

C Medicare B CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

September 2013



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First Coast's newest online tool hits 'the SPOT'

Kay Allwardt manages billing for 56 physician offices representing 120 different Florida health care providers. Her team of 10 billing professionals processes an average of 1,500 Medicare fee for service claims each week.

In August 2012, her team volunteered to help test a new Medicare claims electronic portal with First Coast Service Options Inc. (First Coast). First Coast's new Secure Provider Online Tool (the SPOT) offers providers online access to essential Medicare data, including benefits and eligibility information, claim status, payment history, and comparative data reports.

Medicare fee-for-service claims do not represent the majority of claims processed by her team. However, Allwardt says the SPOT has helped improve business operations dramatically, making their work more efficient, lowering the number of denied claims, and improving the profitability of their business.

"The SPOT has improved our operations in tangible ways," she said. Of all the positive changes implemented by her team, Allwardt points to having access to the Medicare eligibility information through the SPOT as the biggest dividend. "We know if we bill for it, we are going to get paid," Allwardt says confidently.

"With the SPOT, we are able to make eligibility determinations right then and there. The system is live," Allwardt says. She has seen a big decline in the number of denials, specifically codes CO22 and CO24.

"We updated our hospice process. Prior to the SPOT, we guessed at whether or not the episode of care involved hospice. The SPOT gives us specific dates of service and the identification of the hospice provider. We have fewer denials because we have the information in real time," Allwardt said.

"The convenience of having the beneficiaries Part B deductible information immediately available through the SPOT has greatly improved our account receivables."

**– Kay Allwardt,
Billing manager**

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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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Medicare Publications
904-361-0723

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

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About the *Medicare B Connection*

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

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

Who receives the Connection

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

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

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

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

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

Publication format

The Connection is arranged into distinct sections.

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

In addition to the above, other sections include:

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

The Medicare B Connection represents formal notice of coverage policies

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



Advance beneficiary notices

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

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

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

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

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44>.

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Ambulatory Surgical Center

October 2013 update of the ASC payment system

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) 8437 which informs Medicare contractors about the changes to, and billing instructions for various payment policies implemented in the October 2013 ambulatory surgery center (ASC) payment system update. CR 8437 also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staffs are aware of these changes.

Key points of CR 8437

New device pass-through categories

Additional payments may be made to an ASC for covered ancillary services, including certain implantable devices with pass-through status under the outpatient prospective payment system (OPPS). Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. The ASC payment system follows this OPPS policy and implements new device pass-through codes, as appropriate, in the ASC payment system.

The Centers for Medicare & Medicaid Services (CMS) is establishing one new device pass-through category as of October 1, 2013, for the OPPS and the ASC payment system. The new HCPCS code, descriptor, and ASC payment indicator is as follows:

HCPCS	Short descriptor	Long descriptor	ASC payment indicator
C1841	Retinal prosth int/ext comp	Retinal prosthesis, includes all internal and external components	J7

The device offset is a payment deduction from the device pass-through payment that reflects the device portion of the surgical procedure payment. CMS has determined that they are not able to identify a device portion of the surgical procedure payment amount associated with the cost of C1841. Therefore, they will not make any offset deduction from the pass-through payment for C1841.

Billing for drugs, biologicals, and radiopharmaceuticals

- a) **Drugs and biologicals with payments based on average sales price (ASP), effective October 1, 2013:** Payments for separately payable drugs and biologicals based on the ASPs are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2013 release of the ASC DRUG file. The updated payment rates, effective October 1, 2013, are included in the October 2013 update of ASC Addendum BB, and are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.
- b) **New HCPCS codes for drugs and biologicals separately payable under the ASC payment system, effective October 1, 2013:** Two drugs and biologicals have been granted ASC payment status effective October 1, 2013. These items, along with their descriptors and ASC payment indicator, are as follows:

HCPCS code	Short descriptor	Long descriptor	ASC payment indicator
C1204	Tc 99m tilmanocept	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	K2

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Quality (continued)

HCPCS code	Short descriptor	Long descriptor	ASC payment indicator
C9132	Kcentra, per i.u.	Prothrombin complex concentrate (human), Kcentra, per i.u. of Factor IX activity	K2

c) **Fluzone (influenza virus vaccine):** CPT® code 90685 was effective January 1, 2013, however, the flu vaccine associated with this code was not approved by the FDA until June 7, 2013. Because of this recent FDA approval, CMS is revising the ASC payment indicator for CPT® code 90685 from “Y5” (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to “L1” (Influenza vaccine; pneumococcal vaccine; packaged item/service; no separate payment made) effective June 7, 2013.

d) **Revised ASC payment indicators for HCPCS codes Q4135 and Q4136, effective October 1, 2013:** Effective October 1, 2013, the ASC payment indicators for HCPCS code Q4135 (Mediskin, per square centimeter) and HCPCS code Q4136 (Ez-derm, per square centimeter) will change from “Y5” (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to “K2” (Drugs and biological paid separately when provided integral to a surgical procedure on the ASC list). For the remainder of CY 2013, HCPCS code Q4135 and Q4136 will be separately paid and the prices for these codes will be updated on a quarterly basis. The codes are as follows:

HCPCS code	Long descriptor	ASC payment indicator
Q4135	Mediskin, per square centimeter	K2
Q4136	Ez-derm, per square centimeter	K2

e) **Updated payment rates for certain HCPCS codes, effective July 1, 2013, through September 30, 2013:** The payment rate for one HCPCS code was incorrect in the July 2013 ASC drug file. The corrected payment rate is shown below and has been installed in the revised July 2013 ASC drug file, effective for services furnished on July 1, 2013, through September 30, 2013. Suppliers who received an incorrect payment for dates of service between July 1, 2013, and September 30, 2013, may request contractor adjustment of the previously processed claims.

HCPCS code	Short descriptor	Corrected payment rate	ASC payment indicator
J1566	Immune globulin, powder	\$30.66	K2

Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

Additional information

The official instruction, CR 8437, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2770CP.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: MM8437
 Related Change Request (CR) #: CR 8437
 Related CR Release Date: August 16, 2013
 Effective Date: October 1, 2013
 Related CR Transmittal #: R2770CP
 Implementation Date: October 7, 2013

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Implementation of the ASC quality reporting program payment reduction

Provider types affected

This *MLN Matters*[®] article is intended for physicians and ambulatory surgical centers (ASCs) submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries and paid under the ASC payment system.

What you need to know

This article is based on change request (CR) 8349, which instructs Medicare contractors to implement payment reductions for those ASCs that do not successfully meet ASC quality reporting program requirements. Please be sure your staffs are aware of the reporting requirements and the application of the ASCQR program penalties.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented a quality reporting program for ASCs in the 2012 outpatient prospective payment system (OPPS)/ASC final rule with comment period (76 *Federal Register* (FR) 74492 to 74517), finalizing additional program policies in the fiscal year (FY) 2013 Inpatient Prospective Payment System (IPPS)/Long Term Care Hospital (LTCH) final rule with comment period (77 FR 53637 to 53644).



Beginning with January 1, 2014 services, ASCs that do not successfully meet ASCQR program requirements shall be subject to a payment reduction.

Section 109(b) of the Medicare Improvement and Extension Act of 2006 under Division B, Title I of the Tax Relief and Health Care Act of 2006 (MIEA-TRCHA; Pub. L. 109-432) amended Section 1833(i) of the Social Security Act to state that the Secretary may provide that any ASC that does not submit quality measures to the Secretary in accordance with paragraph (7) shall incur a 2.0 percentage point reduction to any annual increase provided under the revised ASC payment system for such year. Any facility that receives Medicare payment under part B as an ASC and is subject to this annual payment increase, whether independent or operated by a hospital, is subject to these provisions.

The application of a reduced ASC fee schedule (ASCFS) update results in reduced national unadjusted payment rates that will apply to certain ASC services provided by Medicare certified ASCs

that fail to meet the ASCQR program requirements. All other ASCs paid under the CY 2014 ASC payment system will receive the full ASC payment update without the reduction.

For the first affected payment update, that is, for 2014, CMS will analyze fee-for-service claims data from dates of service October 1, 2012, to December 31, 2012, paid by the Medicare administrative contractor by April 30, 2013, to determine if an ASC successfully meets ASCQR program requirements. ASCs that are not successful, and are subject to these requirements, will be subject to the payment reduction to the 2014 payment rates. The processing of claims with the reduced ASCFS payment rates for certain ASCs constitutes the application of the ASCQR program penalty.

Participation in the ASC quality reporting program

ASCs will be deemed successful and not penalized, for purposes of the ASCQR program by meeting program requirements during a specified reporting period. For purposes of the CY 2014 payment determination, ASCs must report quality data codes (QDCs) on Medicare Part B claims submitted for reimbursement using the CMS-1500 or related electronic data set and must meet data completeness requirements. The QDCs for reporting are outlined in CR 7754, transmittal 2425, dated March 16, 2012, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2425CP-.pdf>.

The QDCs are also outlined in the *MLN Matters*[®] article MM7754, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7754.pdf>.

