective Date: March 1, 2013
Related CR Transmittal #: R166BP
Implementation Date: March 1, 2013

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Plan to mitigate risk for a smooth ICD-10 transition

To make your transition to ICD-10 smooth, consider following these steps:

- **Establish a transition plan**. Outline the steps your practice intends to follow to comply with ICD-10 requirements. Establish milestones to keep your practice on track. Share your transition plan with your EHR and practice management system vendors and billing services. Talk to them about how you can set up testing before the deadline.
- **Communicate with your vendors regularly**; encourage them to take action now to avoid reimbursement delays. Talk to your vendors about making sure your practice management systems will be able to handle ICD-10 transactions. Ask them about their schedule for training your practice's staff on the system changes. Make sure you and your vendors allow ample time for testing ICD-10 systems.
- **Identify everywhere that your practice uses ICD-9**. Any function where you currently use ICD-9 will be affected by the transition to ICD-10. By taking a look at where you use ICD-9, you will see where you need to be prepared to use ICD-10 codes.
- **Plan for staff training**. Decide who needs training, what type of training they need, and when they need it. Anyone who will test ICD-10 systems before the transition will need training in advance so they can perform meaningful testing. Others who use ICD codes can be trained six to nine months before the October 1, 2014, transition.
- **Network with peers**. Talking with your peers in other practices can help you to identify best practices and opportunities for sharing resources.
- **Set up an emergency fund to cover potential cash-flow disruptions from claim processing**. If you think you might have a serious disruption in getting claims processed after the transition, having a cash reserve on hand could be helpful.
- **Process ICD-9 transactions before the deadline**. Get claims with ICD-9 transactions processed before the deadline to avoid facing a major backlog after the October 1, 2014, ICD-10 transition.

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ICD-10 checklists and timelines

To assist with preparation for ICD-10, the Centers for Medicare & Medicaid Services (CMS) has released new *checklists and timelines* for small and medium provider practices, large provider practices, small hospitals, and payers. These resources are designed to provide a high-level understanding of what the ICD-10 transition requires and how your ICD-10 preparations compare with recommended timeframes.

Checklists

The checklists offer easy-to-understand lists of tasks that CMS recommends completing before the October 1, 2014, ICD-10 deadline. Each task also includes an estimated timeframe, allowing you to plan based on your current progress. Depending on your organization, you may be able perform some of the tasks on a compressed timeline or at the same time as other tasks.

Timelines

The timelines are an at-a-glance resource for getting a sense of how your transition is moving forward. The timelines provide a visual guide to key transition activities by phase.

Use these resources to identify where you need to focus your efforts. Then you can consult the more in-depth ICD-10 resources available on the CMS website.

Keep up to date on ICD-10

Visit the *CMS ICD-10 website* for the latest news and resources to help you prepare for the October 1, 2014, deadline.

Practical transition tips

Read *recent ICD-10 email update messages*

Access the *ICD-10 continuing medical education modules* developed by CMS in partnership with Medscape

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

Risk *(continued)*

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Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

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.

April 2013 healthcare provider taxonomy codes update

Provider types affected

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

What you need to know

This article is based on change request (CR) 8211 which instructs carriers and Part B MACS to obtain the most recent healthcare provider taxonomy codes (HPTC) set and use it to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, among them health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used.

Health care claims are among the health care transactions for which standards were adopted under HIPAA. Among the current versions of the standard implementation guides for health care claim transactions are the 5010 versions of the ASC X12 837 institutional technical report 3 (TR3) for institutional claims and the ASC X12 837 professional TR3 for professional (and some supplier) claims. (There are other standards for other types of claims). Both the current ASC X12 837 institutional and professional TR3s require that the National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Code (HPTC) set be used to identify provider specialty information on a health care claim. However, the standards do not mandate the reporting of provider specialty information via a HPTC be on every claim, nor for every provider to be identified by specialty.

The standards implementation guides state that this information is:

- "Required when the payer's adjudication is known to be impacted by the provider taxonomy code."; and
- "If not required by this implementation guide, do not send."

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

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

CR 8211 implements the NUCC HPTC code set that is effective April 1, 2013. When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

- New items are green
- Modified items are orange
- Inactive items are red

Additional information

The official instruction, CR 8211, issued to your carriers and B MACs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2660CP.pdf*.

If you have any questions, please contact your carriers or Part 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: MM8211
Related Change Request (CR) #: CR 8211
Related CR Release Date: February 15, 2013
Effective Date: April 1, 2013
Related CR Transmittal #: R2660CP
Implementation Date: July 1, 2013 (Contractors with the capability may implement April 1, 2013 or after)

Prepared *(continued from front page)*

First Coast Service Options Inc. offers providers several resources to guide them through the enrollment process, including *How to complete a CMS-855 form FAQ* and its *Internet-based PECOS resources page*. Providers may also refer to CMS' fact sheet: *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners*.

Laboratories, imaging centers, DMEPOS suppliers, and HHAs should begin immediately working with ordering and referring providers to ensure they are prepared for this change. Since 2009, Medicare contractors alerted providers when claims were missing or did not have complete provider enrollment information on referring or ordering providers. Billing providers are encouraged to review recent adjustment claims for informational alerts on ordering/referring provider documentation.

The Affordable Care Act of 2009 requires physicians or other eligible health professionals to be enrolled in the Medicare program to order or refer items or services for Medicare beneficiaries. Designed to protect the Medicare trust fund and prevent Medicare fraud, the ordering/referring edits are a result of the passage of this law.

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

Full implementation of edits on the ordering/referring providers

Note: This special edition *MLN Matters*® article is a consolidation and update of prior articles SE1011, SE1201, SE1208, and SE1221. Effective May 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will turn on the Phase 2 denial edits. This means that Medicare will deny claims for services or supplies that require an ordering/referring provider to be identified and that provider is not identified, is not in Medicare's enrollment records, or is not of a specialty type that may order/refer the service/item being billed.

