Medicare B CONNECTION

A Newsletter for MAC Jurisdiction 9 Providers

April 2013

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Phase 2 edits for ordered/referred items and services delayed

Important announcement on April 25, 2013: Temporary delay in implementing ordering and referring denial edits. Due to technical issues, the implementation of the phase 2 denial edits is being delayed. These edits would have checked certain claims for an approved or validly opted-out physician or non-physician who is an eligible specialty type with a valid individual national provider identifier (NPI). If this information were missing or incorrect, the following types of claims would deny:

- Claims from laboratories for ordered tests
- Claims from imaging centers for ordered imaging procedures
- Claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for ordered DMEPOS
- Claims from Part A home health agencies (HHAs)

The Centers for Medicare & Medicaid Services (CMS) will advise you of the new implementation date in the near future. In the interim, informational messages will continue to be sent for those claims that would have been denied had the edits been in place. Language regarding beneficiary liability has also been updated in this version of the article.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, an advance beneficiary notice is not appropriate in this situation. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

Note: This article was previously revised on April 19, 2013, to add references to the CMS-1450 form and to add question h. on under "Effect of Edits on Providers." Previously, it was revised on April 3, 2013, to advise providers to not include middle names and suffixes of ordering/referring providers on paper claims. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first letter of the first name and the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html*. This information was

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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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904-361-0723

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

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About the *Medicare B Connection*

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

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website at *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, Puerto Rico, 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 (waiver of liability statement on file).

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

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

Annual *Medicare B Connection* hardcopy registration form

To receive free editions of the Part B publication in hardcopy or email format, you must complete this registration form. To receive a hardcopy or email of future issues of the Part B publication, **your form must be faxed to 1-904-361-0723 by July 9, 2013.** Providers currently receiving hardcopy publications must renew by using this form. **Providers who do not renew by the July 9 deadline will no longer receive free hardcopy versions after the September 2013 issue.** The publication cycle begins every year on October 1 and concludes September 30.

If you miss the registration deadline, you still have the ability to receive a hard copy through subscription. The annual cost for a hardcopy subscription is $33. Please note that you are not obligated to complete this form to access information contained in the Part B publication. Issues dating back to 1997 are available free on First Coast Service Options' provider website: *http://medicare.fcso.com/Publications_B/index.asp*.

Provider/facility name: ____________________

National provider identifier (NPI): ____________________

Address: ____________________

City, state, ZIP code: ____________________

Contact person/title: ____________________

Telephone number: ____________ Fax number: ____________ E-mail address: ____________

Registration type: NEW ❑ RENEWAL ❑

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Fax your completed form to:

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1-904-361-0723

Please share your questions and/or concerns regarding this initiative with us. ____________________

Additional questions or concerns may be submitted via the Medicare provider education website at *http://medicare.fcso.com/Feedback/index.asp*. You also may fax your questions or comments to 1-904-361-0723. **Our Provider Contact Center will not be able to respond to inquiries about this form.**

Medicare fee-for-service claim processing guidance for implementing ICD-10

Note: This article was revised on March 27, 2013, to add a reference to article MM8207 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8207.pdf*), which alerts DMEPOS providers and suppliers of modifications being made to the claims processing systems to report the appropriate NCD/LCD captured during claim processing based on their associations with either ICD-9 or ICD-10 diagnosis codes, the claim line service date, and the and the ICD-10 diagnosis code effective date. This article was previously revised on March 21, 2013, to add a reference to article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information remains unchanged. This information was previously published in the September 2011 *Medicare B Connection*, Pages 5-8.

Provider types affected

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

Provider action needed

For dates of service on and after October 1, 2013, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2013. Make sure your billing and coding staffs are aware of these changes.

Key points of CR 7492

- **General reporting of ICD-10**

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to *http://www.cms.gov/Medicare/Coding/ICD10/index.html* for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

- **General claim submission information**

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2013. Institutional claims containing ICD-9 codes for services on or after October 1, 2013, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2013, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2013, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2013, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2013, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2013, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2013. Institutional claims containing ICD-10 codes for services prior to October 1, 2013, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2013, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

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ICD-10 (*continued*)

- **Claims that span the ICD-10 implementation date**

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional providers

Bill type	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
11x	Inpatient hospitals (incl. TERFHA hospitals, prospective payment system (PPS) hospitals, long term care hospitals (LTCHs), critical access hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
12x	Inpatient Part B hospital services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
13x	Outpatient hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
14x	Non-patient laboratory services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
18x	Swing beds	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
21x	Skilled nursing (inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
22x	Skilled nursing facilities (inpatient Part B)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
23x	Skilled nursing facilities (outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
32x	Home health (inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH

(continued on next page)

ICD-10 (*continued*)

Bill type	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
3x2	Home health – Request for anticipated payment (RAPs)*	* Note - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	*See Note
34x	Home health – (outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
71x	Rural health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
72x	End-stage renal disease (ESRD)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
73x	Federally qualified health clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74x	Outpatient therapy	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
75x	Comprehensive outpatient rehab facilities	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
76x	Community mental health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
77x	Federally qualified health clinics (effective 4/4/10)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
81x	Hospice-hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
82x	Hospice – non-hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM
83x	Hospice – hospital-based	N/A	N/A
85x	Critical access hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013, and later.	FROM

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ICD-10 (*continued*)

Table B - Special outpatient claim processing circumstances

Scenario	**Claim processing requirement**	**Use FROM or THROUGH date**
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional claims

Type of claim	**Claim processing requirement**	**Use FROM or THROUGH date**
All anesthesia claims	Anesthesia procedures that begin on 9/30/13, but end on 10/1/13, are to be billed with ICD-9 diagnosis codes and use 9/30/13, as both the FROM and THROUGH date.	FROM

Table D –Supplier claims

Supplier type	**Claim processing requirement**	**Use FROM or THROUGH/TO date**
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13, and the TO date of service occurs after 10/1/13).	FROM

Additional information

The official instruction, CR 7492, issued to your carrier, FI, RHHI, or MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R950OTN.pdf*.

See article MM7818, available at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7818.pdf*, for information on the creation and updating of hard-coded Medicare shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes and the operational changes needed to implement the conversion.

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

MLN Matters® Number: MM7492 *Revised*
Related Change Request (CR) #: 7492
Related CR Release Date: August 19, 2011
Effective Date: October 1, 2013
Related CR Transmittal #: R950OTN
Implementation Date: January 1, 2012

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Billing the correct units of service

The Centers for Medicare & Medicaid Services (CMS) guidance requires physicians and other providers to bill using the appropriate HCPCS or *CPT*® code and to accurately report the units of service. Physicians and other providers should ensure that the units billed do not exceed the maximum number of units per day based on the code descriptor, reporting instructions associated with the code, and/or other CMS local or national policy.

Source: CR 8247

Diagnostic Services

Incorrect denial of claims for procedure code *95910*

First Coast Service Options Inc. (First Coast) has discovered that claims containing *Current Procedural Terminology* (*CPT*®) code *95910* that were billed with either modifier 26 or TC may have denied in error. The specific message code being received is "Procedure modifier was invalid on the date of service." **This processing issue was corrected March 7**.

No action is required by the provider

First Coast is working diligently to identify all services that have been denied in error and will make any necessary adjustments to impacted claims – it is unnecessary to call the provider contact center regarding these incorrect denials. In addition, First Coast requests that providers do not submit appeal or reopening requests for these impacted claims.

First Coast apologizes for any inconvenience this issue may have caused impacted providers.

Durable Medical Equipment

Payment related to prior authorization for power mobility devices

Note: This article was revised April 8, 2013, to reflect the revised change request (CR) 8056 issued April 5. In this article, the CR release date, transmittal number and the Web address for accessing CR 8056 were revised. All other information remains the same. This information was previously published in the February 2013 *Medicare B Connection*, Page 12.

Provider types affected

This *MLN Matters*® article is intended for Medicare fee-for-service (FFS) physicians/treating practitioners who prescribe power mobility devices (PMDs) for Medicare beneficiaries who reside in the demonstration states of California, Texas, Florida, Michigan, Illinois, North Carolina, and New York and submit a prior authorization request to DME Medicare administrative contractors for a PMD.

Stop – impact to you

This article is based on CR 8056 and outlines the requirements for the PMD demonstration prior authorization initiative.

Caution – what you need to know

If a physician/treating practitioner submits the initial prior authorization request, the physician/treating practitioner is entitled to a G-code (G9156) incentive payment. This incentive payment is for his/her initial prior authorization request for a beneficiary only. Only one G9156 code may be billed per beneficiary per PMD even if the physician/treating practitioner must resubmit the prior authorization request. The $10 incentive payment is issued to the physician/treating practitioner on a quarterly basis by a designated Medicare payment contractor that issues the incentive payments for all Medicare contractors.

Go – what you need to do

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

Background

The Centers for Medicare & Medicaid Services (CMS) has the authority under the Social Security Act (Section 1834(a)(15) see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) to develop and periodically update a list of durable medical equipment (DME) items which are subject to prior authorization before claim payment. Under demonstration authority CMS is proposing a three year prior authorization process for PMDs in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on beneficiary addresses, an initiative

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PMD *(continued)*

referred to hereafter as prior authorization. This initiative is designed as a tool to protect the Medicare Trust Fund by deterring fraudulent and abusive billing practices and make the physician or treating practitioner more accountable for the items he or she orders to prevent improper payments.

Under this PMD demonstration the physician/treating practitioner may submit the prior authorization request. If the prior authorization request is submitted by the physician/treating practitioner, the physician/treating practitioner may bill G9156. The physician/treating practitioner is entitled to a quarterly incentive payment of $10 for each G9156 code that meets all eligibility requirements. G9156 is submitted to the Medicare administrative contractor (A/B MACs) and/or carriers with the PMD prior authorization number. The $10 incentive payment is issued to the physician/treating practitioner on a quarterly basis.

In submitting the G9156 code, providers must also show a billed amount of $10 or the claim will reject. If the G9156 is submitted with other codes, Medicare will split the claim. Thus, providers should submit the G9156 code on an assigned claim with no other codes.

Additional information

The official instruction, CR 8056, 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/R1205OTN.pdf*.

MLN Matters® article SE1231 outlines the parameters for the PMD demonstration project and may be reviewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1231.pdf*.

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

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End-Stage Renal Disease

Widespread probe results of end-stage renal disease services

First Coast Service Options Inc. (First Coast) conducted a widespread probe (WSP) in response to an aberrant billing pattern identified for *CPT*® *90960* (*End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face physician visits per month*) billed by specialty 39 (Nephrology) and 11 (Internal Medicine). Puerto Rico is ranked number 2 in the nation with a carrier-to-nation ratio of 2.60. A sample of 100 claims was requested among the top performing providers in Puerto Rico. The results of the widespread probe yielded a 51.62 percent error rate.

Twenty one of the one hundred claims were down coded because the documentation did not support the level of service billed. Forty five claims were denied due to:

- No documentation submitted to support the services billed;
- Insufficient documentation to support the billed service including no evidence that a face-to face visit was made;
- Illegible documentation;
- Progress notes not signed by the physician or the physician's signature was illegible; and
- Documentation submitted did not match the dates of service requested.

Widespread *(continued)*

The following is a brief summary of Medicare requirements for billing end-stage renal disease services.

A physician's services, furnished to dialysis patients who are treated as outpatients, are divided into two major categories: direct patient care and administrative services. Medicare covers physician services furnished to beneficiaries on continuous ambulatory peritoneal dialysis (CAPD).

A. Direct patient care services

These services are part of the medical treatment furnished to an individual patient that:

1. Are personally furnished by a physician to an individual patient;
2. Contribute directly to the diagnosis or treatment of an individual patient; and
3. A physician must ordinarily perform.

They include:

- Visits to the patient during dialysis, in conjunction with review of laboratory test results, nurses' notes, and any other medical documentation, as a basis for adjustment of the patient's medication or diet or the dialysis procedure, prescription of medical supplies, and evaluation of the patient's psychosocial status and the appropriateness of the treatment modality.

- Medical direction of staff in delivering services to a patient during a dialysis session;
- Pre- and post-dialysis examinations where medically appropriate;
- Insertions of a catheter for patients on maintenance peritoneal dialysis who are not provided an indwelling catheter;
- Services which must be furnished at a time other than during the dialysis procedure; e.g., monthly and semi-annual examinations to review health status and treatment; and
- Other services furnished during dialysis; e.g., declotting of shunts, needle insertions into fistulae, care during immediately life-threatening complications related to the dialysis procedure, and care of nonrenal conditions.

B. Administrative services

A component of the facility's cost or charge for dialysis is for "administrative services" furnished by physicians. Administrative services are differentiated from physicians' direct patient care services because they constitute supervision of staff or are not directly related to the care of an individual patient, but benefit all patients and the facility as a whole. The administrative type of physician's services are services that are supportive of the facility as a whole and have benefit to patients in general. Examples of such services include participation in management of the facility, advice on and procurement of facility equipment and supplies, supervision of staff, staff training, and staff conferences. The carrier will disallow all claims for these services with an explanation that such services are paid as part of the dialysis services that are included in the facility charge for dialysis.

The Centers for Medicare & Medicaid Services (CMS) requires that any Medicare service provided or ordered must be authenticated by the author – the one who provided or ordered that service. Authentication may be accomplished through the provision of a hand-written or an electronic signature; however, stamp signatures are unacceptable.

In addition, any documentation submitted to substantiate the medical necessity for a service billed to Medicare must clearly identify the patient, date of service, and the provider of the service. The purpose of the authentication (signature) requirement is to ensure that the services rendered have been accurately and appropriately documented, reviewed, and authenticated.