Determination of whether an ASC failed to meet quality reporting requirements will be made by CMS, at the individual supplier level, based on the billing ASC facility's national provider identifier (NPI).

The payment reduction under the ASCQR program applies to certain Medicare Part B covered ASC services subject to the ASC annual payment update. The payment reduction per statute is a 2.0 percentage point reduction to any payment update provided under the revised ASC payment system for the year applied. CMS will supply the reduced payment rates to contractors as part of the ASCFS update.

ASC module programming will be applied to the quality penalty reduced payment rates on the ASCFS in the

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Quality *(continued)*

same manner and order as is applied to the non-reduced ASCFS schedule amount. For example, in CY 2014, the ASCFS amount for a particular service is \$100. If the ASC is not subject to a payment reduction, the paid amount the ASC will receive is \$80 [$\100 (the allowed ASC fee schedule amount) - ($\$100 \times 20$ percent (beneficiary co-pay) = \$80)]. However, if the ASC is subject to a 2.0 percentage point payment reduction due to not successfully meeting ASCQR program requirements, the 2.0 percentage point reduction will be applied to the initial allowed ASCFS payment. As such, the reduced ASCFS amount is \$98. If the beneficiary co-pay is 20 percent, the beneficiary will pay $\$98 \times 20$ percent = \$19.60. The paid amount to the ASC accounting for the payment reduction will, thus, be $\$98 - \$19.60 = \$78.40$.

Process for removing an ASC from the ASCQR program payment reduction

CMS through a process which was finalized in the FY 2013 IPPS/LTCH final rule with comment period (77 FR 53643). An ASC seeking a reconsideration of a quality reporting payment determination must submit to CMS a completed reconsideration request form by March 17 of the affected payment year. CMS would complete any reconsideration reviews and communicate the results of these determination to the designated ASC staff.

If CMS determines through the reconsideration process that a payment reduction was applied in error, CMS will notify contractors to remove the ASC from the payment reduction via an ASC quality penalty list update file that will be supplied to contractors. This ASC penalty list update file will be sent to contractors up to five times per month at weekly intervals; these will be full replacement files.

Two actions will occur when the contractor receives notice that an ASC is to be removed from the payment reduction. First, the contractor shall no longer process claims submitted by the ASC identified in error using the reduced payment rates. Second, the contractor shall reprocess all claims affected by the reduced payment rates for that supplier for that calendar year no later than 45 days after receipt of the notification to remove the ASC from the payment reduction. The reduced payment rates are only applied as an entire "calendar year" adjustment. ASCs will not be added to the annual ASC quality penalty list during the year; therefore, partial year reduced payment rates will not be assessed.

Note: The two percentage point reduction only impacts the ASCFS. It does not apply to or impact codes appearing on the ASCDRUG file, the ASCPI file code assignments, or the ASC code pair file.

Message codes used to communicate reduced payments

Beginning January 1, 2014, Medicare will use the following messages for the ASCs receiving the reduced payment amount on the ASCFS:

- **Claim adjustment reason code (CARC) 237** – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
- **Remittance advice remark code (RARC): N551** – Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.
- **CARC 237** – Legislated/Regulatory Penalty. At least one Remark Code must be provided; this Remark Code may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.
- **RARC N552** – Payment adjusted to reverse a previous withhold amount.

Additional information

The official instruction, CR 8349, issued to your MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1280OTN.pdf>.

MLN Matters® article MM7754 "April 2012 Update of the Ambulatory Surgical Center (ASC) Payment System" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7754.pdf>.

CR 7754, transmittal 2425, outlines the ASC quality measures, it is available here <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2425CP-.pdf>.

If you have any questions, please contact your 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: MM8349
 Related Change Request (CR) #: CR 8349
 Related CR Release Date: August 16, 2014
 Effective Date: January 1, 2014
 Related CR Transmittal #: R1280OTN
 Implementation Date: January 6, 2014

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Drugs and Biologicals

Influenza vaccine allowances – annual update for 2013-2014 season

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8433 in order to update payment allowances, effective August 1, 2013, for seasonal influenza virus vaccines when payment is based on 95 percent of the average wholesale price (AWP). Be sure your billing staffs are aware of this update.

Background

CR 8433 provides payment allowances for the following seasonal influenza virus vaccine codes when payment is based on 95 percent of the AWP, except when furnished in a hospital outpatient department, a rural health clinic, or a federally qualified health center for which payment is based on reasonable cost:

- *Current Procedural Terminology* (CPT®) codes 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, and 90688; and
- Healthcare Common Procedure Coding System (HCPCS) codes Q2033, Q2035, Q2036, Q2037, and Q2038.

The updated allowance rates are effective for dates of service (DOS) as follows (except when provided in a hospital outpatient department, RHC, or FQHC):

- CPT® 90655 is \$17.243 (DOS 8/1/2013-7/31/2014)
- CPT® 90656 is \$12.398 (DOS 8/1/2013-7/31/2014)
- CPT® 90657 is \$6.022 (DOS 8/1/2013-7/31/2014)
- CPT® 90661 is pending (DOS 8/1/2013-7/31/2014)
- CPT® 90685 is \$23.228 (DOS 8/1/2013-7/31/2014)
- CPT® 90686 is \$19.409 (DOS 8/1/2013-7/31/2014)
- CPT® 90687 is pending (DOS pending-7/31/2014)
- CPT® 90688 is pending (DOS pending-7/31/2014)
- HCPCS Q2035 (Afluria®) is \$11.543 (DOS 8/1/2013-7/31/2014)

- HCPCS Q2036 (Flulaval®) is \$8.579 (DOS 8/1/2013-7/31/2014)
- HCPCS Q2037 (Fluvirin®) is \$14.963 (DOS 8/1/2013-7/31/2014)
- HCPCS Q2038 (Fluzone®) is \$12.044 (DOS 8/1/2013-7/31/2014)

Effective August 1, 2013, HCPCS Q2039 (Flu vaccine adult – not otherwise classified) payment allowance is to be determined by the local claims processing contractor.

As the information becomes available, CMS will post payment limits for influenza vaccines that are approved after the release date of this CR (including CPT® codes 90687 & 90688) on the *CMS Seasonal Influenza Vaccines Pricing Web page* at <http://cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html>.

Payment for the following may be made if your MAC determines its use is medically reasonable and necessary for the beneficiary:

- CPT® 90654 Payment allowance is \$18.918 for DOS of 8/1/2013-7/31/2014.
- CPT® 90662 Payment allowance is \$31.823 for DOS of 8/1/2013-7/31/2014.
- CPT® 90672 Payment allowance is \$24.596 for DOS of 8/1/2013-7/31/2014.
- CPT® 90673 Payment allowance is pending for DOS of 1/1/2014-7/31/2014.
- HCPCS Q2033 (Flublok®) Payment allowance is pending for DOS of 8/1/2013-7/31/2014.

Please note that the payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files. Further, you should be aware that annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Finally, MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims; however, they will adjust claims that you bring to their attention.

(continued Page 11)



January 2014 quarterly ASP Medicare Part B drug pricing files and revisions to prior quarterly pricing files

Provider types affected

This *MLN Matters*[®] article is intended for physicians, 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 Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8448 which instructs Medicare contractors to download and implement the January 2014 average sales price (ASP) drug pricing files; and, if released by the Centers for Medicare & Medicaid Services (CMS), the October 2013, July 2013, April 2013, and January 2013 drug pricing files for Medicare Part B drugs.

Medicare will use the January 2014 ASP and “not other classified” (NOC) drug pricing files to:

- Determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2014, with dates of service January 1, 2014, through March 31, 2014; and
- Update the drug payment limits for claims for infusion drugs furnished through a covered item of DME processed or reprocessed on or after January 1, 2014, with dates of service on or after January 1, 2014.

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

Background

The Medicare Modernization Act of 2003 (MMA) Section 303(c) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost, or prospective payment, basis.

The ASP methodology is based on quarterly data that manufacturers submit to the Centers for Medicare & Medicaid Services (CMS); who will quarterly supply Medicare contractors with the ASP and NOC drug pricing files for Medicare Part B drugs. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER). You can find this manual at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf>.

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

Files	Effective dates of service
January 2014 ASP and ASP NOC	January 1, 2014, through March 31, 2014
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013

Please note that: 1) The ASP and NOC drug pricing files will contain the applicable payment allowance limits (i.e., 106 percent ASP, 106 percent wholesale acquisition cost (WAC), or 95 percent actual wholesale price (AWP)); and as a result, your Medicare contractor will not make any additional payment calculations; 2) For any drug or biological not listed in the ASP or NOC drug pricing files, your contractor will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual*, Chapter 17 (Drugs and Biologicals), Section 20.1.3 (Exceptions to Average Sales Price (ASP) Payment Methodology); which you can find at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>; and 3) Your MAC will seek payment allowances from their local carrier for drugs and biologicals that are not on the ASP file.

In addition, you should be aware that your MAC will not search and adjust claims that have already been processed unless you bring them to their attention.

Additional information

The official instruction, CR 8448, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2780CP.pdf>.