Provider types affected

This special edition *MLN Matters*® 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), the Department of Defense (DoD), 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 regional home health intermediaries (RHHIs), fiscal intermediaries (FIs, who still maintain an HHA workload), and Part A/B MACs.
- Optometrists may only order and refer DMEPOS products/ services and laboratory and X-Ray services payable under Medicare Part B.

Provider action needed

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

What providers need to know

Phase 1: Informational messaging: Began October 5, 2009, to alert the billing provider 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 did not pass the edits indicated the claim/service lacked information that was needed for adjudication.

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Ordering/referring *(continued)*

Phase 2: Effective May 1, 2013, CMS will turn on the edits to deny Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer.

All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the May 1, 2013, implementation date of the ordering/referring Phase 2 provider edits.

Background

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services are Required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. 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). The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures; and
- Claims from suppliers of DMEPOS for ordered DMEPOS.

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:

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.)
- Physician assistants
- Clinical nurse specialists
- Nurse practitioners
- Clinical psychologists
- Interns, residents, and fellows
- Certified nurse midwives, and
- Clinical social workers.

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

CMS would like to highlight the following limitations:

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

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Ordering/referring *(continued)*

- Optometrists may only order and refer DMEPOS products/services, and laboratory and X-Ray services payable under Medicare Part B.

Questions and answers relating to the edits

1. What are the ordering and referring edits?

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

2. Why did Medicare implement these edits?

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

3. How and when will these edits be implemented?

These edits were implemented in two phases:

Phase 1: Informational messaging: Began October 5, 2009, to alert the billing provider 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 did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

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

N264 Missing/incomplete/invalid ordering provider name
N265 Missing/incomplete/invalid ordering provider primary identifier

For adjusted claims, the claims adjustment reason code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is 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 initially processed the claim and added 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 was used.

CMS has taken actions to reduce the number of informational messages

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.[1]

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

[1] NPIs were added only when the matching criteria verified the NPI.

Phase 2: Effective May 1, 2013, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral. Below are the denial edits for Part B providers and suppliers who submit claims to carriers and/or MACs, including DME MACs:

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Ordering/referring *(continued)*

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

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims.

Below are the denial edits for Part A HHA providers who submit claims:

Reason code	This reason code will assign when:
37236	• 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	• 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

Effect of edits on providers

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

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

a) You have a current Medicare enrollment record.

- If you are not sure you are enrolled in Medicare, you may:
  - Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
  - Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
  - Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
  - If you choose iii, please read the information on the Medicare provider/supplier enrollment Web page about Internet-based PECOS before you begin.

b) If you do not have an enrollment record in Medicare.

- You need to submit either an electronic application through the use of Internet-based PECOS or a paper enrollment application to Medicare.
  - **For paper applications** – fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
  - **For electronic applications** – complete the online submittal process and either e-sign or mail a printed, signed, and dated certification statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.

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Ordering/referring *(continued)*

- In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement.
- If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment Web page to learn more about the Web-based system before you attempt to use it. Go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. *Download* and read the documents in the *Downloads* section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that Web page.
- If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via Internet-based PECOS or .pdf for downloading from the CMS forms page (*http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html*).

c) You are an opt-out physician and would like to order and refer services. What should you do?

If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every two years, and the NPI is required on the affidavit).

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

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

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article.
- Ensure you are correctly spelling the ordering/referring provider's name.
- If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the ordering/referring provider edits.
- The Ordering Referring Report will be replaced weekly to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next report.

f) Make sure your claims are properly completed.

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

If there are additional questions about the informational messages, billing providers should contact their local carrier, A/B MAC, or DME MAC.

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

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Ordering/referring *(continued)*

g) What if my claim is denied inappropriately?

If your claim did not initially pass the ordering/referring provider edits, you may file an appeal through the standard claims appeals process.

Additional guidance

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

Additional information

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*.

Note: You must obtain a national provider identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field on your enrollment application. Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*. For more information about NPI enumeration, visit *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html*.

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.*

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Ordering/referring *(continued)*

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® article, MM6856, "Expansion of the Current Scope 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*.

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

MLN Matters® Number: SE1305
Related Change Request (CR) #: 6421, 6417, 6696, 6856
Related CR Release Date: N/A
Effective Date: May 1, 2013
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R7810TN
Implementation Date: May 1, 2013

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How to enter data for referring/ordering provider

Beginning May 1 Medicare will implement phase 2 editing for ordering and referring provider national provider identifier (NPI). This simply means that current informational edits (N264/N265) used in phase 1 will become claim denials with phase 2 editing. To eliminate denials, claims must be completed properly. All data elements must match PECOS exactly or the claim will be denied.

CMS-1500 paper claim form:

- Item 17 – Enter the referring or ordering provider's name (first name first and last name second [e.g., John Smith]); and
- Item 17b – Enter the NPI

837P electronic claim:

- 2310A Referring Provider Loop, segments NM1:
  - NM103 – Enter the referring or ordering provider last name;
  - NM104 – Enter the referring or order provider first name;
  - NM108 – Enter the XX qualifier; and
  - NM109 – Enter the NPI

Reminders

- Ensure the NPI belongs to the provider being entered
- Do not enter an organization's NPI
- Do not use special characters (dash, comma, etc)
- No nicknames, middle initials, or credentials are entered

Hint: If unsure of the naming convention, use the NPI Registry, available at *https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do*.

Update to Chapter 15 of the Program Integrity Manual

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8155 to alert providers of updates to Chapter 15 of the *Medicare Program Integrity Manual (PIM)*. Chapter 15 deals with Medicare provider enrollment and CR 8155 highlights the issues below. Make sure your staff is familiar with the *Key points* of this *MLN Matters*® article.

