Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

May 2013

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Information on the National Physician Payment Transparency Program: Open Payments

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This *MLN Matters*® special edition article is intended to inform physicians and teaching hospitals of the National Physician Payment Transparency Program (Open Payments) being implemented by CMS to satisfy Section 6002 of the Affordable Care Act.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) published, on February 8, 2013, a final rule that is intended to increase public awareness of financial relationships between manufacturers of drugs, devices, biologicals and medical supplies, as well as between applicable group purchasing organizations (GPOs), and physicians and teaching hospitals. Known as the "National Physician Payment Transparency Program: Open Payments," this is one of many steps in the Affordable Care Act designed to create greater transparency in the health care market.

Background

On February 8, 2013, CMS published a final rule, titled the "Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests." With this program, applicable manufacturers and applicable GPOs will begin tracking and reporting payments and other transfers of value made to physicians and teaching hospitals, as well as certain ownership interests held in the organizations by physicians and their immediate family members. CMS will collect the data annually, aggregate it, and publish it on a public website as required by the Affordable Care Act.

As noted by Peter Budetti, M.D., Deputy Administrator for Program Integrity of the Centers for Medicare & Medicaid Services (CMS), US Department of Health and Human Services, and Director of the CMS Center for Program Integrity in a February 1, 2013, CMS press release: "You should know when your doctor has a financial relationship with the companies that manufacture or supply the medicines or medical devices you may need. Disclosure of these relationships allows patients to have more informed discussions with their doctors."

While financial ties alone do not signify an inappropriate relationship, Open Payments will create public transparency, which aims to:

- Promote transparent information regarding financial relationships.
- Disclose the nature and extent of financial relationships between the industry and the physicians and teaching hospitals.

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

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

About the *Medicare B Connection*

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

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website 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.

CMS implements date of service MUEs for some codes

Effective April 1, 2013, the Centers for Medicare & Medicaid Services (CMS) converted some claim line medically-unlikely edits (MUEs) to date of service (DOS) MUEs. The total units of service (UOS) from all claim lines for a Healthcare Common Procedural Coding System (HCPCS)/*Current Procedural Terminology* (*CPT*®) code with the same date of service will be summed and compared to the MUE value. MUE edits are maintained by the National Correct Coding Initiative (NCCI).

Claims denied based on DOS MUEs may be appealed using similar processes to claim line MUE denials. DOS MUEs are based on criteria including, but not limited to, anatomic considerations, *CPT*® code descriptors or instructions, and nature of equipment or service. CMS does not publish which codes have DOS MUEs. Since all UOS for a HCPCS/*CPT*® code on all claim lines with the same date of service are summed, reporting additional UOS on separate claim lines with a HCPCS/*CPT*® modifier will not result in payment of UOS in excess of the MUE value.

Source: *CMS FAQ 8119*

Bilateral procedures and MUEs

First Coast Service Options, Inc. (First Coast) provider contact center has been receiving numerous inquiries regarding medically unlikely edits (MUEs), anatomical modifiers (e.g., RT, LT, E1, E3, etc.) and the usage of modifier 50. The purpose of this article is to provide clarification on how modifier 50 should be billed.

Bilateral surgery is defined as a procedure performed on both sides of the body at the same operative session or on the same day. This definition does not include procedures that are bilateral in nature or include the terms “bilateral” or “unilateral/bilateral” in their descriptors.

When submitting claims for bilateral surgery, use modifier 50 with the procedure code. Claims for bilateral surgical procedures should be billed on a single claim detail line with the appropriate procedure code and modifier 50 and one (1) unit of service (UOS). Modifiers RT and LT should not be used when modifier 50 applies. When billing claims for procedure codes that are bilateral in nature, regardless of whether these services are performed unilaterally or bilaterally, providers should bill the surgical procedure code as a single claim detail line item **without** modifier 50.

To determine if a procedure should be billed with the modifier 50 as a bilateral procedure, providers may access the Medicare physician fee schedule (MPFS) *look-up tool*. Select MPFS, enter the date of service, locality and procedure code. Once you select “Submit,” the details of the procedure code will be revealed. Under the heading “Modifier,” select more. The “Bilateral Surgery” indicator will advise if a modifier 50 should be billed with the code.

Source: CMS IOM Publication 100-04, Chapter 4, Section 20.6.2; Chapter 23

Register for free, hands-on Internet-based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. Select from the following session dates: June 27, July 11, July 18, or August 15, 2013.

Drugs and Biologicals

July 2013 update to drug/biological codes

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8286 which informs Medicare contractors about the updating of specific drug and biological HCPCS codes which occurs quarterly. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Key points of CR 8286

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS codes will no longer be payable for Medicare:

- J3487: Injection, Zoledronic Acid (Zometa), 1 mg
- J3488: Injection, Zoledronic Acid (Reclast), 1 mg
- J9002: Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10 mg

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS codes will be payable for Medicare:

- Q2033: Influenza Vaccine, Recombinant Hemagglutinin Antigens, For Intramuscular Use (Flublok)
- Q2050: Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10 mg
- Q2051: Injection, Zoledronic Acid, not otherwise specified, 1 mg

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS code will be accepted on claims, but not payable by Medicare:

- Q0090: Levonorgestrel-Releasing Intrauterine Contraceptive System (SKYLA), 13.5 mg

Additional information

The official instruction, CR 8286, issued to your FI, carrier, RHHI, DME/MAC, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2695CP.pdf*.

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

MLN Matters® Number: MM8286
Related Change Request (CR) #: CR 8286
Related CR Release Date: May 2, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2695CP
Implementation Date: July 1, 2013

Billing and coverage for drug wastage

Note: This information was previously published in the July 2012 *Medicare B Connection*, Page 5.

First Coast Service Options Inc. (First Coast) will consider payment for the unused and discarded portion of a single-use drug/biological product after administration of the appropriate (reasonable and necessary) dosage for the patient's condition. This applies to drugs priced through the average sales price (ASP) drug/biological program. The Centers for Medicare & Medicaid Services encourages physicians, hospitals, and other providers to provide injectable drug therapy incident to a physician's services in a fashion that maximizes efficiency of therapy in a clinically appropriate manner. If a physician, hospital, or other provider must discard the unused portion of a single-use vial or other single-use package after administering a dose/quantity appropriate to the clinical context for a Medicare beneficiary, the program provides payment for the entire portion of drug or biological indicated on the vial or package label.

If less than a complete vial is administered at the time of service, and the unused portion is discarded, drug wastage must be documented in the patient's medical record with the date, time, and quantity wasted. Upon review, any discrepancy between amount administered to the patient and the billed amount will be denied, unless wastage is clearly documented. The amount billed as "wastage" must not be administered to another patient or billed again to Medicare. All procedures for drug storage, reconstitution and administration should conform to applicable Federal Drug Administration (FDA) guidelines and provider scope of practice.

Note: For billing purposes, First Coast does not require the use of modifier JW. Drug wastage is billed by combining on a single line the wastage and administered dosage amount

Evaluation and Management

CWF editing for billing of new patient visits by same physician or group practice within three years

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8165 which informs Medicare contractors about changes to Medicare's common working file (CWF) system that will detect erroneous billings when there are two new patient *Current Procedure Terminology* (*CPT*®) codes being billed within a three year period of time by the same physician or physician group.

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

Background

The recovery auditors, under contract with the Centers for Medicare & Medicaid Services (CMS), are responsible for identifying and correcting improper payments in the Medicare fee-for-service payment process. The recovery auditors have identified claims with "new patient" evaluation and management (E&M) services to have improper payments, because the new patient services have been billed two or more times within a three-year period by the same physician or physician group. The *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.7 provides that "Medicare interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E&M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years. For example, if a professional component of a previous procedure is billed in a three-year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit."

As a result of overpayments for new patient E&M services that should have been paid as established patient E&M services, CMS will implement changes to the CWF to prompt CMS contractors to validate that there are not two new patient *CPT*®s being paid within a three year period of time.