If you have any questions, please contact your 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: MM8448
 Related Change Request (CR) #: CR 8448
 Related CR Release Date: September 6, 2013
 Effective Date: January 1, 2014
 Related CR Transmittal #: R2780CP
 Implementation Date: January 6, 2014

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.

Evaluation and Management

Initial hospital care and initial nursing facility care evaluation and management services billed as follow up visits

First Coast Service Options, Inc. (First Coast) has identified, through data analysis, incorrect claim payment errors for both Initial hospital care (*Common Procedure Terminology (CPT®) 99221-99223*) and Initial nursing facility services (*CPT® codes 99304-99306*). Data analysis has identified initial care services that are incorrectly billed daily as follow up visits by the same performing provider. Follow up visits in the facility setting are to be billed as subsequent hospital care visits (*CPT® 99231-99233*) and subsequent nursing facility care visits (*CPT® codes 99307-99310*).

As outlined in the Centers for Medicare & Medicaid (CMS) *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.9:

In the inpatient hospital setting all physicians (and qualified nonphysician practitioner where permitted) who perform an initial evaluation may bill the initial hospital care codes (*99221-99223*) or nursing facility codes (*99304-99306*). Contractors consider only one M.D. or D.O. to be the principal physician of record (sometimes referred to as the admitting physician.) The principal physician of record is identified in Medicare as the physician who oversees the patient's care for other physicians who may be furnishing specialty care. Only the principal physician of record shall append modifier "AI" (principal physician of record) in addition to the E/M codes. Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility visits.

First Coast encourages providers to evaluate their current billing patterns. Providers may utilize the interactive voice response (IVR) to reopen claims that have been billed in error. For additional information please access the [IVR Quick Reference Guide](#).

Influenza (continued)

Additional information

The official instruction, CR 8433 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2786CP.pdf>.

If you have any questions, please contact your 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: MM8433

Related Change Request (CR) #: CR 8433

Related CR Release Date: September 13, 2013

Effective Date: August 1, 2013

Related CR Transmittal #: R2786CP

Implementation Date: No later than October 25, 2013

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Laboratory/Pathology

New waived tests

Provider types affected

This *MLN Matters*[®] article is intended for clinical diagnostic laboratories submitting claims to Medicare administration contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare carrier or A/B MAC for a *Current Procedural Terminology (CPT)*[®] code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *CPT*[®] codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and thus requiring certification) change each year. Change request (CR) 8439, from which this article is taken, informs carriers and MACs about the latest new *CPT*[®] codes that are subject to CLIA edits.

Make sure that your billing staffs are aware of these CLIA-related changes for 2014 and that you remain current with certification requirements.

Background

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The *CPT*[®] codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR 8439 (i.e., *CPT*[®] codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The *CPT*[®] code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- G0434QW, January 23, 2008, Phamatech At Home 12 Drug Test (Model 9308T)
- G0434QW, January 23, 2008, Phamatech At Home 12 Drug Test (Model 9308Z)
- 81003QW, January 29, 2013, Henry Schein Urispec Plus Urine Analyzer
- G0434QW, February 27, 2013, CLIAwaived, Inc. Rapid Drug Test Cup

- G0434QW, February 27, 2013, Clinical Reference Laboratory, Inc. Intelligent Transport Cup
- G0434QW, February 27, 2013, Noble Medical Inc. Noble 1 Step Cup
- G0434QW, February 27, 2013, Premier Integrity Solutions P/Tox Drug Screen Cup
- G0434QW, February 27, 2013, US Diagnostics ProScreen Drugs of Abuse Cup
- 84443QW, March 5, 2013, BTNX Rapid Response Thyroid Stimulating Hormone (TSH) Test Cassette (Whole Blood)
- 86308QW, March 11, 2013, Henry Schein OneStep Pro+ Mono {Whole Blood}
- G0434QW, May 15, 2013, UCP Biosciences, Inc. UCP Home Drug Screening Test Cups
- G0434QW, May 17, 2013, Alere Toxicology Services, Inc. Tox Screen Drugs of Abuse Test Cup;
- G0434QW, June 24, 2013, Advin Multi-Drug Screen Test
- 87880QW, July 3, 2013, Henry Schein OneStep Pro+ Strep A Cassette

Additional information

The official instruction, CR 8439, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2779CP.pdf>.

If you have any questions, please contact your 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: MM8439
 Related Change Request (CR) #: CR 8439
 Related CR Release Date: September 6, 2013
 Effective Date: January 1, 2014
 Related CR Transmittal #: R2779CP
 Implementation Date: January 6, 2014

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Medicare Physician Fee Schedule

New claim adjustment reason code to identify a reduction in payment due to sequestration

Note: This article was revised September 5, 2013, to revise the title to be consistent with the change request. All other information is unchanged. This information was previously published in the August 2013 *Medicare B Connection*, Page 31.

Provider types affected

This *MLN Matters*[®] article is intended for physicians, 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 CR 8378 which informs Medicare contractors about a new claim adjustment reason code (CARC) reported when payments are reduced due to sequestration. Make sure that your billing staffs are aware of these changes.

Background

As required by law, President Obama issued a sequestration order on March 1, 2013, canceling budgetary resources across the federal government. As a result, Medicare fee-for-service claims, with dates of service or dates of discharge on or after April 1, 2013, incur a two percent reduction in Medicare payment. The Centers for Medicare & Medicaid services (CMS) previously assigned CARC 223 (Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created) to explain the adjustment in payment.

Effective June 3, 2013, a new CARC was created and will replace CARC 223 on all applicable claims. The new CARC is as follows:

- 253: Sequestration – Reduction in Federal Spending

Also, Medicare contractors will not take any action on claims processed prior to implementation of CR 8378.

Additional information

The official instruction, CR 8378, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2739CP.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: MM8378 *Revised*
Related Change Request (CR) #: CR 8378
Related CR Release Date: July 25, 2013
Effective Date: June 3, 2013
Related CR Transmittal #: R2739CP
Implementation Date: January 6, 2014

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October update to the 2013 Medicare physician fee schedule database

Note: This article was revised September 10, 2013, to reflect the revised change request (CR) 8386 issued September 10. 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 August 2013 *Medicare B Connection*, Page 17.

Provider types affected

This *MLN Matters*[®] article is intended for physicians and other providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services that are paid under the Medicare physician fee schedule database (MPFSDB).

What you need to know

This article is based on CR 8386 and instructs Medicare contractors to download and implement a new MPFSDB, effective October 1, 2013.

Background

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

CR 8386, from which this article is taken, announces that the MPFSDB has been updated effective October 1, 2013; and new payment files were issued to your contractor(s) based upon the CY 2013 Medicare physician fee schedule (MPFS) final rule (published in the *Federal Register* on November 16, 2012); as modified by the American Taxpayer Relief Act of 2012 (applicable January 1, 2013, see <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>), and the October 1, 2013, updated payment files.

Key changes of the October update

- Medicare contractors add HCPCS code G9187 (BPCI home visit) to their systems with an effective date of October 1, 2013; and
- The effective date of HCPCS code G0460 (Autologous platelet-rich plasma (PRP) for chronic non-healing wounds) is adjusted to be August 2, 2012.

For more information and access to the CY 2013 final rule, see the "Physician Fee Schedule" Web page available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>.

CMS will notify your contractors when the new files are available for retrieval, and CR 8386 instructs them to provide you 30 days' notice before implementing the changes. Further, while they do not have to search their files to either retract payment for claims already paid, or to retroactively pay claims; they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 8386, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2784CP.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: MM8386 *Revised*
Related Change Request (CR) #: CR 8386
Related CR Release Date: September 10, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2784CP
Implementation Date: October 7, 2013

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Surgery

Proper entry of clinical trial number helps avoid delays on TAVR claims

On May 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) that outlines coverage for transcatheter aortic valve replacement (TAVR) under coverage with evidence development (CED). [Change request 8255](#) was issued requiring that claims for TAVR carry an approved eight-digit clinical trial registry number for the following:

- Professional claims processed on or after July 1, 2013
- Hospital claims for inpatient hospital discharges on or after July 1, 2013

Note: Claims submitted without the clinical trial registry number will be returned.

Reminders

Electronic claims: Only the eight-digit numeric portion of the approved clinical trial registry number is entered in the electronic 837P in Loop 2300 REF01 (REF01=P4).

Paper claims: The eight-digit registry number is preceded by a “CT” prefix in Field 19 of CMS-1500 claims.

Source: Change request 8255

Therapy Services

Multi-carrier system modifications to liability assignment regarding therapy cap claim denials

Note: This article was revised August 16, 2013, to reflect the revised change request (CR) 8321, issued August 15. In the article, the CR release date, transmittal number, and the Web address for accessing CR 8321 were revised. Also, the implementation date was revised. All other information remains the same. This information was previously published in the June 2013 *Medicare B Connection*, Page 24.

Provider types affected

This *MLN Matters*® article is intended for physicians, therapists, and other providers submitting professional claims to Medicare carriers or Medicare administrative contractors (MACs) for therapy services.