Key points

The following are the provider enrollment issues addressed in CR 8155:

1. **Owning and managing individuals**: If your Medicare contractor is unsure as to whether the officers and directors/board members of the enrolling provider or supplier's corporate owner/parent also serve as the enrolling provider or supplier's officers and directors/board members, your contractor will contact you for clarification.
2. **If there is a change in correspondence or special payments address/change of electronic funds transfer (EFT) information**: Your Medicare contractor may confirm the change with the contract person listed.
3. **Rejections**: Your Medicare contractor may reject an application that was signed more than 120 days prior to the date on which the contractor received the application—assuming the provider or supplier failed to furnish a new, appropriately-signed certification statement within 30 days of the contractor's request to do so.
4. **Timeframe**: Absent a CMS instruction or directive to the contrary, your Medicare contractor will send a rejection letter no later than five business days after the contractor concludes that the provider or supplier's application should be rejected.
5. **Be aware**: If your contractor rejects an application, it will either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.
6. **Potential identity theft or other fraudulent activity**: In conducting the verification activities described in Section 15.7.5 of Chapter 15, if the contractor believes that a case of identity theft or other fraudulent activity likely exists, the contractor will notify its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) at CMS immediately.
7. **Non-certified suppliers and individual practitioners**: Absent a CMS instruction or directive to the contrary, an approval letter under Section 15.9.1 of Chapter 15 will be sent no later than five business days after the contractor concludes that the provider or supplier meets all Medicare requirements and that his/her/its application can be approved.
8. **Unsolicited additional information**: Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request; rather, it is considered to be and will be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first will be processed to completion prior to the second one being processed to completion.
9. **Miscellaneous policies**: In situations where a provider with multiple PTANs is to be deactivated for non-billing, the contractor will only deactivate the non-billing PTAN(s).
10. **Partnerships**: Only partnership interests in the enrolling provider need be disclosed in Section 5 of the Form CMS-855. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in Section 5.
11. **Processing and approval of corrective action plans (CAPs)**: The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements

(continued on next page)

Chapter 15 *(continued)*

associated with a reconsideration request. If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless stated otherwise in another CMS directive or instruction – the effective date is based on the date the supplier came into compliance with all Medicare requirements.

Additional information

You can find the official instruction, CR 8155, issued to your carrier, FI, A/B MAC, or RHHI by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R450PI.pdf*. The entire revised Chapter 15 of the PIM is attached to that CR.

To review other changes to Chapter 15 issued in November of 2012, you may refer to MM8019 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8019.pdf*.

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

MLN Matters® Number: MM8155
Related Change Request (CR) #: CR 8155
Related CR Release Date: February 15, 2013
Effective Date: March 18, 2013
Related CR Transmittal #: R450PI
Implementation Date: March 18, 2013

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

Valid redetermination appeal request requirements

A redetermination is an independent review of an initial claim determination performed by the same contractor that processed the original claim. This independent review is performed by staff not involved with making the original claim determination. A request for a redetermination must be submitted in writing and should be made on the standard Centers for Medicare & Medicaid (CMS) *Form 20027*. If the standard form is not used, the request must include the same elements required on the form:

1. The beneficiary's name,
2. The beneficiary's Medicare health insurance claim (HIC) number,
3. The specific service(s) and/or item(s) for which the redetermination is being requested,
4. The specific date(s) of service, and
5. The name and written signature.

If any of these five elements are missing, the redetermination will be dismissed as invalid. The appellant may resubmit the appeal if still within the original appeal timeframe. Resubmission of the appeal to include originally missing requirements does not extend the original timeframe or in any way constitute good cause for late filing.

To further explain the signature requirement, this signature must be hand-written and not be a stamped or electronic signature. Should the option for submission of claims appeals via an Internet portal/application become available for First Coast providers, further information will be made available regarding the use of an electronic signature. Until this occurs a written signature is a required element and appeals without one will be dismissed.

Source: CMS Internet-only manuals Publication 100-4, Chapter 29, Section 310.1.B.3

Return of claims when there is a name and HICN mismatch

Note: This article was revised March 15, 2013, to reflect a revised change request (CR). The revised CR restores the common working file (CWF) entitlement validation criterion (in bold under *Provider action needed*) used prior to the implementation of CR 7260 (October 1, 2012). The implementation date for CR 7260 was changed to April 1, 2013.The transmittal number, CR release date, and Web address of the CR also changed. This information was previously published in the May 2012 *Medicare B Connection*, Page 40.

Provider types affected

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

Provider action needed

If Medicare systems reject a claim when there is a mismatch of the health insurance claim number (HICN) with the beneficiary's personal characteristics (such as name, sex or date of birth), your Medicare contractor will return the claim to you as unprocessable with the identifying beneficiary information from the submitted claim as follows:

- Your contractor will return to provider (RTP) Part A claims
- Your contractor will return as unprocessable Part B claims. Your contractor will use reason code 140 (Patient/Insured health identification number and name do not match)

When returning these claims as unprocessable, your contractor will utilize remittance advice codes MA130 and MA61. Also, based on CR 7260, you will receive the beneficiary name information you originally submitted when the claim is returned rather than the beneficiary data associated with the potentially incorrectly entered HICN. Previously, Medicare returned the name of the beneficiary that is associated with that HICN within its files.

If an adjustment claim is received where the beneficiary's name does not match the submitted HICN, your contractor will suspend the claim and, upon their review, either correct, develop, or delete the adjustment, as appropriate.

All providers should ensure that their billing staffs are aware of these changes.

Additional information

The official instruction, CR 7260 issued to your FI, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2670CP.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*.