CMS outlines signature requirements for medical documentation as well as exceptions to the guidelines in the *Medicare Program Integrity Manual*, Publication 100-08, Chapter 3, Section 3.4.1.1, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf#page=46*.

(continued on next page)

Widespread *(continued)*

ESRD-related visits may be furnished as a Medicare telehealth service and for general Medicare telehealth policy see Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 270, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf#page=239*. For claim processing instructions see Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 190 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf#page=189.*

Providers are encouraged to review the complete requirements for billing end-stage renal disease services in the following Internet-only manuals (IOM):

Medicare Claims Processing Manual, Chapter 8, Section 140 – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf#page=118*

Medicare Benefit Policy Manual, Chapter 11, Section 80.2 – *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf#page=42*

Evaluation and Management

Recovery of annual wellness visit overpayments

Note: This article was revised April 11, 2013, to reflect changes made to change request (CR) 8153 April 11. The revision clarified the types of contractors taking recovery actions. Information has been added in the last paragraph in the *Background* section. The transmittal number, CR release date, and Web address of the CR was also changed. All other information is unchanged. This information was previously published in the March 2013 *Medicare B Connection*, Pages 22-23.

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 MACs for certain services to Medicare beneficiaries.

What you need to know

This article is based on 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

(continued on next page)

AWV *(continued)*

service. In other instances, both a professional and institutional claims 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.

For providers who submit claims to Part B MACs or Medicare carriers, contractors will use procedures for recovering overpayments, as provided in the *Medicare Financial Management Manual*, Chapter 3, Overpayments and Chapter 4, Debt Collection (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf*). For these overpayments that 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/R1209OTN.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*.

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*.

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Update to CMS' FAQs for billing transitional care management services

The Centers for Medicare & Medicaid Services (CMS) has updated its frequently-asked questions regarding billing Medicare for transitional care management services. Effective January 1, 2013, Medicare will pay *Current Procedural Terminology®* (*CPT®*) codes *99495* and *99496*, which are used to report physician or qualifying non-physician practitioner care management services for a patient following a discharge from a hospital, skilled nursing facility (SNF), or community mental health center (CMHC) stay, outpatient observation, or partial hospitalization.

For more information, please refer to *CMS' frequently-asked questions about billing Medicare for transitional care management services*.

Medicare Physician Fee Schedule Database

April update to the 2013 Medicare physician fee schedule database

Note: This article was revised March 26, 2013, to reflect a revised change request (CR) 8169 issued March 26, 2013. In this article, the CR transmittal number, CR release date, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published. This information was previously published in the March 2013 *Medicare B Connection*, Pages 20-21.

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 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
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

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MPFSDB *(continued)*

HCPCS code	Old short description	Revised short description
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
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 test: *95907, 95908, 95909, 95910*, *95911, 95912*, and *95913*, are having their 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*, their 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/R2677CP.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*.

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Automatic budget cuts to Medicare effect durable medical equipment rental rates

Medicare fee-for-service claims were reduced by 2 percent for dates of service or dates of discharge on or after April 1, 2013, as a result of automatic budget cuts known as the sequester.

The Centers for Medicare & Medicaid Services (CMS) released the following frequently asked question (FAQ) to clarify how the reduction will affect durable medical equipment rentals.

Q: If a durable medical equipment capped rental period started before April 1, 2013, are the rental payments for months after April 1, 2013, subject to the 2 percent reduction?

A: Any claims for rental payments with a "FROM" date of service on or after April 1, 2013, will be subject to the 2 percent reduction, regardless of when the rental period began. For example, if a capped rental wheelchair was provided in February 2013, the monthly rental payment for May 2013 would be subject to the 2 percent sequestration reduction. The initial and subsequent monthly rental payments billed with a "FROM" date of service beginning on or prior to March 31, 2013 would not be affected by the 2 percent reduction.

Q: How long is the 2 percent reduction to Medicare fee-for-service claim payments in effect?

A: The law specifies that the 2 percent reduction to Medicare fee-for-service payments resulting from the sequestration order that the President was required to issue March 1, 2013, applies to all payments for services furnished in the one-year period after the reductions begin. For Medicare, the reductions begin on the first day of the first month after the order is issued, meaning they began April 1, 2013. Accordingly, this sequestration order covers all payments for services with dates of service or dates of discharge (or a start date for rental equipment or multi-day supplies) April 1, 2013, through March 31, 2014.

Q: Are drugs excluded from the 2 percent reduction?

A: No. All fee-for-service Medicare claim payments are subject to the 2 percent reduction. There are no exemptions provided in the law for drugs or any other health care item or service provided under the fee-for-service program.

Note: Previous FAQs related to sequestration were published in the March 2013 *Medicare B Connection*, Pages 18-19. You may also access the complete list at *http://medicare.fcso.com/faqs/answers/252060.asp*.

Radiology

Magnetic resonance imaging in Medicare beneficiaries with FDA-approved implanted permanent pacemakers

Note: This article was revised on March 22, 2013, to add a reference to article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information is the same. This information was previously published in the September 2011 *Medicare B Connection*, Pages 27-28.

Provider types affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), carriers, or A/B Medicare administrative contractors (A/B MAC)) for providing magnetic resonance imaging (MRI) services to Medicare beneficiaries are affected.

What you need to know

This article, based on change request (CR) 7441, informs you that Medicare believes that the evidence is adequate to conclude that MRIs improve health outcomes for Medicare beneficiaries with implanted Pacemakers (PMs) when the PMs are used according to the Food and Drug Administration (FDA)-approved labeling for use in an MRI environment. Effective for services on or after July 7, 2011, Medicare will allow coverage of MRIs for beneficiaries with implanted PMs when the PMs are used according to the FDA-approved labeling for use in an MRI environment.

Effective for claims with dates of service on or after July 7, 2011, you should include the following information on MRI claims for beneficiaries with implanted PMs that are FDA-approved for use in an MRI environment:

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MRI *(continued)*

- Appropriate MRI code;
- KX modifier; and
- ICD-9 code V45.01 (cardiac pacemaker).

Inclusion of the KX modifier on the claim line(s) means that the provider attests that documentation is on file verifying that FDA-approved labeling requirements are met. For such claims without the KX modifier, Medicare will deny MRI line items using the following remittance advice messages:

- Group code of CO (contractual obligation)
- Claim adjustment reason code (CARC) 188 (This product/procedure is only covered when used according to FDA recommendations.).

As described previously in the *MLN Matters®* article MM7296 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7296.pdf*), Medicare posted a separate decision on February 24, 2011, that allows coverage of MRIs for beneficiaries with implanted PMs or implantable cardioverter defibrillators (ICDs) for use in an MRI environment in a Medicare-approved clinical study. This policy is effective for claims with dates of service on and after February 24, 2011. Providers should follow the instructions issued in the MM7296 article and the additional instructions referenced below.

The following information should be included on MRI claims for beneficiaries with implanted PMs or ICDs for use in an MRI environment in a Medicare-approved clinical study:

- Appropriate MRI code
- Q0 modifier
- ICD-9 code V70.7 - Examination of participant in clinical trial (institutional claims only)
- Condition code 30 (institutional claims only)
- ICD-9 code V45.02 (automatic cardiac defibrillator) or CPT code V45.01 (cardiac pacemaker)

MRI claims for beneficiaries with implanted PMs or ICDs for use in an MRI environment in a Medicare-approved clinical study that do not include all the line items listed above will be denied using the following remittance messages:

- Group code of CO
- CARC B5 (Coverage/program guidelines were not met or were exceeded)
- Remittance advice remarks code (RARC) N386 (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. If you do not have web access, you may contact the contractor to request a copy of the NCD).

Providers are reminded that ICD-10 implementation occurs on October 1, 2013. At that time the ICD-9 codes mentioned above will be replaced by the appropriate ICD-10 codes, which are:

- ICD-10 - Z006 - Encounter for examination for normal comparison and control in clinical research program;
- ICD-10- Z950 - Presence of cardiac pacemaker; and
- ICD-10- Z95810 - Presence of automatic implantable cardiac defibrillator.

Medicare payment for these services is as follows:

- Professional claims (practitioners and suppliers) - based on the Medicare physician fee schedule (MPFS).
- Inpatient (type of bill (TOB) 11x) - Prospective payment system (PPS), based on the diagnosis-related group.

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MRI *(continued)*

- Hospital outpatient departments (TOB 13x) - Outpatient PPS, based on the ambulatory payment classification.
- Rural health clinics (RHCs)/federally qualified health centers (FQHCs) (TOB 71x/77x) - All-inclusive rate, professional component only, based on the visit furnished to the RHC/FQHC beneficiary to receive the MRI. The technical component is outside the scope of the RHC/FQHC benefit. Therefore the provider of the technical service bills their carrier or A/B MAC on the ANSI X12N 837P or hardcopy Form CMS-1500 and payment is made under the MPFS.
- Critical access hospitals (CAHs) (85x) - For CAHs that elected the optional method of payment for outpatient services, the payment for technical services would be the same as the CAHs that did not elect the optional method, which is reasonable cost. The FI or A/B MAC pays the professional component at 115 percent of the MPFS.

Medicare will not adjust claims automatically that were processed prior to implementation of CR 7441. However, they will adjust such claims that you bring to the attention of your Medicare contractor.

Please be sure that your staffs are aware of these changes.

Additional information

To view the article, MM7296, "Magnetic Resonance Imaging (MRI) in Medicare Beneficiaries with Implanted Permanent Pacemakers (PMs) or Implantable Cardioverter Defibrillators (ICDs)," visit *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7296.pdf*.

The official instruction, CR 7441, was issued to your FI, carrier, or A/B MAC regarding this change in two transmittals. The first modified the National Coverage Determinations Manual and is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R135NCD.pdf*.

The second updates the *Medicare Claims Processing Manual* and is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2307CP.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*.

For current information on the new ICD-10 implementation date of October 1, 2014, see article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*.

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Related CR Transmittal #: R2307CP and R135NCD
Implementation Date: September 26, 2011

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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.

General Coverage

Clarification of manual instructions regarding the detection of duplicate claims

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

The purpose of this change request (CR) is for **clarification only** and does not constitute any change in Medicare policy. The Centers for Medicare & Medicaid Services (CMS) is alerting providers to the update of the *Medicare Claims Processing Manual*, Chapter 1, Section 120: "Detection of Duplicate Claims."

Caution – what you need to know

Change request (CR) 8121, from which this article is taken, alerts providers that the claim processing systems contain edits which identify duplicate claims and suspect duplicate claims. All exact duplicate claims or claim lines are auto-denied or rejected (absent appropriate modifiers). Suspect duplicate claims and claim lines are suspended and reviewed by the Medicare contractors to make a determination to pay or deny the claim or claim line.

Go – what you need to do

Please be aware that Medicare contractors examine and compare to the prior bill any bill that is identified as a suspect duplicate. If the services (revenue or HCPCS codes) on a claim duplicate the services for the other, contractors will check the diagnosis. If the diagnosis codes are duplicates, contractors will request an explanation before making payment. The official instruction for CR 8121 spells out what your Medicare contractor looks for when analyzing the history of paid and pending claims, duplicate claims and the criteria for detecting suspect duplicate claims.

Background

Some claims that appear to be duplicates are actually claims or claim lines that contain an item or service, or multiple instances of an item or service, for which Medicare payment may be made. Correct coding rules applicable to all billers of health care claims encourage the appropriate use of condition codes or modifiers to identify claims that may appear to be duplicates, but are in fact, not.

For example, there are some Healthcare Common Procedure Coding System (HCPCS) modifiers that are appropriate to be appended to some services and can indicate that a claim line is not a duplicate of a previous line on the claim. Level I modifiers would typically be used by a biller to indicate that a potential duplicate claim or claim line is not, in fact, a duplicate. Level II modifiers may also be used. The level II modifiers "RT" and "LT," for example, indicate that a service was performed on the right and left side of the body, respectively.

However, not every HCPCS code has an appropriate modifier to indicate that a claim line is not a duplicate. In that case, the claims and claim lines are reviewed by Medicare contactors' local software modules for a determination, or they suspend for contractor review.

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Duplicate *(continued)*

Key points of CR 8121

Exact duplicates

A. Submission of institutional claims

Claims or claim lines that have been determined an exact duplicate are rejected and do not have appeal rights. An exact duplicate for institutional claims is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- Health insurance claim (HIC) number
- Type of bill
- Provider identification number
- From date of service
- Through date of service
- Total charges (on the line or on the bill)
- HCPCS, *CPT*®-4, or procedure code/modifiers

Whenever any of the following claim situations occur, your Medicare contractor develops procedures to prevent duplicate payment of claims. This includes, but is not limited to:

- Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider.
- Outpatient bill is submitted for services on the day of an inpatient admission or the day before the day of admission to the same hospital.
- Outpatient bill overlaps an inpatient admission period.
- Outpatient bill for services matches another outpatient bill with a service date for the same revenue code at the same provider or under a different provider number.

B. Claims submitted by physicians, practitioners, and other suppliers (except DMEPOS suppliers)

Claims or claim lines that have been determined an exact duplicate are denied. Such denials may be appealed. An exact duplicate for physician and other supplier claims submitted to a MAC or carrier is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- HIC number
- Provider number
- From date of service
- Through date of service
- Type of service
- Procedure code
- Place of service
- Billed amount

C. Claims submitted by DMEPOS suppliers

Claims or claim lines that have been determined an exact duplicate are denied. Such denials may not be appealed. An exact duplicate for DMEPOS supplier claims submitted to a DME MAC is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- HIC number
- From date of service
- Through date of service
- Place of service

(continued on next page)

Duplicate *(continued)*

- HCPCS
- Type of service
- Billed amount
- Supplier

Suspect duplicates

Suspect duplicates are claims or claim lines that contain closely aligned elements and require that the claim be reviewed.