What you need to know

Section 603(c) of the American Taxpayer Relief Act of 2012 (ATRA) revised the payment liability for therapy limit denials. The law changes these denials from beneficiary liability to provider liability, effective January 1, 2013. As a result, when Medicare denies professional claims with dates of service (DOS) on or after January 1, 2013, that exceed the therapy caps and do not contain the GA modifier, the claims will be denied with a group code of CO (contractual obligation), instead of group code PR (patient responsibility). The assignment of the PR code will still occur for such claims denied that contain a DOS prior to January 1, 2013.

It is important to note that Medicare will not adjust claims with a DOS on or after January 1, 2013, that were denied with the incorrect group code of PR prior to the implementation of CR 8321. However, Medicare does require providers to refund any payments collected from beneficiaries that are associated with such denied claims and to take steps to avoid further collections from such beneficiaries based on the incorrect assigned liability on those denied claims.



(continued on next page)

General Coverage

Preventing duplicate claim denials

Effective July 1, 2013, new claim system edits may result in additional duplicate claim denials to your practice. Please share this information with your billing companies, vendors and clearing houses. The Centers for Medicare & Medicaid Services (CMS) has instructed Medicare contractors to enhance claim system edits to include same claim details in its



history review of duplicate procedures and/or services. The edits will search within paid, finalized, *pending and same claim details* in history. This means that unless applicable

modifiers are included in your claim, the edits will detect duplicate and repeat services *within the same claim* and/or based on a claim previously submitted.

To minimize a potential increase in duplicate claim denials, please review your billing software and procedures to ensure that you are billing correctly. Some services on a claim may appear to be duplicates

when, in fact, they are not. Please ensure appropriate use of modifiers to identify procedures and services that are not duplicates. A complete list of modifiers can be found in the *Current Procedural Terminology (CPT®)* codebook. The following are a few examples of modifiers that may be used, as applicable, to identify repeat or distinct procedures and services on a claim:

- **Modifier 76** may be used to indicate a repeat procedure or service by the same provider, subsequent to the original procedure or service.
- **Modifier 91** may be used to indicate repeat clinical diagnostic laboratory tests. This modifier is added only when additional test results are medically necessary on the same day.
- **Modifier 59** may be used, as applicable, to identify procedures or services that are normally reported together but are appropriate to be billed separately under certain circumstances. Modifier 59 indicates a procedure or service by the same provider, distinct or independent from other services, performed on the same day.

Note: Procedures, services and modifiers submitted on your claim should be supported by documentation in the patient's medical record.

Sources: *CMS MLN Matters® MM8121*, *Medicare Claims Processing Manual, Chapter 1, Section 120*, and the 2013 *Current Procedural Terminology (CPT®)* codebook.

Therapy (continued)

Additional information

The official instruction, CR 8321, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1283OTN.pdf>.

If you have any questions, please contact your Medicare 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: MM8321 *Revised*
 Related Change Request (CR) #: 8321
 Related CR Release Date: August 15, 2013
 Effective Date: January 1, 2013
 Related CR Transmittal #: R1283OTN
 Implementation Date: August 16, 2013

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Display of ICD-10 LCDs on the Medicare coverage database

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8348, which is issued by the Centers for Medicare & Medicaid Services (CMS) to ensure that International Classification of Diseases, Tenth Revision (ICD-10) LCDs and articles are published in the Medicare coverage database (MCD) in a timely manner to allow providers sufficient time to make provider specific billing system changes. Make sure that your billing staff is aware of these changes.

Background

CR 8348 instructs that all ICD-10 LCDs and associated ICD-10 articles will be published on the MCD no later than April 10, 2014. All other LCDs and articles (i.e., those LCDs and articles that do not contain ICD-10 information, or articles not attached to an LCD) will be published on the MCD no later than September 4, 2014.

Note: All LCDs and articles will receive a new LCD/article ID number. For example, LCD ID 1234 might become LCD ID 4567.

The new LCD/article ID number could have an impact on MACs local systems, such as changing their Medicare summary notice to capture the new LCD/article ID number.

CMS has determined that although new LCD numbers will be assigned to the ICD-10 LCD policies, the policies will not be considered new policies. CMS considers this type of update to be a coding revision that does not change the intent of coverage/non-coverage within an LCD. Therefore, if a MAC only translates ICD-9 codes to the appropriate ICD-10 code, the policy does not need to be vetted through their Carrier Advisory Committee or be sent through the public comment and notice process.

However, if a MAC decides to revise more than just the ICD-10 code(s), they will follow the normal LCD development process outlined in the *Medicare Program Integrity Manual* (Publication 100-08, Chapter 13 (Local Coverage Determinations)) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf>.

Additional information

The official instruction, CR 8348, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1293OTN.pdf>.

If you have any questions, please contact your 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: MM8348

Related Change Request (CR) #: CR8348

Related CR Release Date: September 6, 2013

Effective Date: October 7, 2013

Related CR Transmittal #: R1293OTN

Implementation Date: April 10, 2014

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Advance beneficiary notice of noncoverage, Form CMS-R-131

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8404 which provides:

- 1) instructions for HHA use of the advance beneficiary notice of noncoverage (ABN) to replace the outgoing home health advance beneficiary notice (HHABN), Form CMS-R-296, Option Box 1
- 2) ABN issuance guidelines for therapy services and therapy specific examples, and
- 3) minor editorial changes to clarify existing manual instructions regarding ABN issuance.

HHAs and therapy providers should make sure that their health care and billing staff are aware of these ABN policy changes. All other providers should note that there have been no substantive changes to the ABN form or general instructions for issuance and can reference MM7821 (available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7821.pdf>) for general ABN information.

Background

Section 1879 of the Social Security Act (the Act) protects fee-for-service (FFS) beneficiaries from payment liability (in certain situations) unless the beneficiary is given advance notice of his/her potential liability. The ABN informs beneficiaries about such possible non-covered charges and fulfills this notification requirement when limitation of liability (LOL) applies.

The Centers for Medicare & Medicaid Services (CMS) is expanding use of the ABN to include issuance by HHA providers for Part A and Part B items and services. The ABN will replace the HHABN, Form CMS-R-296, Option Box 1 that is currently used by HHAs. The mandatory date for all HHAs to begin use of the ABN and discontinue use of the HHABN will be posted at <http://cms.gov/Medicare/Medicare-General-Information/BN/HHABN.html>. The guidelines for ABN use published in Chapter 30, Section 50 of the *Medicare Claims Processing Manual* and the ABN form instructions apply to HHAs unless otherwise noted.

Key points from the updated manual instructions

HHA use of ABN – general use

HHAs are required to issue an ABN to original Medicare beneficiaries in specific situations where “limitation on liability” (LOL) protection is afforded under Section 1879 of the Act for items and/or services that the HHA believes Medicare will not cover (see Table 1). In these circumstances, if the beneficiary chooses to receive the items/ services in question and Medicare does not cover the home care, HHAs may use the ABN to shift liability for the non-covered home care to the beneficiary. ABNs are not used in managed care; however, when a beneficiary transitions to Medicare managed care from original Medicare during a home health episode, ABN issuance is required when there are potential charges to the beneficiary that fall under the LOL projections. HHAs should contact their RHHI if they have questions on the ABN or related instructions, since RHHIs process home health claims for original Medicare. The following chart summarizes the statutory provisions related to ABN issuance for LOL purposes.

Table 1 – Statutory provisions related to ABN issuance for LOL purposes

Application of LOL for the Home Health Benefit Citation from the Act	Brief description of situation	Recommended explanation for “Reason Medicare May Not Pay” section of ABN
Section 1862(a)(1)(A)	Care is not reasonable and necessary	Medicare does not pay for care that is not medically reasonable and necessary.
Section 1862(a)(9)	Custodial care is the only care delivered	Medicare does not usually pay for custodial care, except for some hospice services.

(continued on next page)

ABN (continued)

Application of LOL for the Home Health Benefit Citation from the Act	Brief description of situation	Recommended explanation for “Reason Medicare May Not Pay” section of ABN
Section 1879(g)(1)(A)	Beneficiary is not homebound	Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit
Section 1879(g)(1)(B)	Beneficiary does not need skilled nursing care on an intermittent basis	Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit

If one of the above situations applies and the beneficiary chooses to receive the home care items/services that may not be covered by Medicare, HHAs must issue the ABN to the beneficiary to notify him/her of potential financial responsibility. In addition, when Medicare considers an item or service experimental (e.g., a “Research Use Only” or “Investigational Use Only” laboratory test), payment for the experimental item or service is denied under Section 1862(a)(1) of the Act as not reasonable and necessary. In circumstances such as this, the beneficiary must be given an ABN.

HHA triggering events

HHAs may be required to provide an ABN to an original Medicare beneficiary when a triggering event occurs. Table 2 outlines triggering events specific to HHAs.

Table 2 – Triggering events for ABN issuance by HHAs*

Event	Description
Initiation	When an HHA expects that Medicare will not cover an item and/or service delivered under a planned course of treatment from the start of a spell of illness, OR before the delivery of a one-time item and/or service that Medicare is not expected to cover.
Reduction	When an HHA expects that Medicare coverage of an item or service will be reduced or stopped during a spell of illness while continuing others, including when one home health discipline ends but others continue.
Termination	When an HHA expects that Medicare coverage will end for all items and services in total.