MLN Matters® Number: MM7260 *Revised*
Related Change Request (CR) #: CR 7260
Related CR Release Date: March 14, 2013
Effective Date: October 1, 2012
Related CR Transmittal #: R2670CP
Implementation Date: April 1, 2013

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Requesting a comparative billing report

Comparative billing report (CBR) information is available to providers by request. The purpose of the CBR is to show comparative data Medicare considers when determining how a provider's billing patterns contrast with other providers in the same specialty. A CBR may be a helpful tool when conducting self-audits or preparing for a seminar or medical society meeting.

Types of comparative billing reports

Part B: Provider-specific

This type of CBR, best suited for individual physicians and non-physician practitioners, contains comparative information for all procedure codes billed. It is also available to specialties such as independent diagnostic testing facilities or clinical laboratories; however, due to the various types of services offered, the results will not be an "apples-to-apples" comparison. This type of CBR does not have value for physician groups.

Since Medicare bases a CBR on dates of service and not processed dates, Medicare must allow two to three months to permit claims to be finalized before a report can be generated. For example, January data is not available until April or May.

Evaluation and management distribution: Provider-specific

This type of CBR compares an evaluation and management (E/M) code family (example: *CPT*® codes *99211-99215*) to the provider's peer group (specialty) within the state/territory and the nation. The report is a bar graph distribution and depicts a provider's percentage of allowed services per procedure code as compared to the state/territory and the nation. This CBR is useful to identify potential variances in coding within a code family.

Medicare updates the reports two times per year for the following dates of service:

- January through June
- July through December

Since Medicare bases a CBR on dates of service and not processed dates, Medicare must allow three to four months to permit claims to be finalized before a report can be generated. For example, the January through June timeframe is not available until September or October.

Evaluation and management distribution: Service-specific

This CBR compares the state/territory's utilization of E/M codes to the nation by specialty. This report is useful for medical society meetings to show variance within a code family between the state/territory's provider specialties and the nation.

The CMS data center updates the national data two times per year for the following dates of service:

- January through June
- July through December

Medicare must allow three to four months before a report can be generated. For example, the January through June timeframe is not available until September or October.

How to request a comparative billing report

To request a CBR, providers must follow these steps:

- A provider must request a CBR on office or corporate letterhead and the provider/officer signature must be affixed. A request from a corporate entity must be submitted by a corporate officer, or in the case of a hospital, the hospital administrator. If the requesting provider wants the information sent to another party, it must be noted in the letter.
- **The request must include the following information: the type of CBR(s) desired, the individual provider number(s), and the dates of service preferred. Please beware that a CBR cannot be produced using the group Medicare number.**
- The mailing address must be stated clearly and legibly in the letter, since these reports will only be sent via the U.S. mail and not electronically.
- The request must be faxed to Statistical and Medical Data Analysis at 904-361-0543 or mailed to:

  First Coast Service Options
  Statistical and Medical Data Analysis
  P.O. Box 44288
  Jacksonville, FL 32231-4288

There is no fee for providing these reports.

Once Medicare receives a CBR request, the report and a CBR explanation document will be mailed to the requesting provider (or authorized party) within 10 business days.

To view an example of a CBR, *click here*.

Source: CMS Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 11.1.6

Manual updates to clarify inpatient rehabilitation facility claim processing

Note: This article was revised March 18, 2013, to reflect a revised change request (CR) that corrects formatting in the CR. The transmittal number, CR release date, and Web address of the CR also changed. This information was previously published in the January 2013 *Medicare B Connection*, Pages 51-53.

Provider types affected

This *MLN Matters*® article is intended for physicians and providers (including inpatient rehabilitation facilities (IRFs)) submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs)) for inpatient rehabilitation services to Medicare beneficiaries.

Provider action needed

CR 8127, from which this article is taken, updates the *Medicare Claims Processing Manual*, Chapter 3 (Inpatient Hospital Billing), to clarify key components of inpatient rehabilitation facility (IRF) claim processing. These changes are intended only to clarify the existing policies and there are no system or policy changes.

Background

The changes that CR 8127 makes to the manual are clarifications of existing policy. The entire manual revision is attached to CR 8127. Key manual changes of interest to IRFs are summarized as follows:

Medicare IRF classification requirements

A facility paid under the IRF prospective payment system (PPS) is always subject to verification that it continues to meet the criteria for exclusion from the inpatient PPS (IPPS). Your FI or MAC provides the Centers for Medicare & Medicaid Services (CMS) regional office (RO) with data for determining the classification status of each facility and the RO reviews the IRF's classification status each year. A determination that a facility either is or is not classified as an IRF takes effect only at the start of a facility's cost reporting period and applies to that entire cost reporting period. If a facility fails to meet the criteria necessary to be paid under the IRF PPS, but meets the criteria to be paid under the IPPS, it may be paid under the IPPS.

If a patient is admitted to a facility that is being paid under the IRF PPS, but is discharged from the facility when it is no longer being paid under the IRF PPS, then payment to the facility will be made from the applicable payment system that is in effect for the facility at the time the patient is discharged.

For cost reporting periods beginning on or after July 1, 2005, the IRF must have served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified in the revised manual Section 140.1.1C. See CR 8127 for a list of these criteria.

Additional criteria for inpatient rehabilitation units

Inpatient rehabilitation units must also meet additional criteria to be paid under the IRF PPS. These criteria are detailed in Section 140.1.2 of the revised manual, as attached to CR 8127.

Verification process used to determine if IRF meets classification criteria

For cost reporting periods beginning on or after July 1, 2005, the compliance threshold that must be met is 60 percent. Thus, for all compliance review periods beginning on or after January 1, 2013 (except in the case of new IRFs), the compliance review period will be one continuous 12-month time period beginning four months before the start of a cost reporting period and ending four months before the beginning of the next cost reporting period. For complete details of the verification process, see the revised Section 140.1.3 of the manual, which is attached to CR 8127.