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CWF *(continued)*

The new patient *CPT*® codes that will be checked in these edits include 9*9201-99205, 99218-99223, 99304-99306,99324-99328, 99341-99345, 99381-99387, 99460-99461, 99468, 99471, 99475, 99477*, G0245, G0402, and G0344. The edits will also check to ensure that a claim with one of these new patient *CPT*® codes is not paid subsequent to payment of a claim with an established patient *CPT*® code.

If Medicare discovers that a new patient code has been paid more than one time in a three-year period to the same physician, then Medicare contractors will consider this an overpayment and will take steps to recoup the payment. If the situation is detected prior to payment of a second claim, the second claim will be rejected.

Additional information

The official instruction, CR 8165, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1231OTN.pdf*.

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

MLN Matters® Number: MM8165
Related Change Request (CR) #: CR 8165
Related CR Release Date: May 3, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1231OTN
Implementation Date: October 7, 2013

Preventive Services

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

Note: This article was updated May 20 and May 22, 2013, to update a statement under the *Benefit coverage summary* section regarding when a beneficiary is eligible for the initial preventive physical examination (IPPE). All other information remains unchanged. This information was previously published in the March 2013 *Medicare B Connection*, Pages 23-25.

Provider types affected

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

Provider types affected

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

Provider action needed

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

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Reminder *(continued)*

Background

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

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

The information in this special edition *MLN Matters*® article reminds health care professionals that Medicare now pays for these benefits as well as a broad range of other preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their "Welcome to Medicare" physical exam within the first 12 months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the preventive ultrasound screening as part of their "Welcome to Medicare" physical exam.

Benefit coverage summary

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

Effective for dates of service on or after January 1, 2005: Medicare beneficiaries whose Medicare Part B effective date is on or after January 1, 2005, are covered for a one-time IPPE visit. A beneficiary is only eligible for an IPPE within the first 12 months of his or her Medicare Part B effective date. The IPPE is a preventive evaluation and management (E/M) service that includes the following seven components:

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

Important reminders about the IPPE

1. The IPPE is a unique benefit available only for beneficiaries new to the Medicare program and must be received within the first 12 months of the effective date of their Medicare Part B coverage.
2. This exam is a preventive physical exam and not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare does not provide coverage for routine physical exams.

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

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

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

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

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Reminder *(continued)*

Preventive ultrasound screening for abdominal aortic aneurysms (AAA)

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

Important note: Only Medicare beneficiaries who receive a referral from their physician or other qualified non-physician practitioner for the preventive ultrasound screening, as part of their "Welcome to Medicare" physical exam, will be covered for the AAA benefit. (See the *Additional information* section for a link to *MLN Matters*® article MM5235, which provides detailed coverage criteria and billing information about the AAA benefit.)

Additional information

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

- MM5235 (2006), Implementation of a one-time only ultrasound screening for abdominal aortic aneurysms (AAA), resulting from a referral from an initial preventive physical examination, *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5235.pdf*.
- MM3771 (2005), MMA – Clarification for outpatient prospective payment system (OPPS) hospitals billing the initial preventive physical exam (IPPE), *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3771.pdf*.
- MM3638 (2004), MMA – Initial preventive physical rxamination, *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3638.pdf*.

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

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

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

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Surgery

NCD for TAVR – implementation of mandatory reporting of clinical trial number

Provider types affected

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

Provider action needed

Change request (CR) 8255 is being issued to require that claims for TAVR carry an approved clinical trial number, effective for claims processed on or after July 1, 2013. Given that TAVR is covered only under coverage with evidence development (CED), the Centers for Medicare & Medicaid Services (CMS) has ensured that the approved clinical trials and approved registry have obtained valid numbers from *http://www.clinicaltrials.gov* and that those numbers are maintained at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html*. See the *Background* and *Additional information* sections of this article for further details regarding these changes. Please make sure that your billing staffs are aware of these changes.

Background

On May 1, 2012, CMS issued a national coverage determination (NCD) covering TAVR with CED. The TAVR NCD is available at *http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=355*.

TAVR (also known as TAVI or transcatheter aortic valve implantation) is a new technology for use in treating aortic stenosis. A bioprosthetic valve is inserted percutaneously using a catheter and implanted in the orifice of the native aortic valve. The procedure is performed in a cardiac catheterization lab or a hybrid operating room/cardiac catheterization lab with advanced quality imaging and with the ability to safely accommodate complicated cases that may require conversion to an open surgical procedure. The interventional cardiologist and cardiac surgeon jointly participate in the intra-operative technical aspects of TAVR.

CR 8255 requires that claims for TAVR carry an approved clinical trial number. Specific claim processing instructions are as follows:

- For professional claims processed on or after July 1, 2013, Medicare expects this numeric, 8-digit clinical trial (CT) registry number to be preceded by the alpha characters of "CT" in field 19 of paper form CMS-1500 claims or entered similarly in the electronic 837P in loop 2300 REF01 (REF01=P4).
- Professional claim lines for *0256T, 0257T, 0258T, 0259T, 33361, 33362, 33363, 33364, 33365*, and *0318T* must have the CT registry number, a Q0 modifier, and a secondary diagnosis code of V70.7 (ICD-10=Z00.6). Such claims lines will be returned as unprocessable if the CT registry number, the modifier Q0, or the V70.7 (ICD-10=Z00.6) is not present.

Claims for TAVR submitted without the CT registry number will be returned as unprocessable with the following messages:

- **Claims adjustment remarks code (CARC) 16**: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)";

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TAVR *(continued)*

- **Remittance advice remarks code (RARC) MA50**: "Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services."
- **RARC MA130**: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."
- **Group code**: CO (contractual obligation)

TAVR claims submitted without the Q0 modifier will be returned as unprocessable with the following messages:

- **CARC 4**: "The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N29**: "Missing documentation/orders/notes/summary/report/chart."
- **RARC MA130**: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."
- **Group code**: CO (contractual obligation)

For claims processed on or after July 1, 2013, the claim lines for *0256T, 0257T, 0258T, 0259T, 33361, 33362, 33363, 33364, 33365*, and *0318T* will be returned as unprocessable when billed without secondary diagnosis code V70.7 (ICD-10=Z00.6) with the following messages:

- **CARC 16**: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)"
- **RARC M76**: "Missing incomplete/invalid diagnosis or condition."
- **RARC MA130**: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."
- **Group code**: CO (contractual obligation)

Medicare also requires the CT registry number on hospital claims for TAVR for inpatient hospital discharges on or after July 1, 2013. Claims for TAVR for inpatient discharges on or after July 1, 2013, that do not have the registry number will be rejected. Medicare is ensuring the presence of the procedure codes and associated diagnosis and condition codes per CR 7897/TR 2552, issued September 24, 2012.

Additional information

The official instruction, CR 8255 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2689CP.pdf*. Add links to CR 7897 and CR 8168/TR 2628, issued January 7, 2013, for additional claim processing information.

Note: CR 8255 does not eliminate the previous instructions contained in CRs 7897 and 8168 that were not formally replaced/revised.

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

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Related Change Request (CR) #: CR 8255
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Implementation Date: October 7, 2013

Therapy Services

Manual medical review of outpatient therapy claims began April 1

On January 2, 2013, President Barack Obama signed the American Taxpayer Relief Act of 2012. Section 603 of this Act, contains a number of Medicare provisions which directly impacts claims submitted for outpatient therapy services. Revisions of the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 requires original Medicare to temporarily apply therapy caps (and related provisions) to therapy services furnished in outpatient hospital settings between the dates of January 1 through December 31, 2013.

What you need to know

Effective April 1, 2013, recovery auditors began the process of reviewing all therapy claims, which have exceeded the $3,700 threshold cap for the year. Importantly, there are two separate thresholds triggering manual medical reviews (MMRs) and build upon the separate therapy caps as follows: one for occupational therapy (OT) services, and; one for physical therapy (PT) and speech-language pathology (SLP) services combined. Although PT and SLP services are combined for triggering the threshold, the medical review will be conducted separately by discipline. Additional conditions include the requirement that all suppliers and providers who report on the beneficiary's claims for therapy services provide the national provider identifier (NPI) of the physician (or non-physician practitioner where applicable) who is responsible for reviewing the therapy plan of care.