A. Criteria for detecting suspect duplicates on institutional claims

A "suspect duplicate" claim is a claim being processed which, when compared to Medicare's history or pending files, begins with these characteristics:

- Match on the beneficiary information
- Match on provider identification
- Same date of service or overlapping dates of service

B. Suspect duplicate claims submitted by physicians and other suppliers (including DMEPOS claims)

The criteria for identifying suspect duplicate claims submitted by physicians and other suppliers vary according to the type of billing entity, type of item or service being billed, and other relevant criteria. The denial of claim as a duplicate of another claim may be appealed when the denial is based on criteria other than those specified above for exact duplication.

Additional information

You can find the official instruction, CR 8121, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2678CP.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*.

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Related Change Request (CR) #: CR 8121
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April 2013 claim hold lifted

The Centers for Medicare & Medicaid Services has directed its Medicare claims administration contractors to release all claims into processing that they have been holding as a result of technical issues associated with the April 2013 quarterly systems release. The claim types being released on Wednesday, April 17, 2013, are (1) home health final claims, (2) outpatient critical access hospital and rural health clinic claims where dollars have been applied to the beneficiary deductible, (3) inpatient prospective payment (IPPS) system claims with new technology add-on payments, (4) IPPS claims with outlier payments, (5) outpatient claims with outlier payments, (6) end-stage renal disease claims with outlier payments, and (7) psychiatric hospital claims with outlier payments and no other payment. In summary, at this time all Medicare fee-for-service claims are being processed under normal procedures.

As a reminder, the Medicare claim administration contractors released the Medicare Advantage IPPS with indirect medical education claims as well as the assistant-at-surgery services and ambulatory surgical center claims into processing on Monday, April 15, 2013.

Source: CMS PERL 201304-07

Physician delegation of tasks in skilled nursing facilities and nursing facilities

Provider types affected

This *MLN Matters®* article special edition (SE) is intended for physicians, non-physician practitioners (NPPs) and providers who bill for services related to beneficiaries in skilled nursing facilities (SNFs) and nursing facilities (NFs).

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is publishing this article to provide clarification of federal guidance regarding Section 3108 of the Affordable Care Act (ACA), related to physician delegation of certain tasks in SNFs and NFs to NPPs (NPPs are formerly "physician extenders") such as nurse practitioners (NPs), physician assistants (PAs), or clinical nurse specialists (CNSs).

This article addresses the authority of NPs, PAs, or CNSs to perform certain tasks such as conducting physician visits and writing orders, and to sign certifications and re-certifications.

Background

CMS is clarifying the regulatory differences concerning physician delegation of tasks in SNFs and NFs. The distinction in policies between these two settings (SNFs and NFs) is based in statute and regulation. Improper application of these regulations may affect a facility's compliance and payment to providers.

The key to accurate application is to identify:

1. In which setting, SNF or NF, the physician services are being provided;
2. Whether the task must be performed personally by the physician; and
3. Whether or not the NPP is employed by the facility.

The "setting" is determined by whether the visit to a patient in a certified bed is:

1. To a resident whose care is paid for by Medicare Part A in a SNF; or
2. To a resident whose care is paid for by Medicaid in a NF.

Key points

The requirements for long-term care facilities, specified in 42 CFR Section 483.40(e)(2), provide that, "A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under state law or by the facility's own policies." The following bullets outline when and which tasks may be delegated:

Physician required and other medically necessary visits during a SNF stay:

- A required physician visit includes the initial comprehensive visit in a SNF and every alternate required visit thereafter. (See 42 CFR 483.40(c)(4).) The initial comprehensive visit in a SNF is the initial visit during which:
  - The physician completes a thorough assessment; and
  - Develops a plan of care and writes or verifies admitting orders for the resident.
- The initial comprehensive visit must occur no later than 30 days after a resident's admission into the SNF. The physician may not delegate the initial comprehensive visit in a SNF.
- NPPs may perform other medically necessary visits prior to and after the physician's initial comprehensive visit.

(continued on next page)

Delegation *(continued)*

- Once the physician has completed the initial comprehensive visit in the SNF, the physician may then delegate alternate visits to a PA, NP, or CNS who is licensed as such by the state and performing within the scope of practice in that state. These alternate visits, as well as medically necessary visits, may be performed and signed by the NPP (physician co-signature is not required).

Certifications/re-certifications in SNFs:

- 42 CFR 424.20(e)(2) (which reflects the requirements of section 1814 (a)(2) of the Social Security Act (Act)) states that NPs and CNSs who are not employed by the facility and who are working in collaboration with a physician may sign the required initial certification and re-certifications of a beneficiary's need for SNF level of care.
- Effective with services furnished on or after January 1, 2011, physician assistants who are not employed by the facility are authorized to perform the required initial certification and periodic re-certifications of a beneficiary's need for a SNF level of care.

Performance of physician tasks in NFs:

- Similar to a SNF, the initial comprehensive visit in a NF is the initial visit during which:
  - The physician completes a thorough assessment; and
  - Develops a plan of care and writes or verifies admitting orders for the resident.
- The initial comprehensive visit must occur no later than 30 days after admission.

Note: At the option of the state, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a NP, CNS, or PA who is not an employee of the facility but who is working in collaboration with a physician.

In other words, NPPs that have a direct relationship with a physician and who are not employed by the facility may perform the initial comprehensive visit, any other required physician visit, and other medically necessary visits for a resident of a NF as the state allows. NPPs may also perform other medically necessary visits prior to and after the physician initial comprehensive visit.

Medically necessary visits performed by NPs, CNSs, and PAs employed by the facility may not take the place of the physician required visits, nor may the visit count towards meeting the required physician visit schedule prescribed at 42 CFR 483.40(c)(1).

However:

- At the option of the state, NPs, PAs, and CNSs who are employees of the facility, while not permitted to perform visits required under the schedule prescribed at 42 CFR 483.40(c)(1), are permitted to perform other medically necessary visits and write orders based on these visits.
  - For example, if a resident complains of a headache, the NP, CNS, or PA employed by the NF may assess the resident and write orders to address the condition;
  - The physician is not required, other than by state law as applicable, to verify and sign orders written by NPPs who are employed by the facility for other medically necessary visits; and
  - These medically necessary visits performed by NPs, CNSs, and PAs employed by the facility may not take the place of the physician required visits, nor may the visit count towards meeting the required physician visit schedule prescribed at 42 CFR 483.40(c)(1).

NPs, PAs and CNSs must collaborate with a physician:

- In contrast to the initial SNF visit, NPPs may provide initial NF visits and other required visits under 42 CFR 483.40(c)(3) and (f) if the state permits it;
- Required physician tasks, such as verifying and signing orders in an NF, may be delegated to a PA, NP, or CNS who is not an employee of the facility, but who is working in collaboration with a physician; and
- Orders written by an NPP who is employed by the NF and are written during visits that are not required visits, and are therefore "other medically necessary visits," do not require physician co-signature except as mandated by state law.

CMS is issuing this clarification because, where a NPP is permitted to perform a medically necessary visit, the NPP is likewise permitted to write applicable orders during that visit. The federal requirements restricting NPPs who are employed by the NF from performing a required visit, do not apply to other medically necessary visits.

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Delegation *(continued)*

Thus, this guidance clarifies when an NPP employed by a NF may write orders without a countersignature unless state law requires it.

Note: The following regulatory language is included for reference purposes:

Section 483.40(f) Performance of Physician Tasks in NFs: At the option of the state, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.

Dually-certified facilities (SNF/NFs)

In a facility where beds are dually–certified under Medicare and Medicaid, the facility must determine how the particular resident stay is being paid.

- For residents in a Part A Medicare stay, the NPP must follow the guidelines for services in a SNF.
- For residents in a Medicaid stay, the NPP must follow the provisions outlined for care in NFs.
- In a dually certified nursing home, any required physician task for a Medicaid beneficiary in a Medicaid stay, at the option of the state, may be performed by a NPP who is not an employee of the facility but who is working in collaboration with a physician.
- In a dually-certified nursing home and at the option of a physician, required physician visits for a Medicare beneficiary in a Part A Medicare stay may be alternated between personal visits by the physician and visits by a NPP after the physician makes the initial first visit.

The following table summarizes the requirements for NPPs to perform visits, sign orders, and sign certifications and re-certifications, when this function is permitted under the scope of practice for the state.

Authority for NPPs to perform visits, sign orders and sign certifications/re-certifications when permitted by the state*

Provider type	Initial comprehensive visit/orders	Other required visits^	Other medically necessary visits & orders+	Certification/recertification
SNFs				
PA, NP & CNS employed by the facility	May not perform/may not sign	May perform alternate visits	May perform and sign	May not sign
PA, NP & CNS not a facility employee	May not perform/may not sign	May perform alternate visits	May perform and sign	May sign subject to state requirements
NFs				
PA, NP & CNS employed by the facility	May not perform/may not sign	May not perform	May perform and sign	Not applicable ±
PA, NP & CNS not a facility employee	May perform/ may sign	May perform	May perform and sign	Not applicable ±

*This reflects clinical practice guidelines

^Other required visits are the required monthly visits.

+Medically necessary visits may be performed prior to the initial comprehensive visit.

± This requirement relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.

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Delegation *(continued)*

Additional Information

To review 42 CFR 483.40, go to *http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec483-40.pdf*.

To review 42 CFR 424.20 go to *http://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol3/pdf/CFR-2009-title42-vol3-sec424-20.pdf*.

To review the memorandum that is the basis for this article and discusses physician delegation of tasks in SNFs and NFs go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-15-.pdf*.

To review the Section 3108 of the Affordable Care Act (page 300), Permitting Physician Assistants To Order Post-Hospital Extended Care Services, go to *http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf*.

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ICD-10 conversion and related code infrastructure of Medicare shared system as related to NCDs

Provider types affected

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

Provider action needed

Change request (CR) 8197, from which this article is taken, creates and updates national coverage determination (NCD) hard-coded shared system edits that contain International Classification of Diseases (ICD)-9 diagnosis codes with the comparable ICD-10 diagnosis codes, along with all related coding infrastructure such as procedure codes, Healthcare Common Procedure Coding System/*Current Procedural Terminology* (HCPCS/*CPT*®) codes, messages, frequency edits, place of service/type of bill (POS/TOB), provider specialties, etc.

The requirements it describes reflect the operational changes that are necessary to implement the conversion of the Medicare shared system coding from ICD-9 to ICD-10 specific to 30 NCDs that are attachments to CR 8197.

In order to be prepared to meet the timeline to implement the new ICD-10 diagnosis codes October 1, 2014, the shared systems began implementation of the necessary changes to the NCDs in the January 2013, quarterly release with CR 7818, followed by CR 8109 in the April 2013, quarterly release and culminates with this CR split between the July 2013, and October 2013, quarterly releases.

See the *Background* and *Additional information* sections of this article for further details regarding these changes, and be sure that you are ready for ICD-10 implementation by October 1, 2014.

Background

As announced in CMS-40-F, 45 CFR Part 162 [CMS-0040-F] RIN 0938-AQ13, "Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements, and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets" (September 5, 2012), effective October 1, 2014, all Medicare claim submissions will convert from the 9th Edition (ICD-9) to the 10th Edition (ICD-10).

(You can find this document at *http://www.gpo.gov/fdsys/pkg/FR-2012-09-05 on pages 54663-54720*.)

(continued on next page)

Infrastructure *(continued)*

All Health Insurance Portability and Accountability Act (HIPAA)-covered entities must adhere to the conversion, which will require business and systems changes throughout the health care industry. In accordance, per the ICD-10 final rule, published in the January 16, 2009, *Federal Register*, (see *http://www.gpo.gov/fdsys/pkg/FR-2009-01-16/pdf/E9-740.pdf*). The Secretary of the Department of Health and Human Services adopts the ICD-10-CM and ICD-10-PCS code sets for use in appropriate HIPAA standard transactions (including those submitted in both electronic and paper formats) effective October 1, 2014.

General information found in spreadsheets in the attachments

Thirty spreadsheets are attached to CR 8197 indicating certain affected ICD-9 codes and their corresponding ICD-10 codes as they relate to their respective NCDs, in addition to the rest of the coding infrastructure specific to each NCD. To access the attachments, go to the *Downloads* section at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R1199OTN.html*.