HHA initiations

The HHA must issue a beneficiary an ABN prior to delivering care that is usually covered by Medicare, but in this particular instance, the item or service may not be or is not covered by Medicare because:

- The care is not medically reasonable and necessary;
- The beneficiary is not confined to his/her home (is not considered homebound);
- The beneficiary does not need skilled nursing care on an intermittent basis; or
- The beneficiary is receiving custodial care only.

Note: If the HHA believes that Medicare will not (or may not) pay for care for a reason other than ones listed directly above, issuance of the ABN is not required.

Initiation example: A beneficiary requires skilled nursing wound care three times weekly; however, she is not confined to the home. She wants the care done at her home by the HHA.

The HHA must issue the ABN to this beneficiary before providing the home care that will not be paid for by Medicare. This allows the beneficiary to make an informed decision on whether to receive the non-covered care, and to accept the financial obligation.

An ABN, signed at initiation of home health care for items and/or services not covered by Medicare, is effective for up to a year; as long as the items/services being given remain unchanged from those listed on the notice.

Any one-time care that is provided and completed in a single encounter is considered an initiation in terms of triggering events, and is subject to ABN issuance requirements if applicable. When an HHA performs a

(continued on next page)

ABN *(continued)*

beneficiary's initial assessment prior to admission but does not admit him/her; an ABN is not required if there is no charge for the assessment. However, if an HHA charges for an assessment, it must provide notice to the beneficiary before performing and charging for this service.

Since Medicare has specific requirements for payment of home health services, there may be occasions in which a payment requirement is not met, and therefore, the HHA expects that Medicare will not pay for the services. The HHA cannot use the ABN to transfer liability to the beneficiary when there is concern that a billing requirement may not be met. (For example, a home health agency cannot issue an ABN at initiation of home care services in order to charge the beneficiary if the provider face to face encounter requirement is not met.)

HHA reductions

Reductions involve any decrease in services or supplies, such as frequency, amount, or level of care that an HHA provides and/or that is part of the plan of care (POC). If a reduction occurs for an item or service that will no longer be covered by Medicare, but the beneficiary wants to continue to receive the item or service and will assume the financial charges, the HHA must issue the ABN prior to providing the noncovered items or services. (Technically, this is an initiation of noncovered services following a reduction of services).

Reduction with subsequent initiation example: A beneficiary requires physical therapy (PT) for gait retraining five times per week for two weeks, then reduce to three times weekly for two weeks. After two weeks of PT, the beneficiary wants to continue therapy five times a week even though this amount of therapy is no longer medically reasonable and necessary. The HHA would issue an ABN so that he understands the situation and can consent to financial responsibility for the PT not covered by Medicare.

HHA terminations

A termination is the cessation of all HHA-provided Medicare covered services. If a beneficiary wants to continue receiving home health care that will not be covered by Medicare for any of the statutory reasons listed in Table 1 and a physician orders the services; the HHA must issue the beneficiary an ABN in order to charge the beneficiary or a secondary insurer. If the beneficiary will not be getting any further home care after discharge, there is no need for ABN issuance.

When all Medicare covered home health care is terminated, HHAs may sometimes be required to deliver the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS-10123. The NOMNC informs beneficiaries of the right to an expedited determination by a quality improvement organization (QIO) if they feel that termination of home health services is not appropriate. Detailed information and instructions for issuing the NOMNC can be found on the CMS website under the link for "FFS ED Notices" at <http://www.cms.gov/Medicare/Medicare-General-Information/BN/index.html>.

If a beneficiary requests a QIO review upon receiving a NOMNC, the QIO will make a fast decision on whether covered services should end. If the QIO decides that Medicare covered care should end and the beneficiary wishes to continue receiving care from the HHA even though Medicare will not pay, an ABN must be issued since this would be an initiation of non-covered care.

Effect of other insurers/payers

If a beneficiary is eligible for both original Medicare and Medicaid (dually eligible) or is covered by original Medicare and another insurance program or payer (such as waiver programs, Office on Aging funds, community agencies (e.g., Easter Seals) or grants), ABN requirements still apply.

Effect of Other Insurers/Payers

For example, when a beneficiary is a dual eligible and receives home health services that are covered only under Medicaid, but are not covered by Medicare for one of the reasons listed in Table 1; an ABN must be issued at the initiation of this care to inform the beneficiary that Medicare will likely deny the services.

Some states have specific rules regarding HHA completion of liability notices in situations where dual eligible beneficiaries need to accept liability for Medicare noncovered care that Medicaid will cover. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort" (meaning other federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid assumes any remaining charges).

On the ABN, the first check box under the "options" section indicates the choice to bill Medicare and is equivalent to the third checkbox on the outgoing HHABN. HHAs serving dual eligibles should comply with existing HHABN state policy within their jurisdiction as applicable to the ABN unless the state instructs otherwise.

Note: If a state has issued a directive to select the third checkbox on the HHABN, HHAs must mark **the first check box** when issuing the ABN.

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ABN (continued)

Where there is no state specific directive, HHAs are permitted to instruct beneficiaries to select option 1 on the ABN when a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer. HHAs may add a statement in the *Additional Information* section to help a dual eligible better understand the payment situation such as, “We will submit a claim for this care to your other insurance,” or “Your Medical Assistance plan will pay for this care.”

HHAs may also use the *Additional Information* on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the *Additional Information* section of the notice.

HHA exceptions to ABN notification requirements

ABN issuance is **not** required in the following HHA situations:

- Initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge;
- Care that is never covered by Medicare under any circumstances (i.e., an HHA offers complimentary hearing aid cleaning and maintenance);
- Telehealth monitoring used as an adjunct to regular covered HH care; or
- Noncovered items/services that are part of care covered in total under a Medicare bundled payment (e.g., HH prospective payment system (PPS) episode payment).

Other HHA ABN guidance**ABN for voluntary notice by HHAs**

HHAs may use the voluntary ABN, as a courtesy, to alert beneficiaries of impending financial obligation for items and services that are never covered by Medicare as described in the *Medicare Claims Processing Manual*, Chapter 30 (Financial Liability Protections), Section 50.3.2 (Voluntary ABN Uses).

Effect of initial payment determinations on liability

An ABN informs a beneficiary of his/her HHA's expectation with regard to Medicare coverage. If the care described on the ABN is actually provided, Medicare makes a payment determination on the items and/or services at issue when adjudicating the related claim. Such adjudications may uphold the provider's expectation, in which case the beneficiary will remain liable for payment if agreeing to accept this liability based on a valid ABN. However, adjudication may not conform to the provider's expectation, in which case the decision made on the claim supersedes the expectation given on the ABN. That is, Medicare may cover and pay for care despite the HHA's expectation, or deny the claim and find the provider liable. In such cases, if the HHA collected funds from the beneficiary, the HHA must promptly refund the appropriate amount to the beneficiary.

Use of abbreviations

When completing the ABN, HHAs must avoid using abbreviations in the body of the notice unless the abbreviation is already spelled out elsewhere. For example, an abbreviation such as “PT” that can have multiple meanings in a home health setting (part-time, physical therapy, prothrombin time) should be spelled out at least once on the ABN next to the abbreviation of the word(s). When this is done, the abbreviation can be used again on the notice. ABNs containing abbreviations that are not defined in this manner on the notice may be invalidated by contractors.

Cost estimate

HHAs should follow the ABN form instruction guidelines for providing cost estimates for items or services. The cost estimate must be a good faith estimate based on agency charges and the expected frequency and duration of each service. Cost estimates per visit or per number of visits weekly are acceptable. A difference in the cost estimate and actual cost will not automatically invalidate the ABN. The cost estimate must give the beneficiary an idea of what their out of pocket costs might be if they choose to receive the care listed on the ABN.

Cost estimate examples:

- \$440 for 4 weekly nursing visits in 1/13.
- \$260 for 3 physical therapy visits 1/3-1/7/13.
- \$50 for spare right arm splint.

When more than one item and/or service is at issue, the HHA must enter separate cost estimates for each item or service as clearly as possible, including information on the period of time involved when appropriate.

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ABN (continued)**Outpatient therapy services use of the ABN**

Section 603(c) of the American Taxpayer Relief Act (ATRA) amended Section 1833(g)(5) of the Act to provide limitation of liability protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don't qualify for a therapy cap exception. This amendment affected financial liability for certain therapy services that exceed the cap.

Prior to the ATRA amendment, claims for therapy services at or above therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable for the non-covered services. CMS had encouraged suppliers and providers to issue a voluntary ABN as a courtesy; however, ABN issuance wasn't required for the beneficiary to be held financially liable.

Now, with this ATRA amendment to the Act, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable. ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges.

Therapists are required to issue an ABN to beneficiaries before providing them therapy that is not medically reasonable and necessary, regardless of the therapy cap. Statutory changes (mentioned above) mandate ABN issuance when therapy services are not medically reasonable and necessary and exceed the cap amount. Policies for mandatory ABN issuance for services below the therapy cap remain unchanged. If a beneficiary will be getting therapy services that will not be covered by Medicare because the services are not medically necessary, an ABN must be issued before the services are provided so that the beneficiary can choose whether to obtain the services and accept financial responsibility for them.