Recovery auditors will complete two types of review:

Prepayment review

- Eleven states will be participating in the recovery audit prepayment review demonstration. All therapy claims that have exceeded the $3,700 therapy cap threshold for the year will be reviewed and compared to the medical record before the claim is processed for payment. The demonstration will occur in the following 11 states: FL, CA, MI, TX, NY, LA, IL, PA, OH, NC, and MO.
- If the recovery auditors determine an improper claim has been submitted, a review results letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the recovery auditor findings and detailed description of the Medicare policy or rule that was violated.
- Typical additional documentation requests (ADR) limits will not apply. All therapy claims at or above the $3,700 threshold cap will trigger the MMR process and will need to be reviewed by the recovery auditors.
- The recovery auditors will conduct prepayment review within 10 business days of receiving the medical record.
- The ADR will be sent to the provider by the Medicare administrative contractor (MAC) with instructions to send the records to the recovery auditor.

Post-payment review

- In the remaining states, the recovery auditor shall conduct immediate post-pay reviews.
- All therapy claims that have exceeded the $3,700 therapy cap threshold for the year will be reviewed and compared to the medical record after the claim has been processed for payment.
- If the recovery auditor determines an improper payment has resulted, a demand letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the recovery auditor findings and detailed description of the Medicare policy or rule that was violated.
- Typical ADR limits will not apply. All therapy claims at or above the $3,700 threshold cap will trigger the

(continued on next page)

Therapy *(continued)*

manual medical review process and will need to be reviewed by the recovery auditor.

- The ADR will be sent to the provider immediately after the claim is paid. The ADR will be sent by the MAC to the provider with instructions to send the records to the recovery auditor.

The threshold cap will accrue for claims with dates of service from January 1 through December 31, 2013. The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Private practices
- Part B skilled nursing facilities
- Home health agencies (TOB 34x)
- Outpatient rehabilitation facilities (ORFs)
- Rehabilitation agencies (comprehensive outpatient rehabilitation facilities)
- Outpatient hospitals

Questions

Additional guidance on the MMR process for therapy claims above the $3,700 threshold, as well as helpful medical review guidelines can be found on the *Therapy Cap* Web page. For all additional questions, please contact the appropriate recovery audit contractor (RAC) and/or A/B MAC in your region at their toll-free number, which may be found on the *Provider Compliance Group Interactive Map*.

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

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

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

Phase III electronic remittance advice enrollment operating rules

Provider types affected

This *MLN Matters*® article is intended for physicians, providers and suppliers enrolling for electronic remittance advice (ERA) with Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHI), A/B Medicare administrative contractors (MACs) and durable medical equipment (DME MACs)).

What you need to know

Stop – impact to you

This article is based on change request (CR) 8223, which instructs Medicare contractors on the steps they must take to come into compliance with Phase III ERA enrollment operating rule requirements by October 1, 2013. Contractors must have paper-based ERA enrollment forms in compliance with Attachment 1 of CR 8223 no later than July 1, 2014.

Caution – what you need to know

Medicare contractors must update their electronic remittance advice (ERA) enrollment forms to comply with Attachment 1 of CR 8223. The contractors must comply with the following requirements:

1. Identify a maximum set of standard data elements to be requested from providers for enrollment to receive electronic remittance advice (ERA).
2. Apply "controlled vocabulary" – predefined and authorized terms – for use when referring to the same data element.
3. Use standard data elements to appear on paper enrollment form in a standard format and flow, using consistent data elements and vocabulary as on the electronic form.
4. Use specific information or instruction to providers to assist in manual paper-based ERA enrollment.
5. Offer electronic ERA enrollment.

Go – what you need to do

Make sure that your billing staffs are aware of these updates to the ERA enrollment operating rules.

Background

Section 1104 of the Affordable Care Act requires the Secretary of Health and Human Services to adopt and regularly update standards, implementation specifications, and operating rules for the electronic exchange and use of health information for the purpose of financial and administrative transaction.

What you need to know about the ERA enrollment form

Providers who have a signed ERA enrollment form on file with a particular Medicare contractor or common electronic data interchange (CEDI) are not required to submit a new signed ERA enrollment form to the same Medicare contractor or CEDI each time they change their method of electronic billing or begin to use another type of electronic data interchange (EDI) transaction, e.g., changing from direct submission to submission through a clearinghouse or changing from one billing agent to another.

Additionally, providers are not required to notify their Medicare contractor or CEDI if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance.

Medicare contractors and CEDIs must inform providers that providers are obligated to notify them in writing in advance of a change that involves a change in the billing agent(s) or clearinghouse(s) used by the provider, the effective date on which the provider will discontinue using a specific billing agent and/or clearinghouse, if the provider wants to begin to use additional types of EDI transactions, or of other changes that might impact their use of ERA.

When a Medicare contractor or CEDI receives a signed request from a provider or supplier to accept ERA transactions from or send ERA transactions to a third party, the Medicare contractor or CEDI must verify that an ERA enrollment form is already on file for that provider or supplier. The request cannot be processed until both are submitted and issued.

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Phase III *(continued)*

The binding information in an ERA enrollment form does not expire if the person who signed that form for a provider is no longer employed by the provider or that Medicare contractor or CEDI is no longer associated with the Medicare program. Medicare responsibility for ERA oversight and administration is simply transferred in that case to that entity that the Centers for Medicare & Medicaid Services (CMS) chooses to replace that Medicare contractor or CEDI, and the provider as an entity retains responsibility for those requirements mentioned in the form regardless of any change in personnel on staff.

Contractors may require a wet signature to be submitted in conjunction with the electronic enrollment. (**Note**: A wet signature is an original signature on a document that is then scanned and sent by email.)

The document will become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to the Medicare contractor, CEDI, or other contractor if designated by CMS. Either party may terminate the arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

Additional information

The official instruction, CR 8223, issued to your FI, carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1235OTN.pdf*.

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

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Implementation Date: October 7, 2013

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Fraud

Transparency *(continued from front page)*

- Discourage inappropriate influences on research, education, and clinical decision-making.
- Curtail potential conflicts of interest that can compromise clinical integrity and patient care.

Final rule details

Relevant definitions

1. Applicable manufacturers

Those entities that operate in the United States and (1) are engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply, but not if such covered drug, device, biological or medical supply is solely for use by or within the entity itself or by the entity's own patients (this definition does not include distributors or wholesalers (including, but not limited to, repackagers, relabelers, and kit assemblers) that do not hold title to any covered drug, device, biological or medical supply); or (2) are entities under common ownership with an entity described in part (1) of this definition, which provide assistance or support to such entities with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological or medical supply.

2. Applicable GPOs

Those that operate in the United States and purchase, arrange for purchase, or negotiate the purchase of a covered drug, device, biological, or medical supply for a group of individuals or organizations that are not solely using the covered supply.

3. Covered Products:

Any drug and biologic for which payment is available under Medicare, Medicaid or the Children's Health Insurance (CHIP) program, either separately (such as through a fee schedule) or as part of a bundled payment (for example, under the hospital inpatient prospective payment system), and require a prescription to be dispensed.

Any device or medical supply for which payment is available under Medicare, Medicaid or the Children's Health Insurance (CHIP) program, either separately (such as through a fee schedule) or as part of a bundled payment (for example, under the hospital inpatient prospective payment system (IPPS)), and require premarket approval by or premarket notification to the U.S. Food and Drug Administration (FDA).

4. Teaching hospitals

Hospitals that receive payment for Medicare direct graduate medical education (GME), IPPS indirect medical education (IME), or psychiatric hospital IME programs.

Implementation timeline

In order to give applicable manufacturers and applicable GPOs sufficient time to prepare after publication of the final rule, industry data collection will begin on August 1, 2013. For the 2013 Open Payments program cycle, it will be abbreviated with only five months of data to be collected and reported, as compared to the 12-month cycles in subsequent years (January through December). Then, applicable manufacturers and applicable GPOs will submit the data to CMS by March 31, 2014, and CMS will make the data publicly available by September 30, 2014. CMS is developing an electronic system to facilitate the reporting process and the reported information will be easily aggregated, downloaded, and searchable on the program website.