Each spreadsheet contains the following information:

- NCD number/title
- Internet-Only Manual (IOM) searchable link related to the NCD
- Medicare coverage database (MCD) searchable link related to the NCD

Within each spreadsheet, there are three tabs:

- ICD diagnosis
- ICD
- Rule description

Spreadsheets attached to CR 8197 explain the following NCDs:

NCD	Title
20.4	Implantable Automatic Defibrillator
20.7	Percutaneous Transluminal Angioplasty
20.16	Cardiac Output Monitoring by Thoracic Electrical Bioimpedance
20.30	Microvolt T-Wave Alternans
20.31	Intensive Cardiac Rehabilitation Programs
20.31.1	The Pritikin Program
20.31.2	Ornish Program for Reversing Heart Disease
40.1	Diabetes Outpatient Self-Management Training
40.7	Outpatient Intravenous Insulin Treatment
50.3	Cochlear Implantation
100.14	Surgery for Diabetes
110.4	Extracorporeal Photopheresis
110.8.1	Stem Cell Transplantation
150.10	Lumbar Artificial Disc Replacement
180.1	Medical Nutrition Therapy
190.1	Histocompatibility Testing
190.3	Cytogenetic Studies
190.5	Sweat Test
190.8	Lymphocyte Mitogen Response Assays
190.11	Home Prothrombin Time/International Normalized Ratio Monitoring for Anticoagulation Management
210.2	Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer
210.4	Smoking and Tobacco-Use Cessation Counseling
210.4.1	Counseling to Prevent Tobacco Use
210.7	Screening for the Human Immunodeficiency Virus Infection

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Infrastructure *(continued)*

NCD	Title
210.10	Screening for Sexually Transmitted Infections and High-Intensity Behavioral Counseling to Prevent STIs
220.4	Mammograms
220.6.16	FDG PET for Infection and Inflammation
220.6.19	Positron Emission Tomography (NaF-18) to Identify Bone Metastasis of Cancer
260.1	Adult Liver Transplantation
260.9	Heart Transplants

Should your contractor deny claims associated with the NCDs addressed by CR 8197, they will use:

- Group code PR (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed Advance Beneficiary Notice of Noncoverage (ABN) is on file).
- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
- Claim adjustment reason code (CARC) 50: These services are non-covered services because this is not deemed a "medical necessity" by the payer; and

Additionally, where appropriate and not specifically indicated in the various attached spreadsheets, they will use:

- Remittance advice remark code (RARC) N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Additionally, NCD 190.11 includes a change to CR 6313 dated January 8, 2009, and is also a change to the spreadsheet attached to CR 8109/TR 1162.

Likewise, NCD 110.4 includes a change to CR 7806/TR 2551 correction dated September 24, 2012, that removed 996.88 from CR 7806 dated August 3, 2012, and a change to the spreadsheet attached to CR 7818 dated September 14, 2012.

Additional information

The official instruction, CR 8197, issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1199OTN.pdf*.

You will find spreadsheets that contain all affected ICD-9 codes and their corresponding ICD-10 codes as they relate to their respective NCDs, in addition to the rest of the coding infrastructure specific to each NCD as attachments to this CR. To access those spreadsheets, visit the *Downloads* section at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R1199OTN.html*.

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

MLN Matters® Number: MM8197
Related Change Request (CR) #: CR 8197
Related CR Release Date: March 15, 2013
Effective Date: Please note that the implementation date is prior to the effective date in order to be prepared to meet the timeline to implement the new ICD-10 diagnosis codes October 1, 2014. The shared systems began implementation of the necessary changes to the NCDs in the January 2013 systems release with CR 7818, followed by CR 8109 in the April 2013 release, and finishing up with this CR split between the July 2013 and October 2013 releases (analysis and design/implementation).
Related CR Transmittal #: R1199OTN
Implementation Date: July 1, 2013

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

Note: This article was revised March 27, 2013, to add a reference to article MM8207 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8207.pdf*) to alert DMEPOS providers and suppliers of modifications being made to the claim processing systems to report the appropriate NCD/LCD captured during claim processing based on their associations with either ICD-9 or ICD-10 diagnosis codes, the claim line service date, and the ICD-10 diagnosis code effective date. It was previously revised, to add information on accessing the attachment to change request (CR) 7818. All other information is unchanged. This information was previously published in the October 2012 *Medicare B Connection*, Page 23.

Provider types affected

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

Provider action needed

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

Background

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

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

The purpose of CR 7818 is to both create and update NCD hard-coded Medicare shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes, plus all associated editing such as procedure codes, HCPCS/*CPT*® codes, denial messages, frequency edits, place of service (POS)/type of bill (TOB)/provider specialty editing, etc. The requirements described in CR 7818 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the Medicare NCDs listed as an attachment to CR 7818. To access that attachment, visit *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals-Items/R1122OTN.html*.

Note: This exercise is in no way intended to expand, restrict, or alter existing Medicare national coverage. Also, it is not intended to minimize the authority granted to Medicare administrative contractors (MACs) in their discretionary implementation of NCDs or local coverage determinations (LCDs). However, where hard-coded

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ICD-10 *(continued)*

edits were not initially implemented due to time and/or resource constraints, doing so at this time will better serve the intent and integrity of national coverage and the Medicare program overall.

Additional information

The official instruction, CR 7818, issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1122OTN.pdf*. To access the attachment to CR 7818, visit *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals-Items/R1122OTN.html*.

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: MM7818 Revised
Related Change Request (CR) #: CR 7818
Related CR Release Date: September 14, 2012
Effective Date: October 1, 2014
Related CR Transmittal #: R1122OTN
Implementation Date: January 7, 2013

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

Revised and clarified place of service coding instructions

Note: This article was revised on April 9, 2013, to revise the second sentence of the "Provider types affected" section. All other information is the same. This information was previously published in the December 2012 *Medicare B Connection*, Pages 36-41.

Provider types affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers and Medicare administrative contractors (A/B MACs)) for services paid for under the Medicare physician fee schedule (MPFS). Clarification on the place of service for pathology and laboratory services will be provided through another change request (CR) and subsequent provider education article.

What you need to know

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

Background

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

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

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Place *(continued)*

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

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

A previous CMS instruction, transmittal 1873 (now rescinded) regarding the assignment of POS codes, instructed physicians to use the 2-digit POS code to describe where he/she was physically when rendering the service; in this instance, the POS code corresponded to the service location. (CMS-1500 claim form Items 24B and 32, respectively, and the corresponding loops on the ANSI 12X N 837-P electronic format information). The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable “locality” and geographic practice cost index (GPCI)-adjusted payment for each service paid under the MPFS.

CR 7631 establishes that for all services – with two (2) exceptions – paid under the MPFS, that the POS code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule will apply to the overwhelming majority of MPFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician/practitioner will be the setting in which the beneficiary received the technical component (TC) of the service. For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary’s MRI from his/her office location – POS 22 will be used on the physician’s claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

There are two exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as a registered inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service. The correct POS code assignment will be for that setting in which the beneficiary is receiving inpatient care or outpatient care from a hospital, including the inpatient hospital (POS 21) or the outpatient hospital (POS 22). In other words, reporting the inpatient hospital POS 21 or the outpatient hospital POS 22, is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient or an outpatient of a hospital respectively. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient (or hospital outpatient), the appropriate inpatient POS code (or appropriate outpatient POS code) may be reported consistent with the code list annotated in Publication 100-04, *Medicare Claims Processing Manual*, Chapter 26, Section 10.5.

However, it is more important that the physician/practitioner report the POS consistent with the patient’s general inpatient or outpatient hospital status than the precise inpatient/ outpatient POS code (in order to trigger the facility payment rate under the PFS). The *Medicare Claims Processing Manual* (Chapter 26) already requires this for physician services (and for certain independent laboratory services) provided to beneficiaries in the inpatient hospital and CR 7631 clarifies this exception and extends it to beneficiaries of the outpatient hospital, as well.

Facility and non-facility payment assignments

List of settings where a physician’s services are paid at the facility rate include:

- Inpatient hospital (POS 21)
- Outpatient hospital (POS 22)
- Emergency room-hospital (POS 23)
- Medicare-participating ambulatory surgical center (ASC) for a Healthcare Common Procedure Coding System (HCPCS) code included on the ASC approved list of procedures (POS 24)

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Place *(continued)*

- Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS 24)
- Military treatment facility (POS 26)
- Skilled nursing facility (SNF) for a Part A resident (POS 31)
- Hospice – for inpatient care (POS 34)
- Ambulance – land (POS 41)
- Ambulance – air or water (POS 42)
- Inpatient psychiatric facility (POS 51)
- Psychiatric facility - partial hospitalization (POS 52)
- Community mental health center (POS 53)
- Psychiatric residential treatment center (POS 56)
- Comprehensive inpatient rehabilitation facility (POS 61)

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

- Pharmacy (POS 01)
- School (POS 03)
- Homeless shelter (POS 04)
- Prison/correctional facility (POS 09)
- Office (POS 11)
- Home or private residence of patient (POS 12)
- Assisted-living facility (POS 13)
- Group home (POS 14)
- Mobile unit (POS 15)
- Temporary lodging (POS 16)
- Walk-in retail health clinic (POS 17)
- Urgent care facility (POS 20)
- Birthing center (POS 25)
- Nursing facility and skilled nursing facilities (SNFs) to Part B residents (POS 32)
- Custodial care facility (POS 33)
- Independent clinic (POS 49)
- Federally qualified health center (POS 50)
- Intermediate health care facility/mentally retarded (POS 54)
- Residential substance abuse treatment facility (POS 55)
- Non-residential substance abuse treatment facility (POS 57)
- Mass immunization center (POS 60)
- Comprehensive outpatient rehabilitation facility (POS 62)
- End-stage renal disease treatment facility (POS 65)
- State or local health clinic (POS 71)
- Rural health clinic (POS 72)
- Independent laboratory (POS 81)
- Other place of service (POS 99)

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Place *(continued)*

Special guidance for selected POS codes

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

Special considerations for mobile unit settings (POS 15)

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

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

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

It should be noted that, while some entities in the industry may elect to use POS 17 to track the setting of immunizations, Medicare continues to require its billing rules for immunizations claims, which are found in Chapter 18, Section 10 of the *Medicare Claims Processing Manual* found at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*. Providers and suppliers of immunizations must continue to follow these Medicare billing rules. However, Medicare contractors will accept and adjudicate claims containing POS code 17, even if its presence on a claim is contrary to these billing instructions.

Special considerations for services furnished to registered inpatients

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

Special considerations for outpatient hospital departments

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

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

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based department of the hospital as defined in 42.C.F.R. 413.6. Use of POS 11 (office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357.

Special consideration for ambulatory surgical centers (POS 24)

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

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

Special considerations for hospice (POS 34)

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

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

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

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

Clarifications regarding global services

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

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

Clarification regarding determination of payment locality

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

Global service code

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

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

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

Separate billing of professional interpretation

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

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

Additional information

The official instruction, CR 7631, issued to your carrier and/or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2679CP.pdf*.

You may want to review MM8125 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8125.pdf*) which alerts providers to the new POS code 18 used to indicate place of employment/worksite.

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

MLN Matters® Number: MM7631 *Revised*
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Related CR Release Date: March 29, 2013
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Related CR Transmittal #:R2679CP
Implementation Date: April 1, 2013

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New place of service code for employment/worksite

Note: This article was revised on January 25, 2013, to link to MM7631 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7631.pdf*) to alert providers to the latest revised and clarified place of service (POS) coding instructions. All other information is the same. This information was previously published in the December 2012 *Medicare B Connection*, Pages 35-36.

Provider types affected

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

What you need to know

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

Background

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

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

1. Industry entities (other than Medicare) have identified a need to establish the delivery of occupational-related medical and rehabilitation services in the work place in order to: A) reduce employee time lost from work; and B) enable therapists to evaluate the work environment and provide rehabilitation services that are focused on returning the individual to their pre-injury state in a way that maximizes function in the workplace environment and reduces employee time lost.
2. As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with its standards and their implementation guides that are adopted by regulation. Specifically, the currently adopted professional implementation guide for the Accredited Standards Committee (ASC) X12 837 (professional health care claim) standards requires that each electronic claim transaction include a POS code from the POS code set that CMS maintains.

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

Additional information

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

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

MLN Matters® Number: MM8125 *Revised*
Related Change Request (CR) #: CR 8125
Related CR Release Date: November 30, 2012
Effective Date: April 1, 2013
Related CR Transmittal #: R2602CP
Implementation Date: April 1, 2013

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Remittance advice remark and claims adjustment reason code, MREP, and PC Print update

Provider types affected

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

What you need to know

This article is based on change request (CR) 8281, which instructs Medicare contractors to make programming changes to incorporate updates to the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists. It also instructs the fiscal intermediary standard system (FISS) and the VIPs Medicare system (VMS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Please make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARC and appropriate RARC that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions.

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

CR 8281 lists only the changes that have been approved since the last code update CR (CR 8154, transmittal 2618, issued December 21, 2012, available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8154.pdf*), and does not provide a complete list of codes for these two code sets.

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

Changes in CARC list since CR 8154

These are the changes in the CARC database since the last code update with CR 8154. The full CARC list must be downloaded from the WPC website, available at *http://wpc-edi.com/Reference*.

New codes – CARC: none

Modified codes – CARC

Code	Modified narrative	Effective date
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 01/20/2013	11/1/2013
18	Exact duplicate claim/service (Use only with Group Code OA) Start: 01/01/1995 | Last Modified: 01/20/2013	1/20/2013

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RARC *(continued)*

Code	Modified narrative	Effective date
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 01/20/2013	11/1/2013
133	The disposition of the claim/service is pending further review. (Use only with Group Code OA) Start: 02/28/1997 | Last Modified: 01/20/2013	1/20/2013

Deactivated codes – CARC

Code	Current narrative	Effective date
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 11/01/2013	11/1/2013

Changes in RARC list since CR 8154

These are the changes in the RARC database since the last code update CR 8154. The full RARC list must be downloaded from the WPC website, available at *http://wpc-edi.com/Reference*.