New IRFs

An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS for at least five calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.

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IRF *(continued)*

A new IRF must provide written certification that the inpatient population it intends to serve will meet the certification requirements. The written certification is effective for the first full 12-month cost reporting period that occurs after the IRF begins being paid under the IRF PPS, and for any cost reporting period of not less than one month and not more than 11 months occurring between the date the IRF begins being paid under the IRF PPS and the start of the IRF's first full 12-month cost reporting period.

Changes in the status of an IRF unit

For purposes of payment under the IRF PPS, the status of an IRF unit may be changed from not excluded from the IPPS to excluded from the IPPS only at the start of a cost reporting period. If an IRF unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of the hospital's next cost reporting period.

The status of an IRF unit may be changed from excluded from the IPPS to not excluded from the IPPS at any time during a cost reporting period, but only if the hospital notifies the FI/MAC and the RO in writing of the change at least 30 days before the date of the change. In addition, the hospital must maintain the information needed to accurately determine which costs are and are not attributable to the IRF unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the remainder of that cost reporting period.

New IRF beds

Any IRF beds that are added to an existing IRF must meet all applicable state certificates of need and state licensure laws. New IRF beds may be added one time at any time during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified.

Change of ownership or leasing

If an IRF hospital (or a hospital that has an IRF unit) undergoes a change of ownership or leasing, as defined in 42 CFR 489.18, the IRF (or IRF unit of a hospital) retains its excluded status and will continue to be paid under the IRF PPS before and after the change of ownership or leasing if the new owner(s) of the IRF hospital (or the hospital with an IRF unit) accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the IRF PPS. Note that an IRF's payment status under the IRF PPS is a Medicare classification status, which cannot be separated from its host hospital and therefore cannot be purchased outside of the purchase of its host hospital.

If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to the Medicare program to operate a new IRF, under the requirements for new IRFs.

Mergers

If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the IRF PPS before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF PPS. Note that an IRF's payment status under the IRF PPS is a Medicare classification status, which cannot be separated from its host hospital and therefore cannot be merged with another entity outside of the merger with its host hospital.

If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may re-apply to the Medicare program to operate a new IRF under the requirements for new IRFs.

Full time equivalent (FTE) resident cap

Effective for cost reporting periods beginning on or after October 1, 2011, the IRF FTE resident caps may be temporarily adjusted to reflect interns and residents added because of another IRF's closure or the closure of another IRF's residency training program. An IRF is only eligible for the temporary cap adjustment if training the additional interns and residents would cause the IRF to exceed its FTE resident cap. In addition, an IRF that closes a medical residency training program must agree to temporarily reduce its FTE cap before other IRFs can

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IRF *(continued)*

receive temporary adjustments to their caps for training the IRF's interns and residents. IRFs may qualify for the temporary cap adjustment for cost reporting periods beginning on or after October 1, 2011, if they are already training interns and residents displaced by IRF closures or residency training program closures that occurred prior to October 1, 2011.

Outliers

The Social Security Act provides the Secretary of Health and Human Services with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high cost. A case qualifies for outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. CMS calculates the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the case-mix group (CMG) payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, CMS calculates the estimated cost of the case by multiplying the IRF's overall cost-to-charge ratio (CCR) by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

The adjusted threshold amount and upper threshold CCR are set forth annually in the IRF PPS notices published in the *Federal Register*.

Additional information

The official instruction, CR 8127 issued to your FI, carrier, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2673CP.pdf*. As mentioned above, you can find the updated *Medicare Claims Processing Manual*, Chapter 3 (Inpatient Hospital Billing) as an attachment to this CR.

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

MLN Matters® Number: MM8127 *Revised*
Related Change Request (CR) #: CR 8127
Related CR Release Date: January 18, 2013
Effective Date: April 22, 2013
Related CR Transmittal #: R2673CP
Implementation Date: April 22, 2013

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2013 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing may be accessed at *http://medicare.fcso.com/MEDPARD/*.

Source: CMS IOM Publication 100-04, Transmittal 2567, CR 8055

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

Implementation of award for the jurisdiction 6 Medicare administrative contractor

Effective date: July 1, 2013
Implementation date: July 1, 2013

Background

The Centers for Medicare & Medicaid Services (CMS) has awarded the J6 A/B MAC contract for the administration of the Part A and Part B Medicare fee-for-service claims in the states of Illinois, Minnesota and Wisconsin to National Government Services, Inc. (NGS). The contractor will also be responsible for processing Medicare Home Health plus Hospice (HH+H) billings in thirteen states and five U.S. territories: the states of Alaska, Arizona, California, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Oregon, Wisconsin and Washington, as well as the territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. The J6 A/B MAC will also administer Medicare claims for several thousand federally qualified health centers (FQHCs).

The HH+H workload was formerly known as the regional home health intermediary (RHHI) workload.