Industry data collection requirements

The law specifies that, annually:

- Applicable manufacturers of covered drugs, devices, biologicals, and medical supplies must report payments or other transfers of value they make to physicians and teaching hospitals to CMS.
- Applicable manufacturers and applicable GPOs must report to CMS ownership or investment interests held by physicians or their immediate family members. Payments and other transfers of value to these physicians must also be reported.
- Applicable GPOs must report to CMS payments or other transfers of value made to physician owners or investors if they held ownership or an investment interest at any point during the reporting year.

Reportable payments or other transfers of value include such things as consulting fees, honoraria, gifts, entertainment, food and beverages, travel and lodging, and other items.

Research payments

The statute requires **applicable manufacturers** to report numerous types of payments to physicians and teaching hospitals, including consulting fees, food and beverages, and research payments.

Please note, however, that research payments, or other transfers of value may be delayed from publication on the website until the date of FDA approval or up to four years from the date of report (whichever is first), when made under a product research or development agreement in connection

(continued on next page)

Transparency *(continued)*

with: 1) Research on, or development of, a new drug, device, biologic, or medical supply, or a new application of an existing drug, device, biologic, or medical supply; or 2) Clinical investigations regarding a new drug, device, biologic, or medical supply.

Opportunity to review and correct information prior to publication

The law requires CMS to provide the physicians and teaching hospitals, who are being reported about, at least 45 days to review and dispute the information related to them that was submitted by applicable manufacturers and applicable GPOs. The review and correction period starts at least 60 days before the information is made public each year. Any disputed payments or transfers of value will need to be resolved directly between the disputer (physician or teaching hospital) and the relevant applicable manufacturer or applicable GPO. After the 45 days, applicable manufacturers and applicable GPOs will have an additional 15 days to submit corrections based on any disputes identified by physicians, teaching hospitals, and physician owners/investors.

Physicians should maintain their own records of any interaction with applicable manufacturers and applicable GPOs. This can help facilitate the review of the data that is submitted about them.

CMS will notify the physician and teaching hospital communities when the reported information is ready for review using an online posting and through notifications via CMS' listserv, i.e., electronic mailing lists to which physicians may subscribe including the CMS Open Payments listserv (located at *http://go.cms.gov/openpayments*.

Penalties for failure of accurate, complete, and timely reporting of required information

The Affordable Care Act provides that violators of the reporting requirements will be subject to civil monetary penalties (CMPs), capped annually at $150,000 for failure to report, and $1,000,000 for known failure to report. These CMPs only apply to applicable manufacturers and applicable GPOs.

CMS finalized that the HHS Office of Inspector General (OIG) and CMS reserve the right to audit, evaluate, or inspect the records of **applicable manufacturers** and **applicable GPOs** for their compliance with the reporting requirements. In order to facilitate these inspections, **applicable manufacturers** and **applicable GPOs** must maintain all records and documents for at least **five years from the date of payments or other transfers of value or ownership or investment interest is published publicly** on the website.

State law preemption

Section 6002 of the Affordable Care Act also preempts any state or local laws requiring reporting of the same types of information regarding payments or other transfers of value made by applicable manufacturers to covered recipients. No state or local government may require the separate reporting of any information regarding a payment or other transfer of value that is required to be reported under this statute; unless such information is being collected by a federal, state, or local government agency for public health surveillance, investigation, or other public health purposes or health oversight.

Additional information

For more information, please refer to the final rule, CMS-5060-F, "Transparency Reports and Reporting of Physician Ownership or Investment Interests," which is available at *http://www.gpo.gov/fdsys/pkg/FR-2013-02-08/html/2013-02572.htm* or email questions to *openpayments@cms.hhs.gov*.

There is also a dedicated CMS website for Open Payments, which can be found at *http://go.cms.gov/openpayments*.

Also available for physicians to learn more about Open Payments is a continuing medical education (CME) activity, "Are You Ready for the National Physician Payment Transparency Program?" Accessible via MedScape, and accredited by the Accreditation Council for Continuing Medical Education, physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70 percent on the post-test. Through the activity, participants will learn more about Open Payments, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify physician information in advance of website publication.

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Questionable billing by suppliers of lower limb prostheses

Note: This article was revised on April 11 to remove a note box that had appeared in "Key points." All other information is the same. This information was previously published in the June 2012 *Medicare B Connection*, Pages 39-42.

Provider types affected

This *MLN Matters*® special edition article is intended for providers who bill Medicare for lower limb prostheses. No new policies are contained in this article.

What you need to know

This article highlights the August 2011 report from the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) study titled "Questionable Billing By Suppliers of Lower Limb Prostheses." It also discusses Medicare policy regarding the coverage of lower limb prostheses under its Part B durable medical equipment, prosthetics, orthotics, and dupplies (DMEPOS) benefit.

The study was designed to meet the following objectives:

1. Identify payments for lower limb prostheses in 2009 that did not meet certain Medicare requirements;
2. Identify Medicare payments for lower limb prostheses in 2009 for beneficiaries with no claims from their referring physicians;
3. Identify suppliers of lower limb prostheses that had questionable billing in 2009; and
4. Describe the program safeguards in place in 2009 and the first half of 2010 to prevent inappropriate payments for lower limb prostheses.

Background

Between 2005 and 2009, Medicare spending for lower prostheses increased 27 percent, from $517 million to $655 million. The number of Medicare beneficiaries receiving lower limb prostheses decreased by 2.5 percent, from almost 76,000 to about 74,000.

Medicare policy requires that a supplier have an order from the referring physician before providing prostheses to the beneficiary. Upon receipt of the referring physician's order, the supplier can move forward with the prostheses fitting for the beneficiary with the applicable prostheses. Medicare policy also requires that suppliers follow local coverage determination policies. These policies provide guidelines for determining the beneficiary's potential functional level and specify how suppliers must submit claims for certain types and combinations of prostheses.

The study completed by the OIG was based on an analysis of Medicare Part B claims for lower limb prostheses from 2009 and Part A and Part B claims from 2004 to 2009 for beneficiaries who received lower limb prostheses in 2009. OIG staff also completed interviews with the four DME Medicare administrative contractors (MACs), three zone program integrity contractors (ZPICs), and two DME program safeguard contractors (PSCs). The OIG considered a paid claim did not meet the requirements if the supplier:

- Did not indicate whether the prosthesis was for the right or left limb;
- Billed for a prosthesis for both limbs on the same date using two claims;
- Did not meet potential functional level requirements;
- Billed for a higher number of units of a prosthesis than allowed on a claim;
- Billed for combinations of prostheses that were not allowed; or
- Billed for prostheses that were not covered.

Claims data was an additional component of the OIG's analysis to determine the number of claims for beneficiaries with no claims from their referring physicians during the last 5 years and the Medicare payments for these claims. The following elements were analyzed to identify suppliers that had questionable billing:

- Suppliers that had at least 10 beneficiaries, and
- Suppliers that were paid at least $100,000 for lower limb prostheses in 2009.

This sample included 1,632 of the 4,575 Medicare suppliers who had a paid claim for lower limb prostheses in 2009, which accounted for 92 percent of the $655 million who billed for lower limb prostheses.

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Prosthesis *(continued)*

Findings

In 2009, the study found that:

1. In 2009, Medicare inappropriately paid $43 million for lower limb prostheses that did not meet certain requirements. These payments could have been prevented by using claims processing edits.
2. Medicare paid an additional $61 million for beneficiaries with no claims from their referring physicians.
3. In 2009, 267 suppliers of lower limb prostheses had questionable billing. Approximately 136 suppliers frequently submitted claims that did not meet certain Medicare requirements or were for beneficiaries with no claims from their referring physicians. An additional 131 suppliers had other questionable billing. This included billing for a high percentage of beneficiaries with no history of an amputation or missing limb or a high percentage of beneficiaries with unusual combinations of prostheses.
4. Medicare contractors conducted varying degrees of program safeguard activities related to lower limb prostheses.
    - The four DME MACs had varying claims processing edits in place, but none had edits for all requirements.
    - None of the DME MACs conducted medical reviews, and not all had conducted data analyses or provided education related to lower limb prostheses.
    - All ZPICs and DME PSCs conducted data analyses and opened investigations related to lower limb prostheses.