New – RARC

Code	Current narrative	Effective date
N567	Not covered when considered preventative. Start: 03/01/2013	3/1/2013
N568	Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative. Start: 03/01/2013	3/1/2013
N569	Not covered when performed for the reported diagnosis. Start: 03/01/2013	3/1/2013
N570	Missing/incomplete/invalid credentialing data Start: 03/01/2013	3/1/2013
N571	Alert: Payment will be issued quarterly by another payer/contractor. Start: 03/01/2013	3/1/2013
N572	This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted. Start: 03/01/2013	3/1/2013
N573	Alert: You have been overpaid and must refund the overpayment. The refund will be requested separately by another payer/contractor. Start: 03/01/2013	3/1/2013

Modified codes – RARC

Code	Current narrative	Effective date
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. Start: 11/01/2012 | Last Modified: 03/01/2013	3/1/2013

Deactivated codes – RARC: none

Additional information

The official instruction, CR 8281, issued to your FI, RHHI, carrier, DME MAC, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2686CP.pdf*.

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Claim status category and claim status codes update

Provider types affected

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

What you need to know

Change request (CR) 8265, from which this article is taken, requires Medicare contractors to use only National Code Maintenance Committee-approved claim status category codes and claim status codes when sending Medicare healthcare status responses (277 transactions) to report the status of your submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

All code changes approved during the January 2013 Committee meeting will be posted on or about March 1, 2013, at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes* and are to be reflected in the X12 277 transactions issued on and after the date of implementation of CR 8265 (July 1, 2013).

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only National Code Maintenance Committee-approved claim status category codes and claim status codes to explain the status of submitted claims. These codes, which have been adopted as the national standard to explain the status of submitted claim(s), are the only such codes permitted for use in the X12 276/277 Health Care Claim Status Request and Response format.

The National Code Maintenance Committee meets three times each year (February, June, and October) in conjunction with the Accredited Standards Committee (ASC) X12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry six months for implementation of the newly added or changed codes. Therefore, on and after the date of implementation of CR 8265 (July 1, 2013), your Medicare contractor must: 1) Complete the entry of all applicable code text changes and new codes; 2) Terminate the use of deactivated codes; 3) Use these new codes for editing all X12 276 transactions and reflect them in the X12 277 transactions that they issue.

Additional information

The official instruction, CR 8265, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2681CP.pdf*.

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

MLN Matters® Number: MM8265
Related Change Request (CR) #: CR 8265
Related CR Release Date: April 5, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2681CP
Implementation Date: July 1, 2013

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RARC *(continued)*

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

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Implementation Date: July 1, 2013

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5010 requirement for ambulance suppliers

Note This article was revised on March 22, 2013, to add a reference to article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information remains unchanged. This information was previously published in the June 2012 *Medicare B Connection*, Pages 30-31.

Provider types affected

This article is intended for ambulance suppliers submitting claims in the 5010 837P (professional) electronic claim format beginning January 1, 2011, to Medicare carriers or Part A/B Medicare administrative contractors (A/B MAC) for services rendered to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) has decided upon early adoption of version 5010 of the 837P electronic claim format and will implement it on January 1, 2011. If you are an ambulance supplier who plans early adoption of the new standard, this special edition article tells you how to submit your claims electronically in light of the new 837P, version 5010 diagnosis code reporting requirement.

Caution – what you need to know

Effective for claims submitted in the version 5010 837P electronic claim format on and after January 1, 2011, ambulance suppliers will have three options for complying with the new diagnosis reporting requirement.

- **Option 1**: Suppliers may choose a code or codes from the “Medical Conditions List” provided by CMS that corresponds to the condition of the beneficiary at the time of pickup and report the code(s) in the diagnosis field on the claim. The “Medical Conditions List” and instructions for using this list can be found in the *Medicare Claims Processing Manual*, Chapter 15, Section 40, “Medical Conditions List and Instructions,” available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf*. The codes in the medical conditions list are taken from the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) diagnosis code set. Suppliers must continue to accurately maintain transport records to support any data reported on the claim.
- **Option 2**: Suppliers may report an ICD-9 (or ICD-10 when appropriate) diagnosis code that is provided to them by the treating physician or other practitioner.
- **Option 3**: Suppliers may report ICD-9 diagnosis code 799.9 (unspecified illness).

Note: Effective October 1, 2013, the new ICD-10 diagnosis code set will be implemented, thus making the ICD-9 code set obsolete. **Note**: *SE1239* announces the revised ICD-10 implementation date of October 1, 2014.

- Suppliers choosing options 1 or 3 will be given further guidance upon implementation of the new code set.
- Suppliers choosing option 2 should ensure that they are provided with the appropriate ICD-10 diagnosis code for dates of service on and after October 1, 2013. **Note**: *SE1239* announces the revised ICD-10 implementation date of October 1, 2014.

Go – what you need to do

If you choose to submit claims in the version 5010 837P electronic claim format on and after January 1, 2011, you must comply with the requirement to include a diagnosis code. CMS will not be capable of accepting claims submitted under the 5010 version of the 837P that do not comply with this requirement. You may continue to use the 4010A1 version of the 837P until December 31, 2011.

Background

The Administrative Simplification Compliance Act (ASCA) and its implementing regulation require that all initial claims for payment under Medicare be submitted electronically as of October 16, 2003, unless one of the statutory or regulatory exceptions applies. Electronic claim submissions are required to be in compliance with the claim standards adopted for national use under the Health Insurance Portability and Accountability Act of 1996. Ambulance suppliers currently use the American National Standards Institute (ANSI) 837P (professional), version 4010A1 to submit claims for payment.

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Ambulance *(continued)*

The 4010A1 version of the 837P electronic claim does not require submission of a diagnosis code from the ICD-9CM code set in Loop 2300, Segment HI. Additionally, CMS does not currently require ambulance suppliers to submit a diagnosis code on claims for payment. However, the 5010 version of the 837P, which becomes effective on January 1, 2012, requires that a diagnosis code be present on all 837P electronic claims, including ambulance claims.

Additional information

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*.

Also see SE1106 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1106.pdf*) for important reminders about the implementation of HIPAA 5010 and D.O., including fee-for-service implementation schedule and readiness assessments. Another related article is SE1138, which is at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1138.pdf*.

You may want to review MM7489 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7489.pdf*) which alerts ambulance suppliers that Medicare contractors will begin supplying denial notices for billing secondary insurance for those HCPCS codes that identify Medicare statutorily excluded ambulance transportation services, effective January 1, 2012.

For current information on the new ICD-10 implementation date of October 1, 2014, see article SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*.

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Learn the secrets to billing Medicare correctly

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

Ordering/referring *(continued from front page)*

previously published in the March 2013 *Medicare B Connection*, Pages 39-45.

Provider types affected

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

Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), 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 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 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* sections 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.

Important announcement on April 25, 2013: Temporary delay in implementing ordering and referring denial edits. Due to technical issues, implementation of the phase 2 denial edits is being delayed. These edits would have checked certain claims for an approved or validly opted-out physician or non-physician who is an eligible specialty type with a valid individual NPI. If this information were missing or incorrect, the following types of claims would deny:

- Claims from laboratories for ordered tests
- Claims from imaging centers for ordered imaging procedures
- Claims from suppliers of DMEPOS for ordered DMEPOS
- Claims from Part A HHAs

Phase 2: CMS has not determined a date to turn on the phase 2 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. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first letter of the first name and the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found on *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html*. Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.

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 implementation date of the ordering/referring phase 2 provider edits.

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Ordering/referring *(continued)*

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 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
- Claims from suppliers of DMEPOS for ordered DMEPOS, and
- Claims from Part A HHAs.

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
- 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.
- 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 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).

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Ordering/referring *(continued)*

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 are as follows:

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 twice a week. 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: 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. CMS has not determined a date to turn on the phase 2 edits.

Below are the denial edits for Part B providers and suppliers who submit claims to carriers and/or MACs, including DME MACs:

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.

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Ordering/referring *(continued)*

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:
    - i. 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;
    - ii. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
    - iii. 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).
    - iv. 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.
    - i. **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.
    - ii. **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.
    - iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement.
    - iv. 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

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Ordering/referring *(continued)*

"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.

v. 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 twice a week 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.**

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the ordering and referring file found on CMS.gov.
- On paper claims (CMS 1450), you would capture the attending physician's last name, first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.
- On paper claims (CMS-1500), do not enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the ordering/referring name field, as their use could cause the claim to fail the edits.
- 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.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, **an advance beneficiary notice is not appropriate in this situation**. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

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Ordering/referring *(continued)*

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.

How will the technical vs. professional components of imaging services be affected by the edits?

Consistent with the Affordable Care Act and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable X-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

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 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*.

(continued on next page)

Ordering/referring *(continued)*

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

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

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

MLN Matters® 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 *Revised*
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 R781OTN
Implementation Date: May 1, 2013

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DMEPOS contract suppliers announced

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for round 2 and the national mail-order program of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

A list of contract supplier names is available at *www.dmecompetitivebid.com*. Contract supplier locations for each product category in each competitive bidding area can be found in the Supplier Directory at *www.medicare.gov/supplier*.

For additional information:

- *Press release*
- *Fact sheet*

New name for CBIC ombudsmen

CMS is changing the name of the Competitive Bidding Implementation Contractor (CBIC) ombudsmen to CBIC liaisons. This change will help distinguish the CBIC liaisons from the CMS Competitive Acquisition Ombudsman. The CBIC liaisons are now available to assist suppliers, referral agents, and other key stakeholders with questions and concerns about the program, provide assistance locating contract suppliers, and participate in educational events. There is a dedicated CBIC liaison assigned in each of several regional geographic territories consisting of round 1, round 2, and national mail-order competitive bidding areas. A list of CBIC liaisons and their contact information is available at *www.dmecompetitivebid.com* under "Contact Us."

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

Source: CMS PERL 201304-03

Medicare Quality Reporting Incentive Programs Manual update

Note: This article was revised March 26, 2013, to reflect a revised change request (CR) 7727 issued March 26, 2013. In this article, the CR transmittal number, CR release date, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the April 2012 *Medicare B Connection*, Page 70.

Provider types affected

This *MLN Matters*® article is intended for physicians and other eligible professionals (EPs) who bill Medicare contractors (carriers or Medicare administrative contractors (A/B MACs)) for providing certain services to Medicare beneficiaries.

What you need to know

This article is based on CR 7727, which informs you that a third chapter has been added to the *Medicare Quality Reporting Programs Manual*.

- This chapter describes the yearly payment instructions used by the Medicare contractors when making incentive payments described in the *Medicare Quality Reporting Incentives Manual*.
- CR 7727 manualized existing requirements contained in existing CRs and Medicare physician fee schedule (MPFS) legislation, but does not establish any new requirements for the Physician Quality Reporting System (PQRS) and e-Prescribing (eRx) incentive programs.

Background

The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a PQRS, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). The Centers for Medicare & Medicaid Services (CMS) named this program the Physician Quality Reporting Initiative (PQRI). The PQRI was further modified as a result of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) (P. L. 110-275) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (P. L. 110-275). In 2011, the program name was changed to Physician Quality Reporting System (Physician Quality Reporting). All publicly available information on the PQRS incentive program can be found at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html*.

Section 132 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) (MMSEA) authorized a new and separate incentive program for eligible professionals (EPs) who are successful e-prescribers, the e-Prescribing (eRx) incentive program, as defined by the Medicare Improvements for Patients and Providers Act (P.L. 110-275) (MIPPA). While this program has similarities to the PQRS incentive payment program, it is a stand-alone program with distinct reporting requirements and a separate incentive payment. All publicly available information on the eRx incentive program can be found at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html*.

CR 7727 manualized the information contained in existing CRs and MPFS legislation. Changes to the programs are described in the annual MPFS legislation.

Additional information

The official instruction, CR 7727, issued to your carrier or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R11QR1.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: MM7727 *Revised*
Related Change Request (CR) #: 7727
Related CR Release Date: March 26, 2013
Effective Date: June 25, 2012
Related CR Transmittal #: R11QRI
Implementation Date: June 25, 2012

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Tax ID numbers of foreign owning and managing entities and individuals

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8258, which furnishes guidance regarding the reporting of tax identification numbers (TINs) in Sections 5 and 6 of the form CMS-855. Make sure that your staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

In Chapter 15 of the *Medicare Program Integrity Manual*, Section 15.5.6.1 has been added to advise Medicare contractors of new instructions regarding the reporting of TINs of owning and managing organizations and individuals.

The content of the new section is as follows:

Consistent with Sections 1124 and 1124A of the Social Security Act, the TINs (employer identification numbers or social security numbers) of all entities and individuals listed in Sections 5 and 6, respectively, of the form CMS-855 must be disclosed. If a Medicare contractor receives an initial, reactivation, revalidation, or change of ownership form CMS-855 application from a provider and the provider fails to disclose the TIN of a particular organization or individual listed in Section 5 or 6, the contractor shall follow normal development procedures for requesting the TIN. In doing so, if the contractor learns or determines that the TIN was not furnished because the entity or person in question is foreign, the contractor shall take the following steps:

a. The contractor shall ask the provider (via any means) whether the person or entity is able to obtain a TIN or, in the case of individuals, an individual taxpayer identification number (ITIN).

    1) If the provider fails to respond to the contractor's inquiry within 30 days, the contractor shall follow the instructions in (c) below.

    2) If the provider states that the person or entity is able to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the person or entity must obtain a TIN/ITIN, and (ii) the provider must furnish the TIN/ITIN on the form CMS-855 with a newly-signed certification statement within 90 days of the contractor's request.