Therapy cap is not met - ABN mandatory example: A beneficiary has been receiving physical therapy (PT) three times per week, and currently, he has achieved all his PT goals established in the plan of care (POC). The total amount applied to his therapy cap this year is \$780. He requests continued PT services two times per week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that will not be covered by Medicare because they are no longer medically necessary.

Therapy cap has been met - ABN mandatory example: A beneficiary has recently been receiving physical therapy (PT) three times per week, and she has achieved all her PT goals established in the POC. The total amount applied towards her therapy cap this year is \$1900. She requests continued PT services two times a week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that are not medically necessary and exceed the cap in order for the therapist to transfer liability and charge the beneficiary.

In cases such as these, if Medicare denies the claim and a valid ABN was issued, financial liability shifts to the beneficiary. If the provider fails to issue an ABN for therapy that is not medically necessary, the provider will be held financially liable if Medicare denies the claim.

Additional information

The official instruction, CR 8404, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2782CP.pdf>. The revised portions of the *Medicare Claims Processing Manual* are a part of CR 8404.

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: MM8404

Related Change Request (CR) #: CR 8404

Related CR Release Date: September 6, 2013

Effective Date: December 9, 2013

Related CR Transmittal #: R2782CP

Implementation Date: December 9, 2013

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Add-on HCPCS/CPT® codes without primary codes

Note: This article was revised August 16, 2013, to add a reference *MLN Matters*® article MM8271 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8271.pdf>) to alert providers that Medicare contractors will generate an informational unsolicited response (IUR) or reject claims for an add-on *Current Procedural Terminology (CPT)*® code on an outpatient claim when there is no primary procedure *CPT*® code associated with the add-on code OR when the primary procedure *CPT*® code associated with the add-on code associated is not covered by Medicare. This information was previously published in the July 2013 *Medicare B Connection*, Page 24.

Provider types affected

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

Provider action needed

An add-on code is a Health Care Common Procedure System (HCPCS) code or *CPT*® code that describes a service that, with one exception (see *Background* section), is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner on the same date of service.

The Centers for Medicare & Medicaid Services (CMS) has learned from recovery auditor reports that some providers are billing only add-on HCPCS/*CPT*® codes without their respective primary codes resulting in overpayments.

This *MLN Matters*® special edition article provides an overview of billing for HCPCS/*CPT*® Add-on codes, and it is based on CMS manuals and publications including the *Medicare Claims Processing Manual*, (Chapter 12, Sections 30(D) and 30.6.12(I), CR 7501 (Transmittal 2636 dated January 16, 2013) titled “National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION.”

Background

An add-on code is a HCPCS/*CPT*® code that describes a service that is always performed in conjunction with the primary service. An add-on code is eligible for payment only if it is reported with the appropriate primary procedure performed by the same practitioner.

The *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.12(I) requires a provider to report *CPT*® code 99292 (*Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)*), without its primary code *CPT*® code 99291 (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*). If two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service.

For the same date of service only one physician of the same specialty in the group practice may report *CPT*® code 99291 with or without *CPT*® code 99292, and the other physician(s) must report their critical care services with *CPT*® code 99292. See CR 7501 at <http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance/Downloads/R2636CP.pdf> for current information regarding add-on codes in

addition to the manual section mentioned above.

The following shows an example of this issue:

Example:

A provider submitted a claim with *CPT*® code 26863 for one unit for date of service May 5, 2010, without billing for the primary *CPT*® code 26862. Add-on codes billed without their primary codes are considered an overpayment. Overpayment for add-on *CPT*® code 26863 was retracted as a billing error.

- Add-on *CPT*® code 26863 Description: *Fuse/Graft added joint – Arthrodesis, interphalangeal joint with or without internal fixation; with autograft, each additional joint. List separately in addition to code for primary procedure.*
- Primary *CPT*® code 26862 Description: *Fusion/graft of finger – Arthrodesis, interphalangeal joint, without internal fixation; with autograft. This is a parent *CPT*® code and can be reported with add-on *CPT*® code 26863.*

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Add-on (continued)

Additional information

You can find CR 7501 (Transmittal 2636 dated January 16, 2013) titled “National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION” at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf>.

You can review the *Medicare Claims Processing Manual* (Chapter 12, Section 30.6.12(I) Critical Care Services Provided by Physicians in Group Practice(s)) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.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: SE1320
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Learn the secrets to billing Medicare correctly

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Further instruction to use non-alert remittance advice remark 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.

What you need to know

Change request (CR) 7910 was implemented by Medicare in April, 2013. CR 7910 included a business requirement (BR 7910.2) instructing the Medicare shared systems and contractors to stop sending non-alert remittance advice remark codes (RARCs) without associated group codes and/or claim adjustment reason codes (CARCs). It has been reported that this resulted in provider concern and increased provider inquiries. The Centers for Medicare & Medicaid Services (CMS) is working on developing a long term resolution but has decided to continue to send non-alert RARCs without any group code and/or CARC for now.

Additional information

The official instruction, CR 8391, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1285OTN.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: MM8391

Related Change Request (CR) #: CR 8391

Related CR Release Date: August 16, 2013

Effective Date: October 1, 2013

Related CR Transmittal #: R1285OTN

Implementation Date: October 7, 2013, except January 6, 2014 for DME MACs

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Implementation of Phase III CORE 360 CARCs and RARCs rule

Provider types affected

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

Provider action needed

Change request (CR) 8365, from which this article is taken, instructs Medicare contractors and shared system maintainers (SSM) to use (effective January 1, 2014) the May 24, 2013 update to the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) (835) Rule CORE-required Code Combinations for CORE-defined Business Scenarios, version 3.0.2.

Background

On August 7, 2012, the Department of Health and Human Services (HHS) announced adoption of 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. (Refer to <http://www.hhs.gov/news/press/2012pres/08/20120807a.html>). In CR 8182, released May 9, 2013, CMS instructed Medicare contractors to implement this rule set by January 6, 2014. (You may find the associated *MLN Matters*[®] article, MM8182 "Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice" at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8182.pdf>).

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Phase (continued)

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

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:

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

4. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule; and
5. Phase III CORE 350 Health care claim payment/ advice (835) infrastructure rule.

The Health Insurance Portability and Accountability Act (HIPAA) initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim or service has been adjudicated, and now the ERA/EFT operating rules under the Affordable Care Act are mandating consistent and uniform use of remittance advice (RA) codes (group codes, claim adjustment reason codes (CARC) and remittance advice remark codes (RARC)) 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 code combinations 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 of existing codes based on business policy change and/or Federal/state mandate.

CR 8365, from which this article is taken, focuses on rule three, and instructs Medicare contractors and shared system maintainers (SSM) to use (to be effective January 1, 2014, and to be implemented by January 6, 2014) the May 24, 2013, updated CORE combination lists in the document: "CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule CORE-required Code Combinations for CORE-defined Business Scenarios," version 3.0.2 (which may be found as an attachment to

CR 8365).

The following are the CORE-defined claim adjustment/denial business scenarios and descriptions:

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

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

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

Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.O.

Scenario 3: Billed service not covered by health plan

Refers to situations where the billed service is not covered by the health plan.

Scenario 4: Benefit for billed service not separately payable

Refers to situations where the billed service or benefit is not separately payable by the health plan.

Medicare is implementing the code combinations per the ERA/EFT operating rules in two releases (July and October 2013) that relate to these four scenarios (per CR 8182), and is adding the updates to CORE code combinations (per CR 8365), effective January 1, 2014. Finally, the Medicare remit easy print (MREP) and PC print, will be updated if needed, by January 6, 2014.

Additional information

The official instruction, CR 8365, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1281OTN.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: MM8365

Related Change Request (CR) #: CR 8365

Related CR Release Date: August 16, 2013

Effective Date: January 1, 2014

Related CR Transmittal #: R1281OTN

Implementation Date: January 6, 2014

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Remittance advice remark and claims adjustment reason code and Medicare remit easy print and PC print update

Provider types affected

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

What you need to know

CR 8422, from which this article is taken, updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists, effective October 1, 2013; and also instructs the fiscal intermediary standard system (FISS) and VIPs Medicare system (VMS) maintainers to update Medicare remit easy print (MREP) and PC print. You should make sure that your billing staffs are aware of these updates.



Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions, adopted under HIPAA, using valid standard codes. Accordingly, Medicare policy states that two standard code sets (claim adjustment reason codes (CARC) and remittance advice remark codes (RARC)) must be used for:

- Transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, (along with Group Code) to report payment adjustments; and Informational RARCs to report appeal rights, and other adjudication related information; and
- Transaction 837 (coordination of benefits (COB)).

The Centers for Medicare & Medicaid Services (CMS) usually request the CARC and RARC changes that impact Medicare, in conjunction with a policy change. If an entity other than CMS initiates a modification for a code that Medicare currently uses, contractors must either use the modified code (or another code), if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

CARC and RARC code sets are regularly updated three times a year. CR 8422 lists only the changes that have been approved since the last code update CR (CR 8281, Transmittal 2686, issued on April 12, 2013), and does not provide a complete list of codes for these two code sets.