Recommendations

The OIG made six recommendations based upon their findings. The Centers for Medicare & Medicaid Services (CMS) concurred with five of the six recommendations made by the OIG. The recommendations and CMS actions are as follows:

OIG recommendation 1: Implement additional claims processing edits to prevent inappropriate payments. CMS should instruct the four DME MACs to implement claims processing edits based on all of the local coverage determination requirements.

CMS response: CMS concurred and stated it would instruct the DME MACs to implement consistent claims processing edits based on local coverage determination requirements.

OIG recommendation 2: Strengthen monitoring of billing for lower limb prostheses. CMS should instruct the DME MACs, ZPICs, and DME PSCs to monitor billing for lower limb prostheses using the measures discussed in this report. CMS should develop thresholds for these measures and instruct its contractors to conduct additional reviews of suppliers that exceed the thresholds.

CMS response: CMS concurred and stated it would issue guidance to the DME MACs and instruct them to consider the measures used in the OIG report as supplemental criteria for detecting high-risk suppliers.

OIG recommendation 3: Implement requirements for a face-to-face encounter to establish the beneficiary's need for prostheses. We recommend that CMS implement requirements that the referring physician document that a face-to-face encounter occurred. This would help ensure that lower limb prostheses provided to beneficiaries are medically necessary.

CMS response: CMS concurred and stated it is exploring its current authorities to implement such requirements. CMS also stated that it would issue an educational article to further explain policy requirements for lower limb prostheses and to providers and suppliers.

OIG recommendation 4: Revise the requirements in the local coverage determination. CMS should work with the DME MACs to clarify several aspects of the local coverage determination. First, CMS should clarify the definitions of beneficiaries' functional levels. Second, CMS should revise the local coverage determination or take other steps to require that licensed/certified medical professionals, such as physical therapists, evaluate beneficiaries to determine their potential functional levels. Finally, CMS should consider denying as medically unnecessary certain combinations of prostheses.

CMS response: CMS concurred and stated it would review the definitions for the functional levels and develop refinements as appropriate. CMS also stated it would consider adapting an algorithm to guide determination of the functional status of the beneficiary.

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Prosthesis *(continued)*

OIG recommendation 5: Enhance screening for currently enrolled suppliers of lower limb prostheses. Federal regulations place new DMEPOS suppliers at the high-risk level and currently enrolled DMEPOS suppliers at the moderate-risk level. CMS should consider placing current suppliers of lower limb prostheses at the high-risk level, thus subjecting them to the more rigorous screening procedures.

CMS response: CMS did not concur and stated that it has in place sufficient tools that allow for increased scrutiny of existing DMEPOS suppliers. CMS noted that if an existing supplier meets one of several triggering events, that supplier automatically is elevated to the high-risk level.

OIG recommendation 6: Take appropriate action on suppliers with questionable billing. In a separate memorandum, we will refer the suppliers that we identified to CMS for appropriate action.

CMS response: CMS concurred and stated it would share the information with the DME MACs and the recovery audit contractors. Recovery audit contractors review Medicare claims on a post payment basis to identify inappropriate payments.

The following section reviews Medicare policy for coverage of lower limb prostheses.

Key points

Medicare requirements for lower limb prostheses

Provisions of the Social Security Act (the Act) govern Medicare payment for all items or services, including lower limb prostheses. The Act states that Medicare will cover only services and items considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

In addition, Medicare requires that a supplier have an order from a physician before providing prostheses to the beneficiary. This physician is known as the referring physician. Upon receiving the order, the supplier consults with the referring physician, as needed, to confirm the order and recommend any necessary changes and evaluates the beneficiary. The supplier fits the beneficiary with the most appropriate prostheses. The supplier then determines the group of codes that best describes the prostheses provided, choosing from 178 Healthcare Common Procedure Coding System (HCPCS) codes that are specific to lower limb prostheses.

Further, local coverage determination policies provide additional Medicare requirements for lower limb prostheses. These policies, consistent with policies for other DMEPOS, are identical across the country. The local coverage determination specifies how suppliers must submit claims for certain types and combinations of prostheses. In particular, it states that each claim must include a modifier to indicate whether the prosthesis is for the right or left limb. When a supplier provides prosthesis for each limb on the same date, the supplier must submit only one claim and include both the right and left modifiers on the claim.

The local coverage determination also has guidelines for determining the beneficiary's potential functional level. Specifically, it states that a beneficiary is placed at one of five potential functional levels based on the reasonable expectations of the supplier and the referring physician. When determining the potential functional level, suppliers and the referring physicians must take into account the beneficiary's history, current overall medical condition, and desire to walk. The supplier then uses a modifier on the claim to indicate the beneficiary's potential functional level (K0 to K4). Prostheses are not considered medically necessary if the beneficiary has the lowest potential functional level (K0), which indicates that he or she does not have the ability or the potential to walk. In addition, for some prostheses, the local coverage determination specifies the minimum potential functional level that the beneficiary must have for the prosthesis to be considered medically necessary.

Further, the local coverage determination limits the number of certain items that can be billed on a claim. If the number of units of these prostheses exceeds the limit, the additional items will be denied as not medically necessary. The local coverage determination also considers certain combinations of prostheses to be medically unnecessary. For example, certain sockets are not allowed for use with temporary base prostheses. Finally, the local coverage determination states that HCPCS L5990, a specific type of foot addition, will be denied as not medically necessary.

In addition, CMS recently established new screening procedures for provider enrollment. For example, screening may include licensure and criminal background checks. CMS created three levels of screening – limited, moderate, and high – based on the risk of fraud, waste, and abuse. New DMEPOS suppliers were placed at the high risk level, while currently-enrolled DMEPOS suppliers were placed at the moderate risk level.

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

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Prosthesis *(continued)*

provide. You may want to review *MLN Matters*® article SE1201 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf* for important reminders on the requirements for ordering and referring physicians.

Additional information

If you are unsure of, or have questions about, documentation requirements, contact your Medicare contractor at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The entire OIG report titled "Questionable Billing By Suppliers of Lower Limb Prostheses" is available at *http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf*.

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General Information

Standardizing the standard – operating rules for code usage in remittance advice

Note: This article was revised May 10, 2013, to reflect a revised change request (CR) 8182 issued May 9. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same. This information was previously published in the February 2013 *Medicare B Connection*, Pages 29-30.

Provider types affected

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

What you need to know

CR 8182, from which this article is taken, instructs your Medicare contractor to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set for code usage in electronic funds transfer (EFT) & electronic remittance advice (ERA) by January 1, 2014.

Background

The Health Insurance Portability and Accountability Act (HIPAA) amended Title XI of the Social Security Act by adding Part C (Administrative Simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996, which may be found at *http://aspe.hhs.gov/admnsimp/pl104191.htm#1173*).

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard

(continued on next page)

Standardizing *(continued)*

transactions and by mandating the adoption of a set of operating rules for each of the HIPAA transactions. In December 2011 congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to electronic data interchange (EDI) from paper has been slow and "disappointing." (You can find a copy of this testimony at *http://www.ncvhs.hhs.gov/*).

Note: The same rules will also apply to standard paper remittance (SPR), as Medicare reports the same standard codes in both electronic and paper formats of remittance advice.