    3) If the provider states that the person or entity is unable to obtain a TIN or ITIN, the contractor shall send an e-mail, fax, or letter to the provider stating that (i) the provider must submit written documentation to the contractor explaining why the person or entity cannot legally obtain a TIN or ITIN, and (ii) the explanation – which can be in any written format and may be submitted electronically or via fax – must be submitted within 30 days of the contractor's request.

b. If the provider timely submits the explanation in (a)(3) above, the contractor shall forward the explanation to the appropriate contact at the Centers for Medicare & Medicaid Services (CMS). CMS will notify the contractor as to how the application should be handled.

c. If the provider fails to timely respond to the contractor's inquiry in (a) or fails to timely furnish the TIN/ITIN in (a)(2), the contractor shall – unless another CMS instruction directs otherwise - reject the application in accordance with the procedures identified in Chapter 15.

In addition:

- For purposes of Section 15.5.6.1 only, the term "change of ownership" - as used in the first paragraph of this section - refers to (1) CHOW, acquisition/merger, and consolidation applications submitted by the new owner, (2) change in majority ownership applications submitted by a home health agency (HHA), and (3) change of information applications in which a new entity or individual (e.g., owner, managing employee, corporate director) is being added in Section 5 or 6.

Additional information

The official instruction, CR 8258, issued to your FI, carrier, RHHI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R459PI.pdf*.

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

MLN Matters® Number: MM8258
Related Change Request (CR) #: CR 8258
Related CR Release Date: April 12, 2013
Effective Date: May 13, 2013
Related CR Transmittal #: R459PI
Implementation Date: May 13, 2013

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CMS offers new tools for electronic health record incentive programs

The Centers for Medicare & Medicaid Services (CMS) recently added new resources for health care providers as they transition to greater use of electronic health records (EHR).

Stage 2 Tool Kit

In March, CMS released its new interactive *Stage 2 Toolkit*, which includes materials on Stage 2 and the 2014 clinical quality measure (CQM) requirements. Stage 2 represents the second EHR incentive program benchmark in a series for health care providers to show they have converted their business operations from predominantly paper records to conducting tracking and care delivery processes through electronic methods. The toolkit includes the following information:

- An overview of Stage 2
- Stage 2 FAQs
- How the Stage 2 provisions affect Stage 1 requirements
- Comparison tables of Stage 1 and Stage 2 criteria
- Details about payment adjustment and hardship exemptions
- 2014 CQMs, including descriptions, technical release notes, and the recommended core sets for EPs and eligible hospitals

The earliest that the criteria for Stage 2 will be effective is October 1, 2013, for eligible hospitals and critical access hospitals. For eligible professionals such as physicians, the earliest effective date is January 1, 2014. To receive any incentive payment under the Medicare EHR incentive program, providers must enroll before 2014.

Incentive payments

Since January 2011, 180,000 health care providers have received $10.3 billion in payments for participating in the EHR incentive programs. This includes nearly 14 thousand individual providers and 91 hospitals in Florida.

Incentive program audits

CMS performs audits on Medicare providers who are participating in the EHR incentive programs. To help providers gather supporting documentation and prepare for a potential audit, CMS recently added a new fact sheet. The fact sheet and a sample audit request letter for both EPs and eligible hospitals are also available on the *Educational Resources* Web page of the EHR incentive programs website.

Updated FAQs

To keep you updated with information on the EHR incentive programs, CMS also recently added several new FAQs and answers to the *EHR FAQ database*.

- Can attestation information submitted for the EHR incentive programs be updated, changed, cancelled or withdrawn after successful submission in the EHR registration and attestation system?
- How can an EP that is new to a practice meet the patient volume/practice predominantly criteria to be eligible for the Medicaid EHR incentive program?
- How should EPs select menu objectives for the Medicare and Medicaid EHR incentive programs?

Visit the *Medicare EHR incentive programs* website for answers to these questions and the latest news on the EHR incentive programs.

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

Medicare payments for drugs used to treat wet age-related macular degeneration

Providers who treat beneficiaries for age-related macular degeneration may be interested in the following report from the Office of the Inspector General (OIG) Medicare payments for drugs used to treat wet age-related macular degeneration (report OEI-03-10-00360). A summary and link to the full report are available on the following OIG website: *https://oig.hhs.gov/oei/reports/oei-03-10-00360.asp*.

Source: CR 8247

Implementation of award for the jurisdiction E Medicare administrative contractor

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

Background

The Centers for Medicare & Medicaid Services (CMS) has awarded the JE A/B Medicare administrative contractor (MAC) contract for the administration of the Part A and Part B Medicare fee-for-service claims in the states and territories of California, Hawaii, Nevada, American Somoa, Guam and the Northern Marianas to Noridian Administrative Services, LLC (NAS).

NAS' address is:

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

Palmetto Government Benefit Authorizers (PGBA) is the outgoing contractor (OGC) for the current Jurisdiction 1 (J1) A/B MAC workloads. (The A/B MAC was renamed for the current award.) PGBAs address is:

Palmetto Government Benefit Authorizers
17 Technology Circle
Columbia, South Carolina 29203

CMS has determined that the JE workloads currently processed by the J1 A/B MAC 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 outgoing and the incoming A/B MAC. The workload numbers shall be changed and the workloads shall be transitioned to the JE A/B MAC as follows:

Part A

Workload description: Part A California JE A/B MAC
MAC workload number: 01111
Effective date: August 26, 2013
Current contractor workload number: 01101; OGC-PGBA

Workload description: Part A Hawaii, American Somoa, Guam, and the Northern Marianas JE A/B MAC
MAC workload number: 01211
Effective date: August 26, 2013
Current contractor workload number: 01201; OGC-PGBA

Workload description: Part A Nevada JE A/B MAC
MAC workload number: 01311
Effective date: August 26, 2013
Current contractor workload number: 01301; OGC-PGBA

Workload description: Part A J1 WPS Legacy JE A/B MAC
MAC workload number: 01911
Effective date: August 26, 2013
Current contractor workload number: 01901; OGC-PGBA

Part B

Workload description: Part B Northern California JE
MAC workload number: 01112
Effective date: September 16, 2013
Current contractor workload number: 01102; OGC-PGBA

Workload description: Part B Southern California JE A/B MAC
MAC workload number: 01182
Effective date: September 16, 2013
Current contractor workload number: 01192; OGC-PGBA

Workload description: Part B Hawaii, American Somoa, Guam, and the Northern Marianas JE A/B MAC
MAC workload number: 01212
Effective date: September 16, 2013
Current contractor workload number: 01202; OGC-PGBA

Workload description: Part B Nevada JE MAC
MAC workload number: 01312
Effective date: September 16, 2013
Current contractor workload number: 01302; OGC-PGBA

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

- Administrative qualified independent contractor (AdQIC)
- CMS analysis, reporting and tracking system (CMS ARTS)
- Contractor administrative, budget and cost reporting system (CAFM)
- Comprehensive error rate testing system (CERT)
- Contractor management information system (CMIS)
- CMS Baltimore data center (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)

(continued on next page)

JE MAC *(continued)*

- Customer service assessment and management system (CSAMS)
- Debt collection system (DCS)
- Electronic correspondence referral system (ECRS)
- Electronic Health Records Incentive Program (EHR)
- Electronic prescription file (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 1201, change request 8226

Implementation of CMS ruling 1455-R

On March 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued ruling 1455-R which establishes an interim process for hospitals to bill Medicare for Part B services following a denial of a claim for an inpatient admission as not reasonable and necessary. Affected providers shall follow temporary instructions for both the Part B types of bills (TOB), TOB 12x and TOB 13x that can be found at the following link: *http://www.cms.gov/Center/Provider-Type/Hospital/Other-Content-Types/Quick-Reference-CMS-1455-R.pdf*.

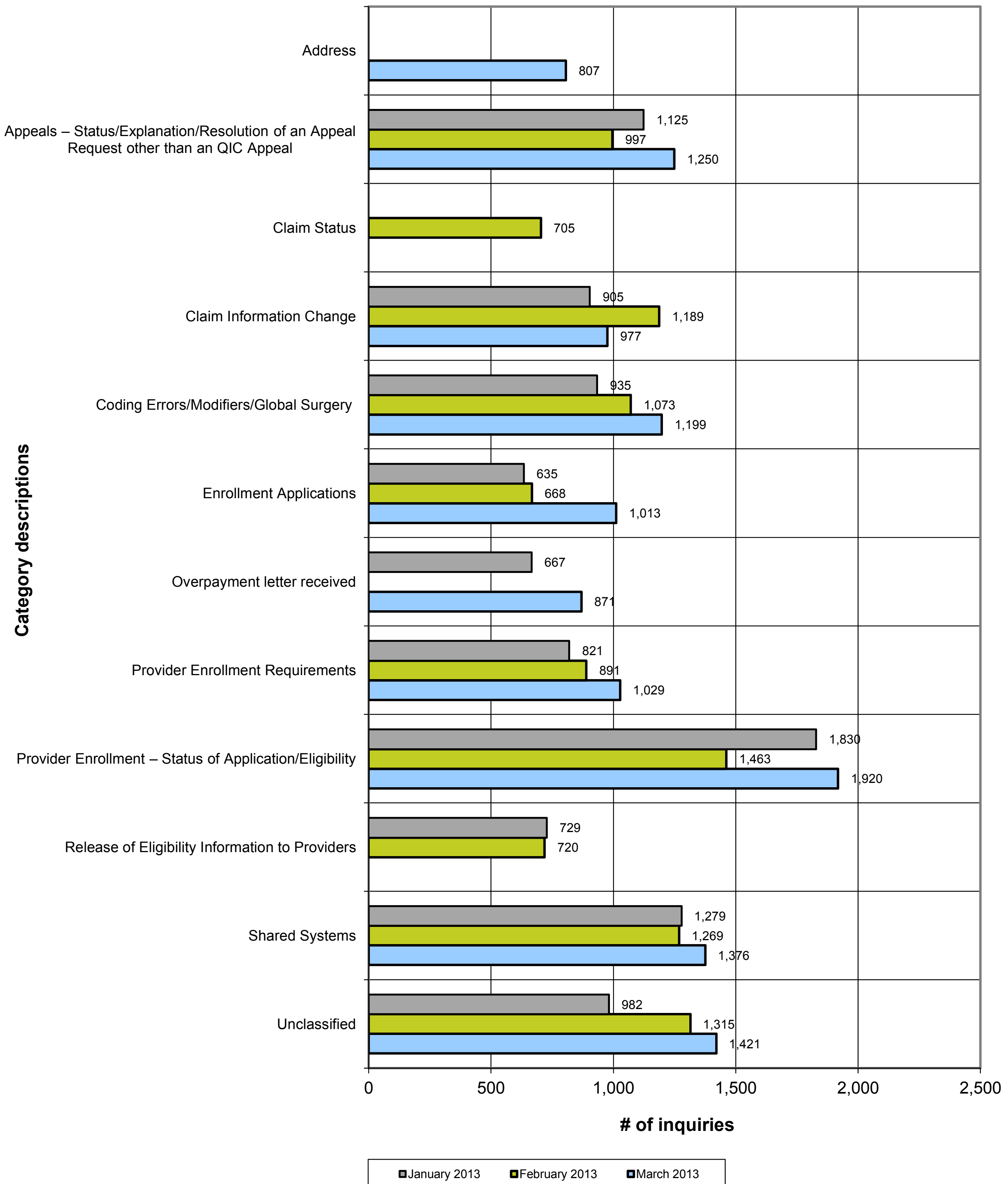
The answer is right at your fingertips

Available Monday-Friday, from 10 AM-2 PM ET, First Coast's Live Chat will allow you to connect with a team of experts who will respond to your **website-related inquiries** and help you get the most out of every visit to *medicare.fcso.com*.

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 January-March 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*.