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

Changes in CARC list since CR 8281

These are the changes in the CARC database since the last code update CR 8281. The full CARC list may be downloaded from the WPC website, available at <http://wpc-edi.com/Reference>.

New codes – CARC

Code	Narrative	Effective date
253	Sequestration - reduction in federal spending.	06/02/2013
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	06/02/2013
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with group code OA)	06/02/2013
256	Service not payable per managed care contract.	06/02/2013
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with group code CO or OA)	06/02/2013

(continued on next page)

Remittance (continued)

Code	Narrative	Effective date
W6	Referral not authorized by attending physician per regulatory requirement.	06/02/2013
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	06/02/2013
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	06/02/2013
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	06/02/2013

Modified codes – CARC

Code	Modified narrative	Effective date
16	Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.) Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment Information REF), if present.	06/02/2013
18	Exact duplicate claim/service (Use only with group code OA except where state workers' compensation regulations requires CO)	06/02/2013
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with group codes PR or CO depending upon liability)	07/01/2013
136	Failure to follow prior payer's coverage rules. (Use only with group code OA)	07/01/2013
163	Attachment/other documentation referenced on the claim was not received.	06/02/2013
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	06/02/2013
173	Service/equipment was not prescribed by a physician.	07/01/2013
201	Workers' compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with group code PR)	07/01/2013
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with group code OA)	07/01/2013
221	Claim is under investigation. Note: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 insurance policy number segment (loop 2100 other claim related information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF). (Note: To be used by property & casualty only)	07/01/2013
226	Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)	07/01/2013
229	Partial charge amount not considered by Medicare due to the initial claim type of bill being 12x. Note: This code can only be used in the 837 transaction to convey coordination of benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with group code PR)	07/01/2013

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Remittance (continued)

Code	Modified narrative	Effective date
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the national correct coding initiative or workers compensation state regulations/ fee schedule requirements.	07/01/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with group code PR)	07/01/2013
242	Services not provided by network/primary care providers Notes: This code replaces deactivated code 38	06/02/2013
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	06/02/2013
250	The attachment/other documentation content received is inconsistent with the expected content.	06/02/2013
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	06/02/2013
252	An attachment/other documentation is required to adjudicate this claim/service. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT).	06/02/2013
W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 class of contract code identification segment (loop 2100 other claim related information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF) if the regulations apply.	06/02/2013
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 insurance policy number segment (loop 2100 other claim related information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF) if the regulations apply. To be used for workers' compensation only.	06/02/2013
Y1	Payment denied based on Medical payments coverage (MPC) or personal injury protection (PIP) benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 insurance policy number segment (loop 2100 other claim related information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF) if the regulations apply. To be used for P&C auto only.	06/02/2013
Y2	Payment adjusted based on medical payments coverage (mpc) or personal injury protection (PIP) benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 insurance policy number segment (loop 2100 other claim related information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF) if the regulations apply. To be used for P&C auto only.	06/02/2013

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Remittance (continued)

Code	Modified narrative	Effective date
Y3	Medical payments coverage (MPC) or personal injury protection (PIP) benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 class of contract code identification segment (loop 2100 other claim related information REF). If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF) if the regulations apply. To be used for P&C auto only.	06/02/2013

Deactivated codes (also included in CR 8281) – CARC

Code	Current narrative	Effective date
125	Submission/billing error(s). At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)	11/01/2013

Changes in RARC list since CR 8281

These are the changes in the RARC database since the last code update CR 8281. The full RARC list may be downloaded from the WPC website, available at <http://wpc-edi.com/Reference>.

New codes – RARC

Code	Current narrative	Effective date
N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	07/15/2013
N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.	07/15/2013
N576	Services not related to the specific incident/claim/accident/loss being reported.	07/15/2013
N577	Personal injury protection (PIP) coverage.	07/15/2013
N578	Coverages do not apply to this loss.	07/15/2013
N579	Medical payments coverage (MPC).	07/15/2013
N580	Determination based on the provisions of the insurance policy.	07/15/2013
N581	Investigation of coverage eligibility is pending.	07/15/2013
N582	Benefits suspended pending the patient's cooperation.	07/15/2013
N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.	07/15/2013
N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	07/15/2013
N585	Benefits are no longer available based on a final injury settlement.	07/15/2013
N586	The injured party does not qualify for benefits.	07/15/2013
N587	Policy benefits have been exhausted.	07/15/2013
N588	The patient has instructed that medical claims/bills are not to be paid.	07/15/2013
N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.	07/15/2013
N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	07/15/2013
N591	Payment based on an independent medical examination (IME) or utilization review (UR).	07/15/2013
N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.	07/15/2013

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Remittance (continued)

Code	Current narrative	Effective date
N593	Not covered based on failure to attend a scheduled independent medical exam (IME).	07/15/2013
N594	Records reflect the injured party did not complete an application for benefits for this loss.	07/15/2013
N595	Records reflect the injured party did not complete an assignment of benefits for this loss.	07/15/2013
N596	Records reflect the injured party did not complete a medical authorization for this loss.	07/15/2013
N597	Adjusted based on a medical provider's apportionment of care between related injuries and other unrelated medical conditions/injuries.	07/15/2013
N598	Health care policy coverage is primary.	07/15/2013
N599	Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida no-fault statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the participating level of Medicare Part B fee schedule for the locale in which the services were rendered.	07/15/2013
N600	Adjusted based on the applicable fee schedule for the region in which the service was rendered.	07/15/2013
N601	In accordance with Hawaii administrative rules, Title 16, Chapter 23 motor vehicle insurance law payment is recommended based on Medicare resource based relative value scale system applicable to Hawaii.	07/15/2013
N602	Adjusted based on the Redbook maximum allowance.	07/15/2013
N603	This fee is calculated according to the New Jersey medical fee schedules for automobile personal injury protection and motor bus medical expense insurance coverage.	07/15/2013
N604	In accordance with New York no-fault law, regulation 68, this base fee was calculated according to the New York workers' compensation board schedule of medical fees, pursuant to regulation 83 and / or appendix 17-C of 11 NYCRR.	07/15/2013
N605	This fee was calculated based upon New York all patients refined diagnosis related groups (APR-DRG), pursuant to regulation 68.	07/15/2013
N606	The Oregon allowed amount for this procedure is based upon the workers compensation fee schedule (OAR 436-009). The allowed amount has been calculated in accordance with section 4 of ORS 742.524.	07/15/2013
N607	Service provided for non-compensable condition(s).	07/15/2013
N608	The fee schedule amount allowed is calculated at 110% of the Medicare fee schedule for this region, specialty and type of service. This fee is calculated in compliance with Act 6.	07/15/2013
N609	80% of the providers billed amount is being recommended for payment according to Act 6.	07/15/2013
N610	Alert: Payment based on an appropriate level of care.	07/15/2013
N611	Claim in litigation. Contact insurer for more information.	07/15/2013
N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	07/15/2013
N613	Alert: Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. Unless corrected, a claim with this ordering provider will not be paid in the future.	07/15/2013

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Remittance (continued)

Code	Current narrative	Effective date
N614	Alert: Additional information is included in the 835 healthcare policy identification segment (loop 2110 service payment information).	07/15/2013
N615	Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a qualified health plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.	07/15/2013
N616	Alert: This enrollee is in the first month of the advance premium tax credit grace period.	07/15/2013
N617	This enrollee is in the second or third month of the advance premium tax credit grace period.	07/15/2013
N618	Alert: This claim will automatically be reprocessed if the enrollee pays their premiums.	07/15/2013
N619	Coverage terminated for non-payment of premium.	07/15/2013
N620	Alert: This procedure code is for quality reporting/informational purposes only.	07/15/2013
N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	07/15/2013
N622	Not covered based on the date of injury/accident.	07/15/2013
N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.	07/15/2013
N624	The associated workers' compensation claim has been withdrawn.	07/15/2013
N625	Missing/Incomplete/Invalid workers' compensation claim number.	07/15/2013
N626	New or established patient E/M codes are not payable with chiropractic care codes.	07/15/2013
N627	Service not payable per managed care contract.	07/15/2013
N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	07/15/2013
N629	Reviews/documentation/notes/summaries/reports/charts not requested.	07/15/2013
N630	Referral not authorized by attending physician.	07/15/2013
N631	Medical Fee Schedule does not list this code. An allowance was made for a comparable service.	07/15/2013
N632	According to the official medical fee schedule this service has a relative value of zero and therefore no payment is due.	07/15/2013
N633	Additional anesthesia time units are not allowed.	07/15/2013
N634	The allowance is calculated based on anesthesia time units.	07/15/2013
N635	The Allowance is calculated based on the anesthesia base units plus time.	07/15/2013
N636	Adjusted because this is reimbursable only once per injury.	07/15/2013
N637	Consultations are not allowed once treatment has been rendered by the same provider.	07/15/2013
N638	Reimbursement has been made according to the home health fee schedule.	07/15/2013
N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.	07/15/2013
N640	Exceeds number/frequency approved/allowed within time period.	07/15/2013
N641	Reimbursement has been based on the number of body areas rated.	07/15/2013
N642	Adjusted when billed as individual tests instead of as a panel.	07/15/2013
N643	The services billed are considered covered or non-covered (NC) in the applicable state fee schedule.	07/15/2013
N644	Reimbursement has been made according to the bilateral procedure rule.	07/15/2013
N645	Mark-up allowance	07/15/2013