The EFT & ERA operating rule set includes the following rules:

(Please note that CR 8182 focuses only on rule numbers 3 and 4)

1. Phase III CORE 380 EFT Enrollment Data Rule
2. Phase III CORE 382 ERA Enrollment Data Rule
3. Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule
4. CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule
5. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule, and
6. Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

HIPAA initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim/line has been adjudicated, and now the ERA/EFT operating rules under the Affordable Care Act are mandating a standard use of those standard codes. The ERA/EFT operating rules mandate consistent and uniform use of remittance advice (RA) codes (group codes, claim adjustment reason codes (CARCs), and remittance advice remark codes (RARCs)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up
- Faulty electronic secondary billing
- Inappropriate write-offs of billable charges
- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay.

Business scenarios

The CORE Phase III ERA/EFT operating rules define four business scenarios, and specify the maximum set of the standard codes that a health plan may use. This list will be updated and maintained by a CORE task group when the two code committees update the lists and/or when there is need for additional combinations based on business policy change and/or federal/state mandate.

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for each business scenario is specified in the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule), that is an attachment to CR 8182. This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published four times a year) in the future.

Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

Scenario 1: Additional information required – missing/invalid/incomplete documentation

This scenario refers to situations in which additional documentation is needed from the billing provider or an ERA from a prior payer.

(continued on next page)

Standardizing *(continued)*

Scenario 2: Additional information required – missing/invalid/incomplete data from submitted claim

This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario 3: Billed service not covered by health plan

This scenario refers to situations in which the billed service is not covered by the health plan.

Scenario 4: Benefit for billed service not separately payable

This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

Finally, by October 7, 2013, the Medicare remit easy print (MREP) and PC print software will be modified as necessary.

Additional information

The official instruction, CR 8182, 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/R1233OTN.pdf*. You will find a copy of the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule).

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 as an attachment to that CR.

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html.

MLN Matters® Number: MM8182 *Revised*
Related Change Request (CR) #: CR 8182
Related CR Release Date: May 9, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1233OTN
Implementation Date: October 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.

CY 2013 update to the AIC requirements for ALJ and federal district court appeals

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) requires an annual reevaluation of the dollar amount in controversy required for an administrative law judge (ALJ) hearing (third level review) or federal district court (fifth level) review.

- **ALJ hearing request**: The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2012, is $130. This amount increased to $140 for ALJ hearing requests filed on or after January 1, 2013.
- **Federal district court review**: The amount that must remain in controversy for federal district court review requests filed on or before December 31, 2012, is $1,300. This amount increased to $1,400 for appeals to federal district court filed on or after January 1, 2013.

Take the time to 'chat' with the website team

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast's new Live Chat service.

HIPAA eligibility transaction system to replaces CWF eligibility queries

Note: This article was revised on April 23, 2013, to update certain language to reflect the current status of this change. Also, clarifications have been made to the last question in the frequently asked questions section. This information was previously published in the December 2012 *Medicare B Connection*, Pages 46-47.

Provider types affected

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

Provider action needed

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

What you need to know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that the Centers for Medicare & Medicaid Services (CMS) will implement in the coming months. In April 2013, access to CWF eligibility query functions implemented in the multi-carrier system (MCS) and ViPS Medicare system (VMS), also referred to as PPTN and VPIQ, was terminated. CMS intends to terminate access to the other CWF eligibility queries implemented in the fiscal intermediary standard system (FISS) direct data entry (DDE), often referred to the HIQA, HIQH, ELGA and ELGH screens and HUQA. A change request will be issued later this year to terminate these queries effective April 2014. This will not affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare contractor's interactive voice response (IVR) units and/or Internet portals.

Background

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

Key points

General information

CMS plans to discontinue access to the CWF queries through the shared systems. Medicare providers and their agents that currently access the CWF queries through the shared system screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS

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

Frequently asked questions

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

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

(continued on next page)

HIPAA *(continued)*

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

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

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

By April 2014, HETS will return all of the information provided by the CWF eligibility queries that is needed to process Medicare claims. Changes are currently underway in HETS to return psychiatric information to authorized providers and to return hospice period information in the same format as CWF. These changes will be in place before the April 2014 termination date for the FISS DDE CWF query access.

HETS returns additional information that CWF does not return. For example, HETS returns:

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

The *HETS 270/271 Companion Guide* provides specific details about the eligibility information that is returned in the HETS 271 response. The guide is available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf*.

Additional information

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

MLN Matters® Number: SE1249 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

CMS releases comparative billing reports on evaluation and management services

The Centers for Medicare & Medicaid Services (CMS) issued national provider comparative billing reports (CBR) in May to assist providers with addressing the documentation and billing practices of evaluation and management services (E/M) for Medicare beneficiaries.

CBRs, produced by SafeGuard Services, were sent to select providers who may benefit from a state and national comparison of' billing and payment patterns related to E/M services.

According to CMS, the CBR is intended to help providers identify potential errors in their billing practice of E/M services provided to Medicare beneficiaries. A CBR contains peer comparisons with state and national data which can be used to provide helpful insights into coding and billing practices.

To review a sample of the evaluation and management services CBR, please visit the *CBR Services*, or call the SafeGuard Services' provider help desk at 530-896-7080.

First Coast Service Options Inc., (First Coast) also maintains abundant information to assist providers in improving their billing practices. For more information about documenting and billing E/M services, click on the First Coast E/M page *here*.

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

Update to Chapter 15 of the *Program Integrity Manual*

Provider types affected

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

What you need to know

This article is based on change request (CR) 8222, which makes several revisions to Chapter 15 of the Centers for Medicare & Medicaid Services (CMS) *Medicare Program Integrity Manual* (PIM). The key clarification is as follows:

- Sections 15.25.1.2 and 15.25.2.2 (Reconsideration Requests) are revised as follows: Consistent with 42 CFR 498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request of a provider enrollment denial or revocation at any time prior to the hearing officer's (HO's) decision. The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:
  - The initial determination itself
  - The findings on which the initial determination was based
  - The evidence considered in making the initial determination, and
  - Any other written evidence submitted under 42 CFR 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

Additional information

The official instruction, CR 8222, issued to your FI, RHHI, carrier, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R461PI.pdf*.

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

MLN Matters® Number: MM8222
Related Change Request (CR) #: CR 8222
Related CR Release Date: April 26, 2013
Effective Date: May 28, 2013
Related CR Transmittal #: R461PI
Implementation Date: May 28, 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.

Free ICD-10 webinar – sign up today

The Centers for Medicare & Medicaid Services (CMS) will offer a free webinar to help providers develop strategies for the transition to the International Classification of Diseases, Tenth Revision (ICD-10).

The webinar is scheduled for 10-11 a.m., EDT, Thursday, June 20. To reserve your place today, *click here*.

An additional webinar for providers in Central time will take place, noon, CDT, June 20. To reserve a spot for the Central time webinar, *click here*.

The webinar will inform about best practices and offer resources for providers in making the transition to ICD-10. Providers are encouraged to mark the date and time on their calendars and stay tuned to First Coast Service Options' eNews for webinar registration information.

The United States is planning its transition to ICD-10 for October 1, 2014. ICD-10 will control diagnoses and inpatient procedures for all health care providers covered by Health Insurance Portability and Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims.