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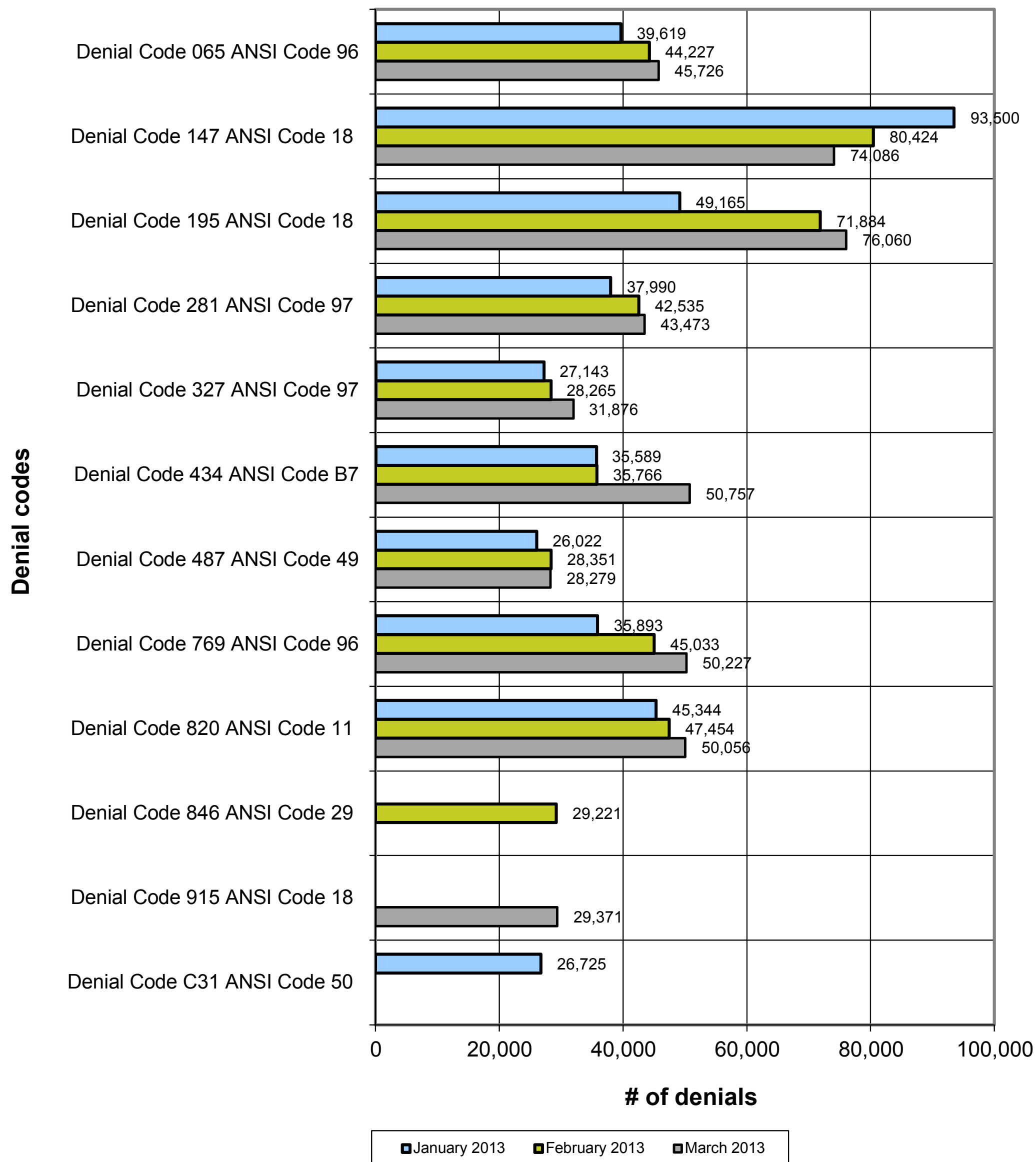


What to do when your claim is denied

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

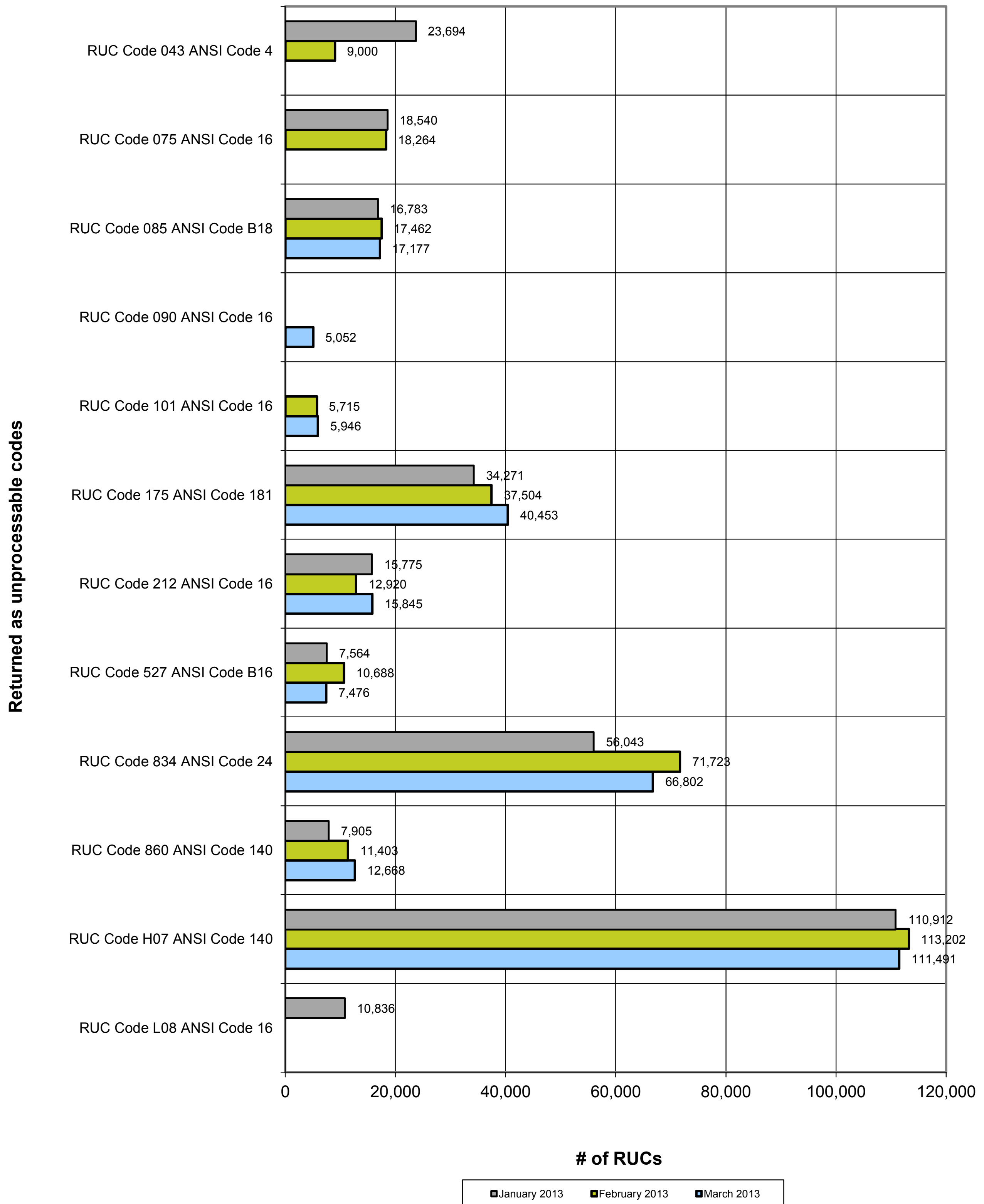
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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 January-March 2013



This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage Web page at *http://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the First Coast eNews mailing list. Simply go to *http://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

More information

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

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

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Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

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

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Looking for LCDs?

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

New LCD

PSYCH: Psychiatric diagnostic evaluation and psychotherapy services – new LCD

LCD ID number: L33128 (Florida/Puerto Rico/U.S. Virgin Islands)

The psychiatry section of the *CPT*® book includes diagnostic, psychotherapy, and other psychiatry services provided to an individual, family, or group and are reported without regard to setting. A new coding structure in this section of the 2013 *CPT*® book addresses coding concepts that reflect the different work performed by physicians and other qualified health care professionals. Some of the psychiatry services may be reported with evaluation and management (E/M) services.

Historically, psychotherapy services have been an outlier, confirmed by data analysis, which led to the development of multiple psychiatry-related local coverage determinations (LCDs).

This new LCD was developed to address the recent restructuring of the coding in the psychiatry section of the 2013 *CPT*® book and consolidate the following psychiatry-related LCD's currently found in the First Coast Service Options Inc. (First Coast) website: psychiatric diagnostic evaluation, psychotherapy, interactive complexity services, family psychotherapy, and group psychotherapy. These LCD's will be retired once the new LCD becomes effective.

Effective date

This new LCD is effective for services rendered **on or after June 04, 2013**. First Coast LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

Revisions to LCDs

J0881: Erythropoiesis stimulating agents – revision to the LCD

LCD ID number: L29168 (Florida)
LCD ID number: L29339 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for erythropoiesis stimulating agents was most recently revised January 1, 2013. Since that time, the LCD has been revised under the "Indications" section for Peginesatide (OMONTYS®) based on the U.S. Food and Drug Administration (FDA) recently issuing a voluntary nationwide recall of all lots of Omontys® (peginesatide) injection by Affymax, Inc. and Takeda Pharmaceuticals Company Limited effective February 23, 2013. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after February 23, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

J1459: Intravenous immune globulin – revision to the LCD

LCD ID number: L29205 (Florida)
LCD ID number: L29356 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for intravenous immune globulin was most recently revised January 1, 2013. Since that time, based on the Centers for Medicare & Medicaid Services (CMS) change request 8237, transmittal 2662 (April 2013 Update of the Ambulatory Surgical Center [ASC] Payment System), dated March 1, 2013, the LCD was revised to add HCPCS code C9130 (Injection, immune globulin [Bivigam], 500 mg) for ASCs under the "*CPT*®/HCPCS Codes" section of the LCD. In addition, HCPCS codes J3490 and J1599 for physician services were added under the "*CPT*®/HCPCS Codes" section of the LCD. Also, the "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections of the LCD were updated.

Effective date

The LCD revision for the addition of HCPCS code C9130 is effective for services rendered **on or after April 1, 2013**. The LCD revision for the addition of HCPCS codes J3490 and J1599 is effective for services rendered **on or after December 19, 2012**, based on the Food and Drug Administration (FDA) approval. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

NCSVCS: Noncovered Services – revision to the LCD

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

The local coverage determination (LCD) for noncovered services was most recently revised January 29, 2013. Since that time, the "*CPT*®/HCPCS Codes" section of the LCD was revised as follows:

- Based on change request (CR) 8237, transmittal 2662, dated March 1, 2013, *CPT*® code *90661* was removed from the LCD. The effective date of this revision is for claims processed **on or after April 1, 2013**, for services rendered **on or after November 20, 2012**. In addition, HCPCS code C9734 was added to the LCD. The effective date of this revision is for services rendered **on or after April 1, 2013**.
- Based on CR 7909, transmittal 2529, dated August 24, 2012, HCPCS code J1056 was deleted from the LCD. The effective date of this revision is for services rendered **on or after January 1, 2013**.
- HCPCS code C9727 was added to the LCD. The effective date of this revision is for services rendered **on or after September 30, 2008**.
- The "unlisted" procedure codes were separated from the "listed" procedure codes into their own individual list. In addition, an asterisk was added to those "listed" codes that contain additional information beyond the *CPT*® descriptor. The effective date of this revision is for services rendered **on or after April 1, 2013**

Also, the "Coding Guidelines" attachment was updated to remove *CPT*® codes *43999* (Gastric balloon for treatment of obesity) and *44799*GY (Intestinal bypass for obesity) as they are now included in the surgical management of morbid obesity LCD.

First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

NCSVCS: Noncovered Services – CAC revision to the LCD

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

The local coverage determination (LCD) for noncovered services was most recently revised April 1, 2013. Since that time, a revision was made to the LCD. The following codes were evaluated and determined not to be medically reasonably and necessary at this time based on the current published evidence (e.g., peer-reviewed medical literature, published studies): HCPCS code G0455 was added to the "Local Noncovered Decisions-Devices" section of the LCD. *CPT*® codes *0310T, 0312T, 0313T, 0314T, 0315T, 0316T, 0317T, 43206* and *43252* were added to the "Local Noncoverage Decisions-Procedures" section of the LCD and *CPT*® code *88375* was added to the "Local Noncovered Decisions-Laboratory Procedures" section of the LCD. In addition, under the "Related Documents" section of the LCD a reference page was included.

Effective date

This LCD revision is effective for services rendered **on or after June 4, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

SKINSUB: Skin substitutes – revision to the LCD

LCD ID number: L29279 (Florida)
LCD ID number: L29393 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for skin substitutes was most recently revised January 1, 2013. Since that time, a revision was made to the LCD based on the ASC payment indicator file related to the Centers for Medicare & Medicaid Services (CMS) change request 8237, transmittal 2662 (April 2013 Update of the Ambulatory Surgical Center [ASC] Payment System), dated March 1, 2013. HCPCS C9367 was deleted from the section of the LCD "The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products".

Effective date

This LCD revision is effective for claims processed **on or after April 1, 2013**, for services rendered **on or after January 1, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

THERSVCS: Therapy and rehabilitation services – revision to the LCD

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

The local coverage determination (LCD) for therapy and rehabilitation services was most recently revised January 1, 2013. Since that time, the LCD was revised based on change request (CR) 8005, transmittal 2622, dated December 21, 2012, which included updates to the language in the Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual*, Publication 100-04, Chapter 5, Sections 10.6. Therefore, the "Documentation Requirements" section of the LCD was revised to add "Functional Reporting" information. The "Documentation Requirements" section of the LCD was also updated under "Progress Report" to reflect the current CMS language in the *Medicare Benefit Policy Manual*, Publication 100-02, Chapter 15, Section 220.3D. This LCD revision is effective for dates of service **on or after January 1, 2013**.

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THERSVCS *(continued)*

Effective date

This LCD revision related to CR 8005 is effective for claims processed **on or after January 7, 2013**, for services rendered **on or after January 1, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

64566: Posterior tibial nerve stimulation (PTNS) – revision to the LCD

LCD ID number: L32304 (Florida/Puerto Rico/US. Virgin Islands)

The local coverage determination (LCD) for posterior tibial nerve stimulation (PTNS) was effective January 31, 2012. Since that time, a revision was made to the LCD based on an external reconsideration request. Language was added to the "Limitations" and "Utilization Guidelines" sections of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after April 23, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

78459: Myocardial imaging, positron emission tomography (PET) scan – revision to the LCD

LCD ID number: L29231 (Florida)
LCD ID number: L29455 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for myocardial imaging, positron emission tomography (PET) scan was most recently revised October 1, 2011. Since that time, the LCD was revised based on data analysis that revealed overutilization for carrier to nation ratio for *CPT*® code *78492* (*Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress*), and HCPCS codes A9526 (Nitrogen N-13 ammonia, diagnostic, per study dose, up to 40 millicuries) and A9555 (Rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries).