NGS is the incumbent contractor for Illinois Part A, Wisconsin Part A and HH+H (RHHI) Region D workloads. NGS' address is:

National Government Services, Inc.
8115 Knue Road
Indianapolis, IN 46250

Wisconsin Physicians Services (WPS) is the outgoing contractor (OGC) for Illinois Part B, Minnesota Part B and Wisconsin Part B. WPS' address is:

Wisconsin Physicians Services
1717 W. Broadway
Madison, WI 53708

Noridian Administrative Services, LLC (NAS) is the OGC for the Minnesota Part A workload. NAS' address:

Noridian Administrative Services
900 42nd Street South
Fargo, North Dakota 58103

CMS has determined that the J6 workloads currently processed by NGS, WPS and NAS will require new workload numbers when they are transitioned. This change is being made because CMS needs to differentiate between the workload processed by the legacy contractors and the incoming J6 A/B MAC. The workload numbers shall be changed and the workloads shall be transitioned to the J6 A/B MAC as follows:

Part A

Workload description: Part A Illinois J6 MAC
MAC workload number: 06101
Effective date: July 13, 2013
Current contractor workload number: 00131; OGC-NGS

Workload description: Part A Minnesota J6 MAC
MAC workload number: 06201
Effective date: August 10, 2013
Current contractor workload number: 00320; OGC-Noridian

Workload description: Part A Wisconsin J6 MAC
MAC workload number: 06301
Effective date: July 13, 2013
Current contractor workload number: 00450; OGC-NGS

Workload description: HH+H (RHHI) Region D (WI, MN, MI, NY, NJ, PR and the VI)
MAC workload number: 06004
Effective date: July 13, 2013
Current contractor workload number: 00450; OGC-NGS

Workload description: HH+H (RHHI) Region D (AK, American Samoa, AZ, CA, Guam, HI, ID, Northern Marianas, NV, OR, WA)
MAC workload number: 06004
Effective date: July 13, 2013
Current contractor workload number: 00456; OGC-NGS

Part B

Workload description: Part B Illinois J6 MAC
MAC workload number: 06102
Effective date: September 7, 2013
Current contractor workload number: 00952; OGC-WPS

Workload description: Part B Minnesota J6 MAC
MAC workload number: 06202
Effective date: September 7, 2013
Current contractor workload number: 00954; OGC-WPS

Workload description: Part B Wisconsin J6 MAC
MAC workload number: 06302
Effective date: September 7, 2013
Current contractor workload number: 00951; OGC-WPS

The following applications or business owners shall accept the new J6 A/B workload number once the above cited workload is transitioned to the J6 A/B MAC.

- Administrative qualified independent contractor (AdQIC)
- CMS analysis, reporting and tracking system (CMS ARTS)
- Contractor administrative, budget and cost reporting system (CAFM)

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Contractor *(continued)*

- Comprehensive error rate testing system (CERT)
- Contractor management information system (CMIS)
- CMS Baltimore data center (BDC)
- Coordination of benefits agreement program (COBA)
- Coordination of benefits contractor (COBC)
- Contractor reporting of operational workload data system (CROWD)
- Common working file (CWF)
- CWF Part B eligibility and security maintenance (CWF ELGE)
- Customer service assessment and management system (CSAMS)
- Debt collection system (DCS)
- Electronic correspondence referral system (ECRS)
- Electronic health records incentive program (eRx)
- Enterprise data centers (EDCs)
- Expert claims processing system (ECPS)
- Fiscal intermediary shared system (FISS)
- Fraud prevention system (FPS)
- Health care information system (HCIS)
- Health care integrated general ledger accounting system (HIGLAS)
- Health insurance master record (HIMR)
- Integrated data repository (IDR)
- Intern and resident information system (IRIS)
- Local coverage determination database (LCD)
- Medicare appeals system (MAS)
- Medicare coverage database (MCD)
- Medicare secondary payer recovery contractor (MSPRC)
- Multi-carrier system (MCS)
- National data warehouse (NDW)
- National level repository (NLR)
- National Part B pricing files
- National provider identifier crosswalk (NPI)
- Next generation desktop (NGD)
- Part B analytics reporting system (PBAR)
- Production performance monitoring system (PULSE)
- Provider enrollment chain and ownership system (PECOS)
- Provider customer service program contractor information database (PCID)
- Provider inquiry evaluation system (PIES)
- Program integrity management reporting system (PIMR)
- Program safeguard contractor (PSC)
- Provider statistical and reimbursement system (PS and R)
- Qualified independent contractor (QIC)
- Quality improvement evaluation system (QIES)
- Recovery auditors (RA), recover management and accounting system (REMAS)
- Renal management information system (REMIS)
- System tracking for audit and reimbursement (STAR)
- Zip code file
- Zoned program integrity contractors (ZPICs)

Policy

N/A

Source: Publication 100-20, transmittal number 1197, change request 8227

Get motivated by Medicare …

Find out about Provider Incentive Programs

- e-Prescribing (eRx)
- Electronic Health Records (EHR)
- Physician Quality Reporting System
- Primary Care Incentive Program (PCIP)