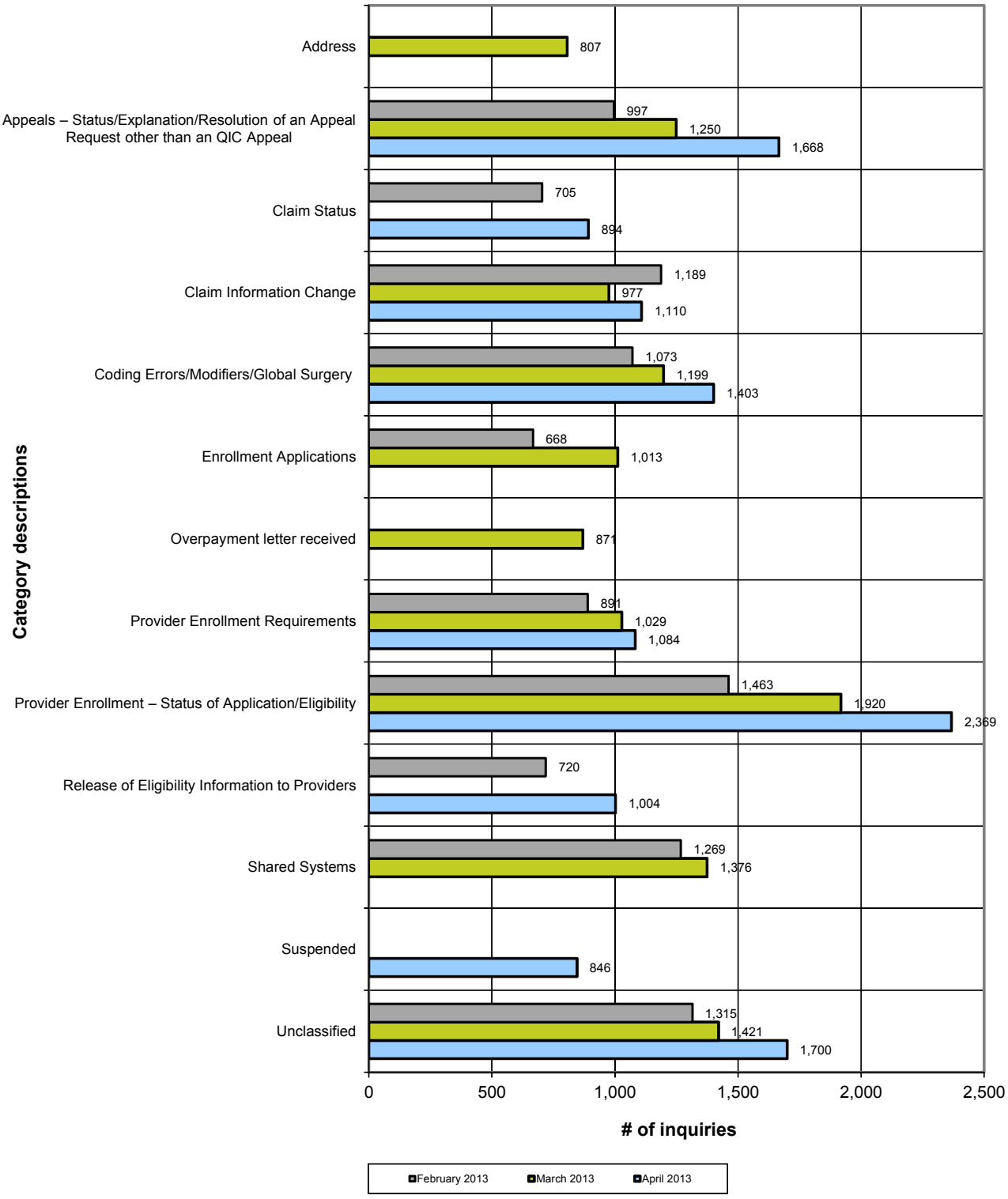
In addition to the webinar, CMS offers *a number of online resources* to assist providers with the transition to ICD-10.

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 February-April 2013.

For tips and resources to help providers avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Part B top inquiries for February-April 2013



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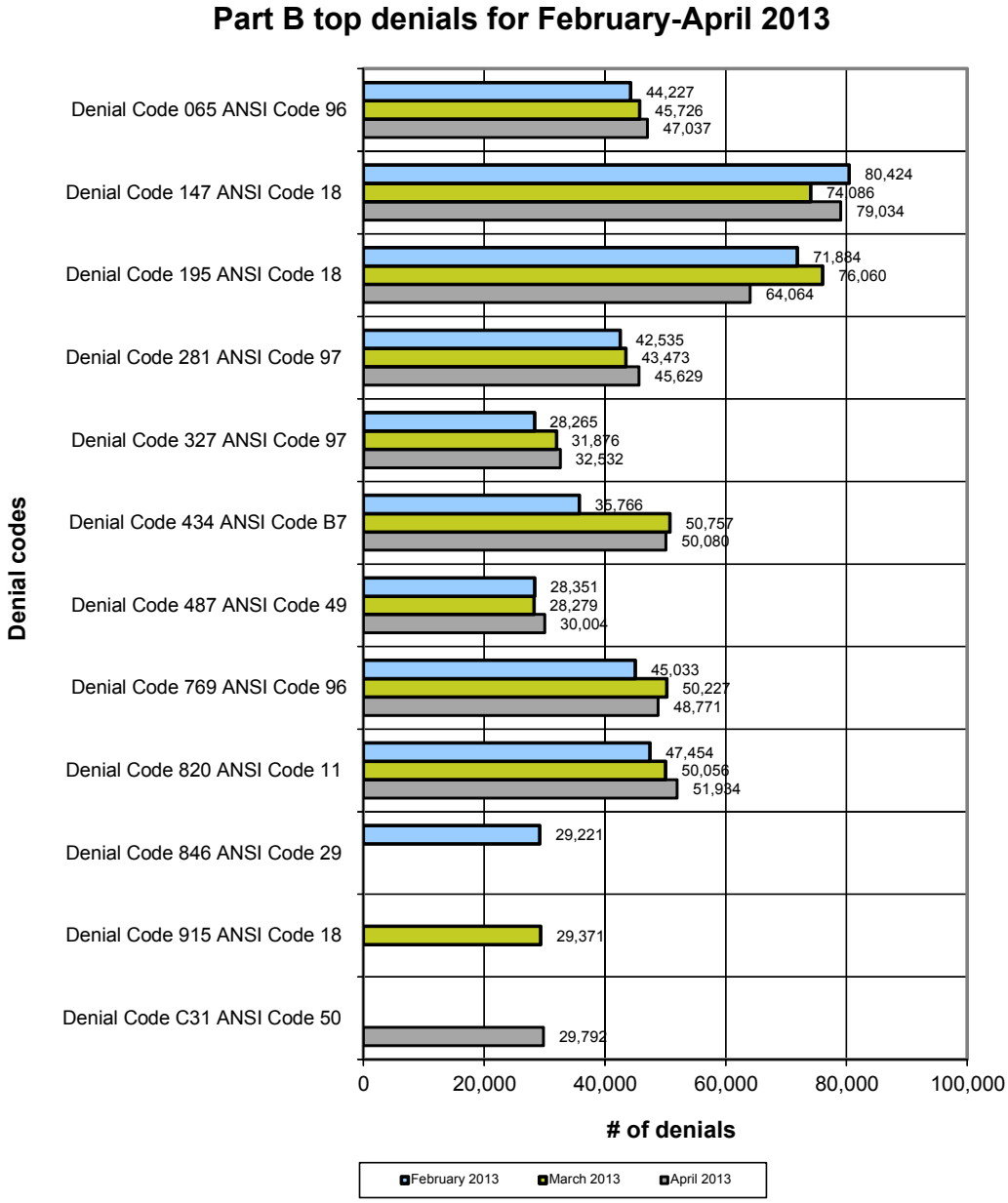
Top *(continued)*



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.