The following sections of the LCD were revised:

- CMS National Coverage Policy
- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines

Effective date

This LCD revision is effective for services rendered **on or after June 4, 2013**.. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

90901: Biofeedback – revision to the LCD

LCD ID number: L29066 (Florida)
LCD ID number: L29084 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for biofeedback was most recently revised January 1, 2013. Since that time, the LCD was revised based on data analysis which identified this service as a high risk for improper claim(s) payment. A trend was noted with several providers who were billing physical therapy services (i.e., *CPT*® codes *97032, 97110, 97112, 97140, 97150, 97530*, and HCPCS code G0283) with biofeedback for urinary incontinence on the same date of service.

Revisions to the LCD include the following:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the following statement was added to the eighth paragraph: "The requirements for anorectal and electromyography studies (EMG) can be found in the LCD for "Anorectal Manometry and EMG of the Urinary and Anal Sphincters."
- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, a new section titled "Limitations of Coverage" was added with the following statements:

"It is not expected that physical therapy or occupational therapy services would be billed on the same day as biofeedback therapy. "If physical therapy or occupational therapy is billed on the same date of service as biofeedback, these claims will be developed for supporting documentation and subject to medical review.

If physical therapy or occupational therapy services are rendered for indications beyond the scope of the indications addressed in this LCD, all requirements for rehabilitative services must be met. These requirements can be found in the "Therapy and Rehabilitation Services" LCD.

Biofeedback training will not be covered for mechanical urinary incontinence, psychosomatic conditions, or functional urinary incontinence as these types of urinary incontinence are not amendable to biofeedback training."

- The "Documentation Requirements" section of the LCD was updated; and
- The "Sources of Information and Basis for Decision" section of the LCD was updated.

In addition, the "Coding Guidelines" attachment of the LCD was revised in the last paragraph under the section "Coding Guidelines."

Effective date

This LCD revision is effective for services rendered **on or after June 4, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

Additional Information

Independent diagnostic testing facility (IDTF) – revision to the LCD 'Coding Guidelines' attachment

LCD ID number: L29195 (Florida)
LCD ID number: L29330 (Puerto Rico/U.S. Virgin Islands)

The "Coding Guidelines" attachment of the local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was most recently revised January 1, 2013. Since that time, the "Credentialing Matrix" in the LCD "Coding Guidelines" attachment has been revised. Revisions include the following:

- The "Supervising Physician and Interpreting Physician Qualification Requirements" column of the "Credentialing Matrix" was revised for *CPT*® code *95872* to read: "Board Certified (ABMS) Neurologist; or Board Certified (ABMS) Physical Medicine and Rehabilitation (PMR) specialist with additional certification

(continued on next page)

IDTF *(continued)*

by: a) American Board of Electrodiagnostic Medicine, b) Clinical Neurophysiology, or c) American Board of Neurophysiology or a Physical therapist who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the service under state law." The associated "Technician Qualification Requirements" column has been revised to read: "Must be performed by the qualified interpreting physician." The effective date of this revision is for claims processed **on or after May 29, 2012**.

- The "Supervising Physician and Interpreting Physician Qualification Requirements" column for *CPT*® codes *95910, 95911*, and *95912* was revised to add "Podiatrist." The effective date of this revision is for services rendered **on or after January 1, 2013**.
- The "Technician Qualification Requirements" column for HCPCS codes G0398, G0399, and G0400 was revised to read: "Credentialed by BRPT: RPSGT, ABRET: R. EEG T. (Polysomnography), CRT: SDS, or RRT: SDS." Also, the "Technician Qualification Requirements" column for *CPT*® codes *77080, 77081*, and *77082* was revised to add "ISCD: CBDT." The section titled "Key for IDTF Table Abbreviations" was also revised to add "The International Society for Clinical Densitometry (ISCD) and Certified Bone Densitometry Technologist (CBDT)." In addition, under the "Supervising Physician and Interpreting Physician Qualification Requirements" column for *CPT*® codes *95860-95864*, *95867-95870*, and *95885-95887*, a punctuation mark was added after Board Certified (ABMS) Neurologist for clarification. The effective date of this revision is for services rendered **on or after March 19, 2013**.
- The "Level of Physician Supervision" column for *CPT*® codes *95907, 95908, 95909, 95910, 95911, 95912*, and *95913* was revised in accordance with the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8169 (April Update to the CY 2013 Medicare Physician Fee Schedule Database [MPFSDB]), dated March 1, 2013. Based on CR 8169 the level of physician supervision for *CPT*® codes *95907, 95908, 95909, 95910, 95911, 95912*, and *95913* was revised from level "9" to level "7A". This revision is effective for claims processed **on or after April 1, 2013**, for services rendered **on or after January 1, 2013**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

PROVENGE®: criteria for prepayment review

PROVENGE® (sipuleucel-T) is an autologous cellular immunotherapy for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. PROVENGE® (sipuleucel-T) was approved by the Food and Drug Administration (FDA) in 2010 and was one of the first federally-approved cancer drugs that use the body's own immune system to fight the disease. In June 2011, the Centers for Medicare & Medicaid Services (CMS) proposed that the evidence was adequate to conclude that the use of autologous cellular immunotherapy treatment – (sipuleucel-T) PROVENGE® improved health outcomes for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer, and thus is reasonable and necessary for this on-label indication under 1862(a)(1)(A) of the Social Security Act. The recommended course of therapy for PROVENGE® is three complete doses (approximately $33,000 allowed dollars per dose), given at approximately two week intervals. PROVENGE® is administered via intravenous infusion over a period of approximately 60 minutes.

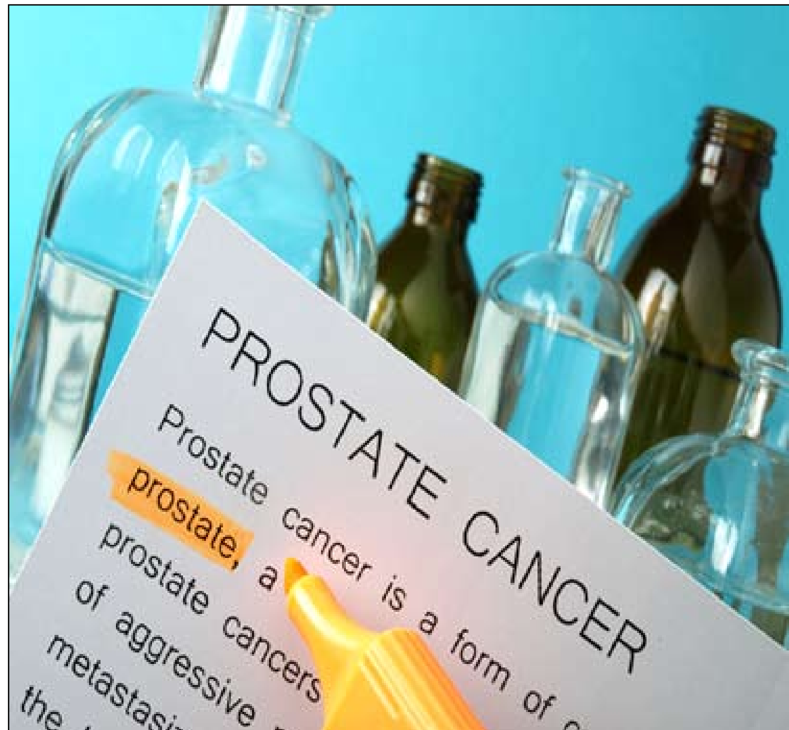
CMS developed the national coverage determination (NCD), Autologous Cellular Immunotherapy Treatment (110.22), outlining the indications and limitations of coverage for PROVENGE®, which became effective June 30, 2011. In an effort to prevent improper payments and protect the Medicare Trust Fund, First Coast Service Options Inc. (First Coast) implemented two edits based on the requirements outlined in the NCD. The first edit applies to the dual diagnosis requirement. If the claim does not meet the dual diagnosis requirement in the NCD the claim automatically denies. If the claim meets the dual diagnosis requirement, the second edit auto-develops and an additional documentation request (ADR) is sent to the provider requesting medical records. The ADR letter requests documentation that demonstrates the medical necessity of the billed service, which includes the patient's history and physical, progress notes, nurses notes, treatments, lab values, order for the treatment with PROVENGE® and infusion records.

Each claim must stand alone, meaning the documentation in the submitted record must support the medical necessity of the service(s) billed on each individual claim. The contractor does not know if or which prior claim

(continued on next page)

Provenge *(continued)*
may contain documentation to support a current claim that is subject to medical review. So, although the provider may have already submitted some (e.g., history and physical [H&P]) of the same records with an earlier claim, the documentation for each additional claim must also support the service under review.

First Coast understands the burden placed on providers in requesting medical records and has worked diligently to reduce the paperwork burden when possible by implementing editing criteria that exclude beneficiary(s) from being subject to editing once medical necessity for a specific service has been established. For example, Tysabri ® is a drug that is administered every four weeks (indefinitely) for certain indications. Once First Coast determines that the coverage criteria for Tysabri® based on the submitted documentation for the beneficiary has been met, subsequent claims, for that beneficiary are "excluded from further review. "



Since PROVENGE® is given approximately every two weeks it is probable that a provider may bill for the second and possibly third dose prior to the first claim (first dose) being medically reviewed due to the time it takes for the provider to receive the ADR, respond to the ADR and for the review to be completed. First Coast considered implementing an exclusion table for beneficiaries that met the requirements for PROVENGE® based on the medical record review of the first dose. However, given the short interval between doses, enough time has not lapsed to put in place the necessary editing to avoid subsequent claims from being developed for the medical records. In addition, First Coast has identified documentation issues through medical record review of the second and third doses that would have resulted in comprehensive error rate testing (CERT) errors had the claim been sampled by the CERT contractor. Due to the potential impact of these large dollar claims on the CERT error rate, prepayment review is necessary to prevent improper payments and protect the Medicare Trust Fund.

An option providers may want to consider is the utilization of the paperwork segment (PWK) of electronic transactions. PWK is a segment within the 2300/2400 Loop of the 837 Professional and Institutional electronic transactions that provides the link between electronic claims and additional documentation. PWK allows providers to submit electronic claims that require additional documentation through the dedicated PWK process, by mailing or faxing the medical records without waiting on the ADR and have the documentation received and imaged by the contractor allowing more timely claims adjudication. Using the PWK process eliminates the need for costly development and allows providers and Medicare contractors to utilize efficient, cost-effective electronic data interchange (EDI) technology, which creates a significant cost savings. Although PWK ultimately will allow electronic submission of additional documentation, the submission of additional documentation can only be submitted via fax or mail at this time. Providers that submit claim(s) via PWK should experience a reduction in the period of time between the receipt and adjudication of claims. Here is a link to more information regarding PWK: *http://medicare.fcso.com/EDI_news/203963.asp*.

Top reasons for denials and tips to avoid denials

- Non response to documentation request (ADR letters): respond to ADRs timely and consider use of PWK.
- Failure to meet NCD (110.22) dual diagnosis requirements: review CMS' NCD requirements at Publication 100-03, Chapter 1, Part 2, Sections 90-160.26. Refer to *http://medicare.fcso.com/Publications_A/2011/213006.pdf#page=12* (Part A) or *http://medicare.fcso.com/Publications_B/2011/212769.pdf#page=12* (Part B).

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Provenge® *(continued)*

- Insufficient documentation: Ensure you submit sufficient medical records (see below):

Physician order for PROVENGE®

FDA labeled indication and NCD criteria are met for coverage as supported by the following:

- Documentation regarding means of castration (e.g., surgically by bilateral orchiectomy or documentation of three or more months of chemical castration and agent used or the medical documentation from the treating physician includes a clear statement of failure of chemical castration)
- Medical records should specifically address evidence of progressive disease after surgical or chemical castration (examples may include: changes in size of lymph nodes or parenchymal masses on physical examination or radiographic studies, bone scan progression, PSA progression, etc.)
- Evidence that the patient is asymptomatic or minimally symptomatic (should include a note about the patient's level of activity)
- Other lab values or other test results relevant to the above criteria
- Infusion record for the date of service billed on the claim

Ensure the submitted records and signatures are legible. For information about Medicare's signature requirements see: *http://medicare.fcso.com/medical_documentation/166303.asp*.

Self-administered drug (SAD) list – J3490/J3590/C9399

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Publication 100-02, Chapter 15, Section 50.2.

Effective for services rendered **on or after June 17, 2013**, the following drug has been added to the MAC J-9 Part B SAD list.

- J3490/J3590/C9399 Injection, Signifor® (pasireotide)

The evaluation of drugs for addition to the self-administered drug (SAD) list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

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

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

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

Educational Events

Upcoming provider outreach and educational events May-June 2013

Medifest 2013 Tampa; Building a stronger Medicare community through education

When: Tuesday-Wednesday, May 21-22
Time: 8:00 a.m.-4:30 p.m.
Type of event: Face-to-face

Prepayment medical review of hospital claims – inpatient DRGs

When: Thursday, June 13
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:

- CMS e-News for Wednesday, March 21, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-21-e-News.pdf*
- CMS e-News for Wednesday, March 28, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-28-enews.pdf*
- 'CMS Medicare FFS Provider e-News': April 4, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-04-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': April 11, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-11-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': April 18, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-18Enews.pdf*
- 'CMS Medicare FFS Provider e-News': April 25, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-25Enews.pdf*

Source: CMS PERL 201303-04, 201303-05, 201304-02, 201304-04, 201304-08, 201304-10

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

Pending request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Denied request for lack of response: Submit as 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.
Medicare EDI
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.
Medicare EDI
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