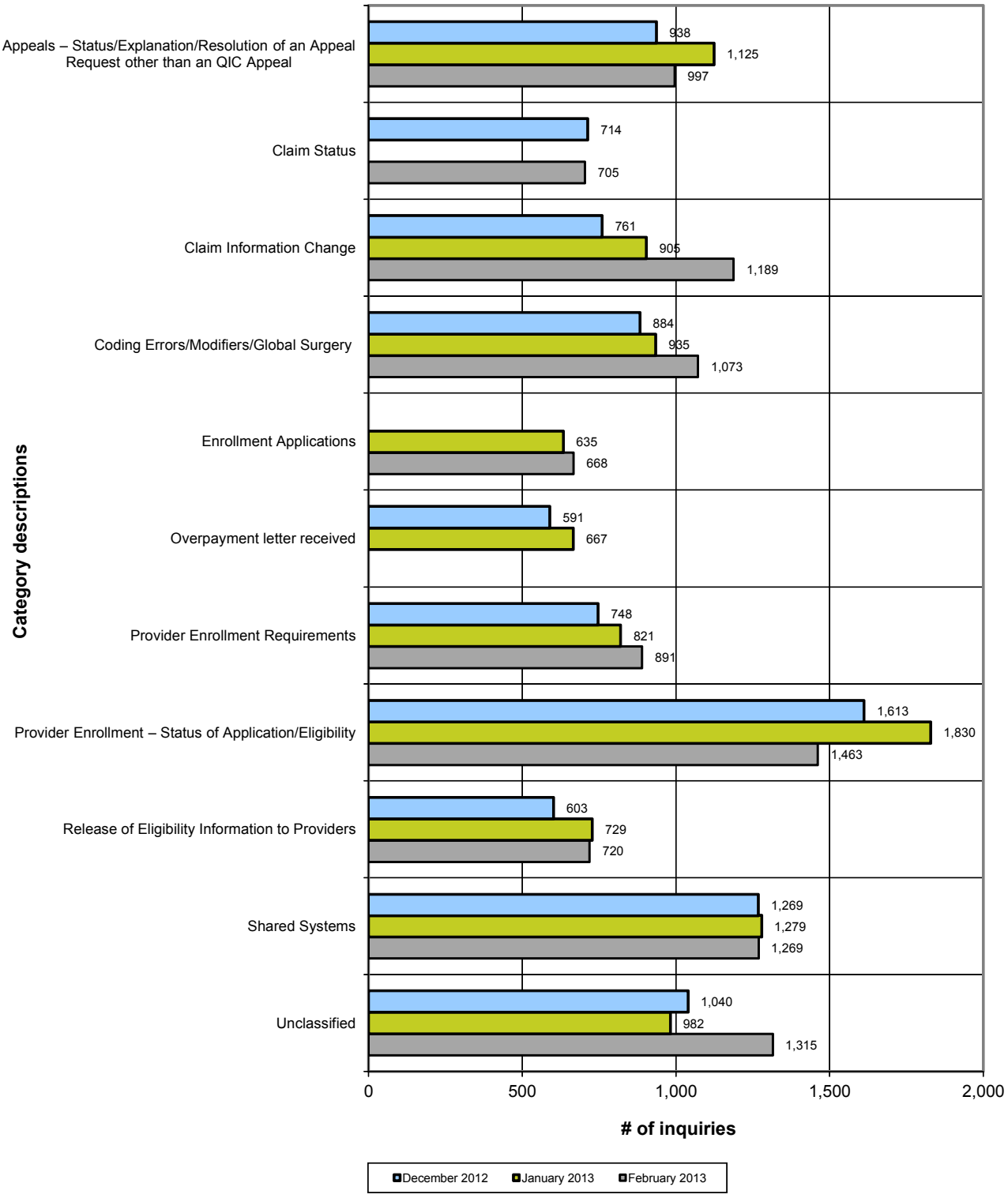
Available at *http://medicare.fcso.com/Landing/191460.asp*

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 December 2012-February 2013.

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 December 2012-February 2013



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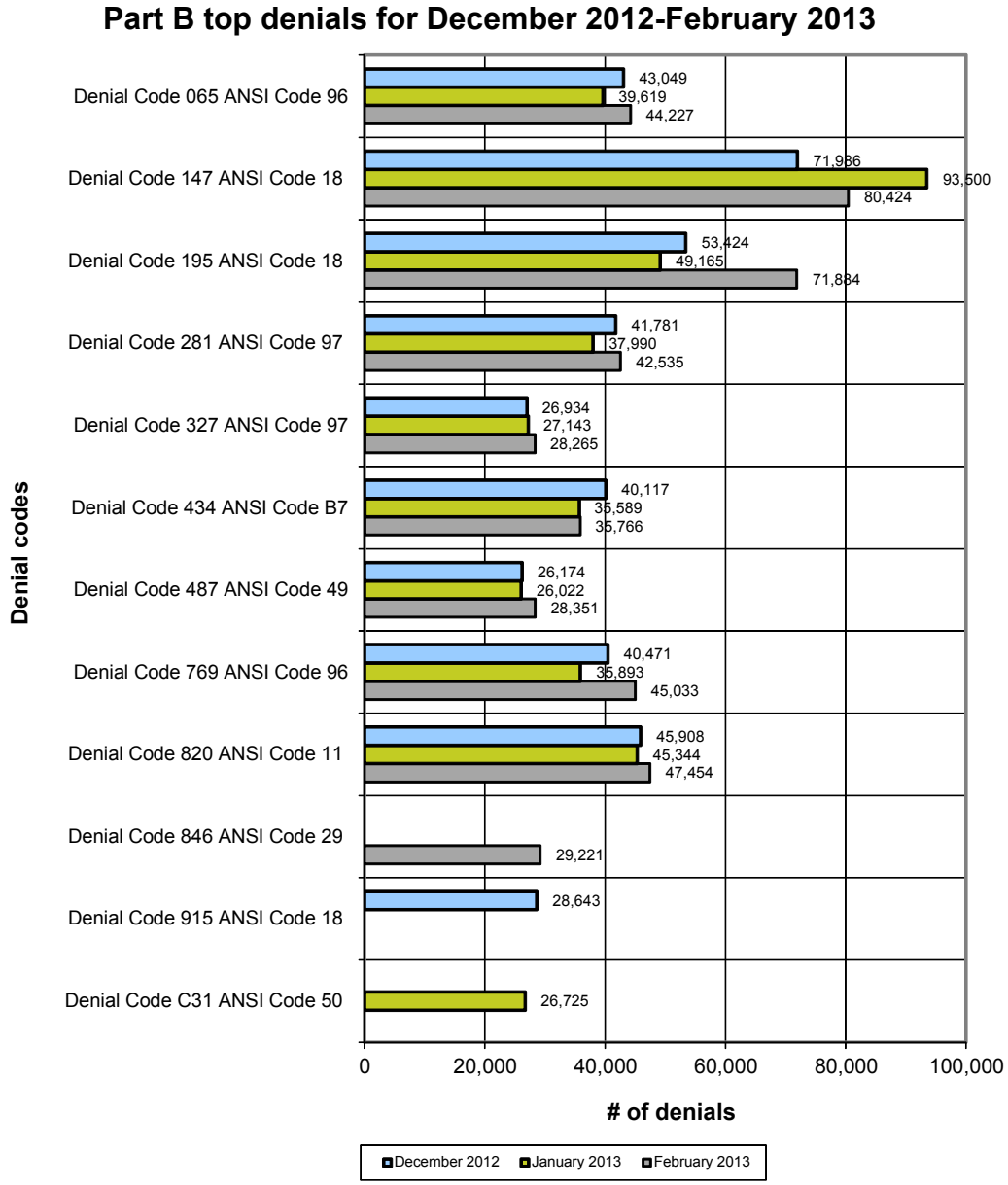