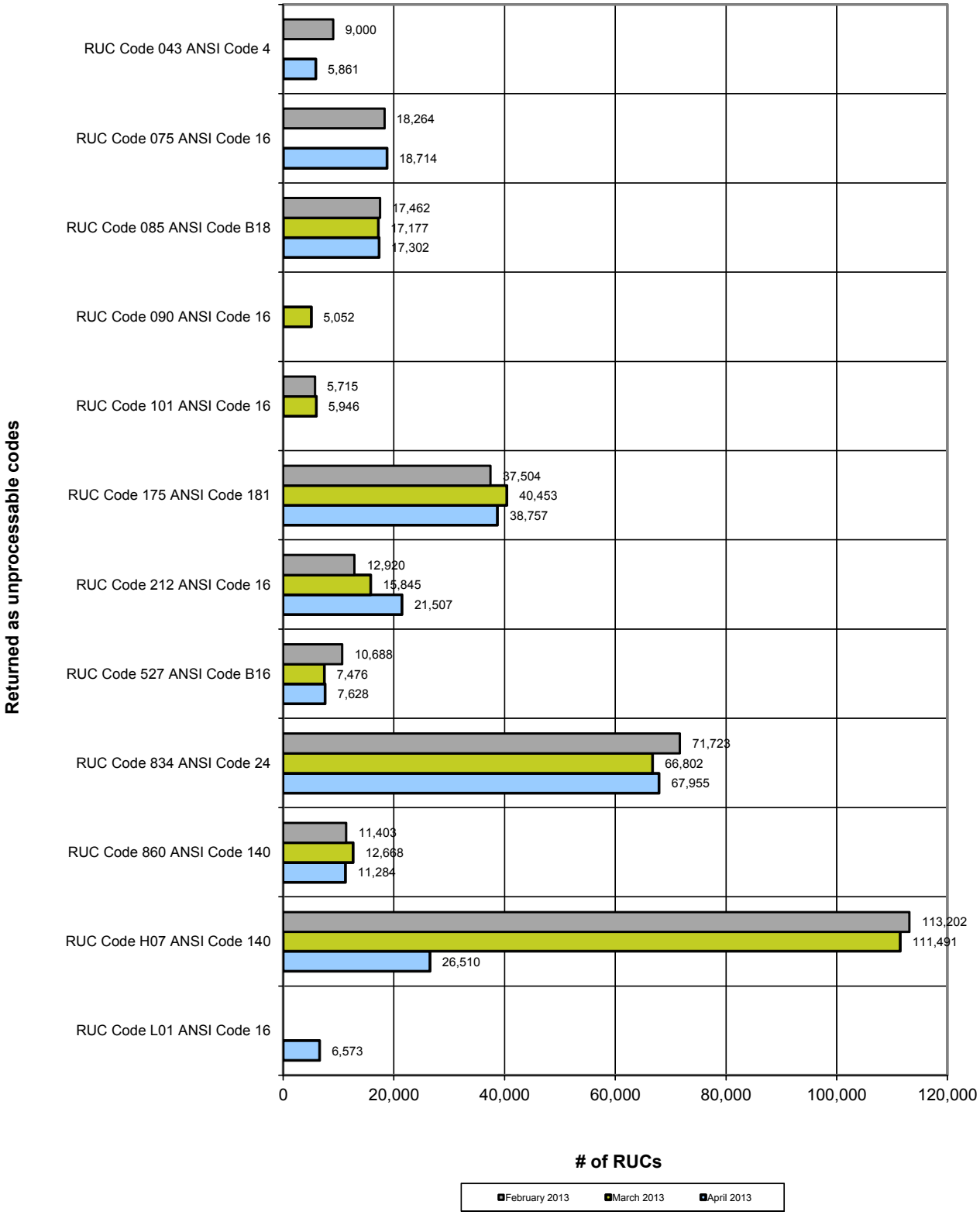
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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 February-April 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

Contents

Advance beneficiary notice

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

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

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

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

Looking for LCDs?

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

Retired LCDs

Psychiatry related services – Part B retired LCDs

LCD ID number: L29264, L29196, L29201, L29173, L29185 (Florida)
LCD ID number: L29471, L29439, L29353, L29425, L29434 (Puerto Rico/U.S. Virgin Islands)

Local coverage determinations (LCDs) *90791* (psychiatric diagnostic evaluation), *90832* (psychotherapy), *90785* (interactive complexity services), *90847* (family psychotherapy), and *90853* (group psychotherapy) are being retired because they are all being combined in a new LCD titled "psychiatric diagnostic evaluation and psychotherapy services" (PSYCH) that has been developed effective for services rendered **on or after June 4, 2013**. This new LCD addresses the recent restructuring of the coding in the psychiatry section of the 2013 *CPT*® book.

Effective date

These LCDs will be retired 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*.

Revisions to LCDs

BOTULINUMTOXINS: Botulinum toxins – revision to the LCD

LCD ID number: L29088 (Florida)
LCD ID number: L29103 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was most recently revised October 18, 2012. Since that time, the LCD was revised based on an external reconsideration request to add a new indication for Botox® (onabotulinumtoxinA), represented by HCPCS code J0585, which was approved by the Food and Drug Administration (FDA) on January 18, 2013. Revisions to the LCD include the following:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the following indication was added under the "FDA Indications for Botox®": "Treatment of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of anticholinergic medication".
- Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, ICD-9-CM diagnosis codes 596.51, 788.31, and 788.33 were added for HCPCS code J0585.
- The "Sources of Information and Basis for Decision" section of the LCD was updated.

In addition, the LCD "Coding Guidelines" attachment was revised to add the FDA indication as noted above for *CPT*® code *52287*.

Effective date

This LCD revision is effective for claims processed **on or after May 10, 2013**, for services rendered **on or after January 18, 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*.

PULMDIAGSVCS: Pulmonary diagnostic services – revision to the LCD

LCD ID number: L29265 (Florida)
LCD ID number: L29382 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pulmonary diagnostic services was most recently revised January 1, 2012. Since that time, the LCD was revised based on an external reconsideration request to update language under the "Indications" section of the LCD. Revisions to the LCD include the following:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the language was updated in the fifth paragraph under "Indications." Under the same section of the LCD, the following statement was added: "Pulmonary function studies *94010, 94060, 94070*, and *94375* must be: (1) performed by a qualified physician, or (2) performed under the general supervision of a qualified physician by a technologist (i.e., medical assistant, nurse) who has been trained to perform these tests by a qualified physician."

Effective date

This LCD revision is effective for services rendered **on or after May 7, 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

SKINSUBSTITUTES: Application of bioengineered skin substitutes for treatment of diabetic and venous stasis ulcers of the lower extremities – draft LCD

LCD ID number: DL33132 (Florida/Puerto Rico/U.S. Virgin Islands)

The draft local coverage determination (LCD) for application of bioengineered skin substitutes for treatment of diabetic and venous stasis ulcers of the lower extremities was posted for comment on February 7, 2013. During the comment period, First Coast Service Options Inc. received a substantial number of comments, as well as a large number of published clinical studies in support of coverage for various skin substitutes currently listed as non-covered in the draft LCD. In order to give due diligence to the comments, including review of the medical literature received, the finalization of the draft LCD has been delayed. It is anticipated that the draft LCD will be finalized in the near future.

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
June - July 2013

Internet-based PECOS class

When: Thursday, June 27, July 11, and July 18
Time: 8:00 a.m.-noon
Type of event: Face-to-face

Medifest 2013 Tallahassee; Building a stronger Medicare community through education

When: Tuesday-Wednesday, July 24-25
Time: 8:00 a.m.-4:30 p.m.
Type of event: Face-to-face

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 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 Medicare FFS Provider e-News': May 2, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-02-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': May 9, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-09-enews.pdf*
- 'CMS Medicare FFS Provider e-News': May 16, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-16-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': May 23, 2013 – *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-23-Enews.pdf*

Source: 201305-01, PERL 201305-02, PERL 201305-03, PERL 201305-04

Training module on the 'National Physician Payment Transparency Program' available

The Centers for Medicare & Medicaid Services has produced a training module called: "Are You Ready for the National Physician Payment Transparency Program?" and accredited by the Accreditation Council for continuing medical education. Physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70 percent on the post-test. Through the activity, participants will learn more about "open payment," the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify their information in advance of website publication.

The module features Dr. Peter Budetti, Deputy Administrator and Director of the Center for Program Integrity and Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity and Director of the Data Sharing and Partnership Group.

Medscape accounts are free and users do not have to be health care professionals to register. Registration is on the landing page of *www.medscape.com*.

Instructions for accessing the Medscape module

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

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

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

Step 4: To view the "Are You Ready for the National Physician Payment Transparency Program?" module, use this link: *http://www.medscape.org/viewarticle/780900*.

Get ready for ICD-10 - Free webinar

The Centers for Medicare & Medicaid Services (CMS) will offer a free webinar to help providers develop strategies for the transition to the International Classification of Diseases, Tenth Revision (ICD-10). The webinar is scheduled for 10-11 a.m., June 20. See page 27 for details and registration information.

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

U.S. Virgin Islands Contact Information

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

Puerto Rico Contact Information

Back to Contents

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