What to do when your claim is denied

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

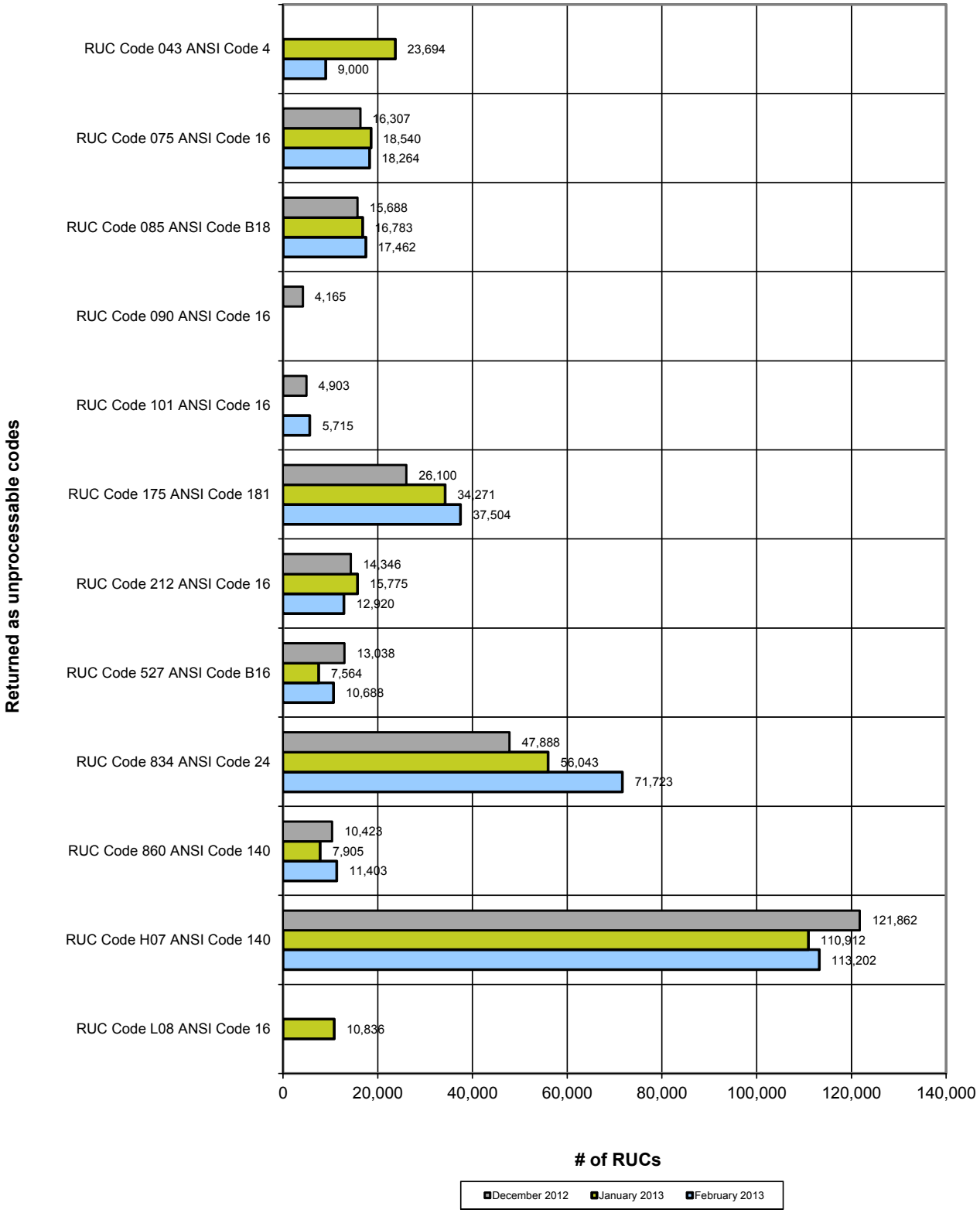
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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 December 2012-February 2013



Educational Events

Upcoming provider outreach and educational events
April 2013

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

When: Wednesday, April 17
Time: 11:30 a.m.-1:00 p.m.

Claims-based data collection and manual medical review of outpatient therapy services

When: Tuesday, April 30
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.

Additional 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:

Note: The link to the February 14 e-News previously published in the February *Medicare B Connection* incorrectly.

- CMS e-News for Wednesday, February 14, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-14-enews.pdf*
- CMS e-News for Wednesday, February 21, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-21-enews.pdf*
- 'CMS Medicare FFS Provider e-News': February 28, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-28Enews.pdf*
- 'CMS Medicare FFS Provider e-News': March 7, 2013 – *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-07-eNews.pdf*
- 'CMS Medicare FFS Provider e-News': March 14, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-14-eNews.pdf*

Source: CMS PERL 201302-02, 201302-03, 201302-04, 201303-01, 201303-03

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
P.O. 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
CGS Administrators, LLC
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

CGS Administrators, LLC
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

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
CGS Administrators, LLC
P.O. Box 20010
Nashville, Tennessee 37202

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

CGS Administrators, LLC
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)
CGS Administrators, LLC
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)

Medicare B Connection

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

Attention Billing Manager