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Remittance (continued)

Code	Current narrative	Effective date
N646	Reimbursement has been adjusted based on the guidelines for an assistant.	07/15/2013
N647	Adjusted based on diagnosis-related group (DRG).	07/15/2013
N648	Adjusted based on stop loss.	07/15/2013
N649	Payment based on invoice.	07/15/2013
N650	This policy was not in effect for this date of loss. No coverage is available.	07/15/2013
N651	No personal injury protection/medical payments coverage on the policy at the time of the loss.	07/15/2013
N652	The date of service is before the date of loss.	07/15/2013
N653	The date of injury does not match the reported date of loss.	07/15/2013
N654	Adjusted based on achievement of maximum medical improvement (MMI).	07/15/2013
N655	Payment based on provider's geographic region.	07/15/2013
N656	An interest payment is being made because benefits are being paid outside the statutory requirement.	07/15/2013
N657	This should be billed with the appropriate code for these services.	07/15/2013
N658	The billed service(s) are not considered medical expenses.	07/15/2013
N659	This item is exempt from sales tax.	07/15/2013
N660	Sales tax has been included in the reimbursement.	07/15/2013
N661	Documentation does not support that the services rendered were medically necessary.	07/15/2013
N662	Alert: Consideration of payment will be made upon receipt of a final bill.	07/15/2013
N663	Adjusted based on an agreed amount.	07/15/2013
N664	Adjusted based on a legal settlement.	07/15/2013
N665	Services by an unlicensed provider are not reimbursable.	07/15/2013
N666	Only one evaluation and management code at this service level is covered during the course of care.	07/15/2013
N667	Missing prescription	07/15/2013
N668	Incomplete/invalid prescription	07/15/2013
N669	Adjusted based on the Medicare fee schedule.	07/15/2013
N670	This service code has been identified as the primary procedure code subject to the Medicare multiple procedure payment reduction (MPPR) rule.	07/15/2013
N671	Payment based on a jurisdiction cost-charge ratio.	07/15/2013
N672	Alert: Amount applied to health insurance offset.	07/15/2013
N673	Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.	07/15/2013
N674	Not covered unless a pre-requisite procedure/service has been provided.	07/15/2013
N675	Additional information is required from the injured party.	07/15/2013
N676	Service does not qualify for payment under the outpatient facility fee schedule.	07/15/2013

Modified codes – RARC

Code	Current narrative	Effective date
N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes.	07/15/2013
N7	Alert: Processing of this claim/service has included consideration under Major Medical provisions.	07/15/2013

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Remittance (continued)

Code	Current narrative	Effective date
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	07/15/2013
N441	This missed/cancelled appointment is not covered.	07/15/2013

Deactivated codes – RARC: None

Additional information

The official instruction, CR 8422, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2776CP.pdf>. If you have any questions, please contact your 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: MM8422

Related Change Request (CR) #: CR 8422

Related CR Release Date: August 30, 2013

Effective Date: October 1, 2013

Related CR Transmittal #: R2776CP

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.

Quarterly provider update

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

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

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

SPOT (continued)

The SPOT also features the ability to view a beneficiary’s up-to-date benefit level. Allwardt says this convenience of having the beneficiaries Part B deductible information immediately available through the SPOT has greatly improved their account receivables. “We are able to see what checks are coming in and plan our work.”

For providers and Medicare billing staff who have yet to sign up for access to the SPOT, Allwardt highly recommends jumping in as soon as possible. “The SPOT is going to be a vital part of your operations. Get started with it now. It’s going to save you so much. It’s already made our lives easier, quicker and more efficient. The SPOT is helping us work smarter,” Allwardt says.

“ SPOT is going to be a vital part of your operations. Get started with it now. It’s going to save you so much. SPOT is helping us work smarter. ”



– Kay Allwardt,
Billing manager

To learn more about the SPOT and how to take advantage of this new provider resource, please review our [On-the SPOT-FAQs](#).

Additional reporting requirements concerning physician ownership and investment in hospitals

Provider types affected

This *MLN Matters*® special edition article is intended for hospitals that have physician ownership or investment interests, and seek to avail themselves of the whole hospital or rural provider exception to the physician self-referral law. In this article, we refer to hospitals with physician owners or investors as “physician-owned hospitals.”

What you need to know

Under Section 1877 of the Social Security Act (the Act), also known as the physician self-referral law, a physician may not refer a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies, and the entity may not present or cause to be presented a claim to Medicare (or bill another individual, entity, or third-party payer) for those referred services.

The Centers for Medicare & Medicaid Services (CMS) issues this article to address the additional reporting requirements imposed by Section 6001 of the Affordable Care Act on physician-owned hospitals seeking to avail themselves of the whole hospital or rural provider exception to the physician self-referral law. This article does not address other additional requirements imposed by Section 6001 of the Affordable Care Act.

Background

Two exceptions to the physician self-referral law for ownership or investment interests are the whole

hospital and rural provider exceptions. Section 1877(i)(1)(C)(i) of the Act requires physician-owned hospitals submit to CMS an annual report containing ownership and investment information to qualify for either exception. This reporting requirement is implemented in the physician self-referral regulations at 42 CFR 411.362(b)(3)(i). (This regulation is available at <http://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=CFR-2011-title42-vol2-sec411-362&packageId=CFR-2011-title42-vol2>.)

Physician-owned hospitals that report ownership and investment information by following the instructions set forth in the Medicare Enrollment Application Form CMS-855A (CMS-855A) for reporting physician-owned hospital ownership and investment information satisfy the above reporting requirement. **Please note that this reporting requirement is not mandatory for Medicare enrollment and does not ensure Medicare enrollment.**

Physician-owned hospitals seeking to avail themselves of the whole hospital or rural provider exception must report ownership and investment information following the above process by December 1, 2013. Physician-owned hospitals that submitted this information on or after December 1, 2012, consistent with this process, will be considered to have met the December 1, 2013, deadline. Hospitals must either update their information or verify that the relevant ownership and investment information in the Medicare provider enrollment, chain, and ownership system is correct on an annual basis to continue to meet the reporting requirement.

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ownership *(continued)*

We remind hospitals that information submitted under this process may be published on the CMS website pursuant to Section 1877(i)(2) of the Act. If a hospital reports ownership or investment information under this process but is not seeking to use the whole hospital or rural provider exception, the hospital may request that CMS either not publish or remove its information from the website by emailing POHExceptions@cms.hhs.gov.

Additional information

For more information about provisions affecting physician-owned hospitals under the physician self-referral law, visit the *Physician Self-Referral Physician-Owned Hospitals* Web page at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals.html.

For more information about Medicare enrollment, visit the *Medicare Provider-Supplier Enrollment* Web page at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>.

MLN Matters® Number: SE1332
 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

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.

Provider options for submitting quality data for the EHR incentive programs

Beginning in 2014, health care providers serving Medicare beneficiaries must report *clinical quality measures (CQMs)* to the Centers for Medicare & Medicaid Services (CMS) as outlined in the *Stage 2* final rule.

According to information recently released by CMS, providers will be required to comply with the new level of reporting regardless of where they are in the implementation of electronic health record (EHR) systems in their practices or facilities.

Eligible professionals must report a total of six CQMs.

- Three core or alternate core measures (only report an alternate core measure if one of the core denominators is zero)

Eligible hospitals must report a total of 15 CQMs.

- Two measures that target emergency department throughput processes

- Seven measures that address the care of patients with stroke
- Six measures that address the care of patients with venous thromboembolism

For more information on these requirements, such as the number of CQMs and how to select which ones to report, visit the *2014 CQMs* Web page.

Providers participating in the Medicare EHR incentive programs may report CQMs for the Medicare EHR incentive program through the *CMS attestation system*. Also, EPs may report through electronic reporting pilot for eligible professionals and hospitals may report through pilot programs through *QualityNet for hospitals*.

For more information on the clinical quality reporting program, visit the *EHR incentive program pages here*.

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

Ophthalmology claims denied in error will be reprocessed

The latest package of National Correct Coding Initiative (NCCI) edits, version 19.2, effective July 1, 2013, was updated appropriately to include the ophthalmology evaluation and management (E&M) procedure codes 92012 and 92014 based on the policy outlined in the *Medicare Claims Processing Manual* (100-04), Chapter 12, Section 40.3.B.

However, the Centers for Medicare & Medicaid Services (CMS) has been made aware that the multi-carrier system inadvertently omitted procedure codes 92012 and 92014 from the E&M range of 99201-99499 and is not allowing the use of separately billed modifiers 25, 24, and 57. This has caused claims to deny inappropriately when the modifiers are appended to these procedure codes.

CMS is correcting this issue and A/B Medicare administrative contractors will reprocess all inappropriately denied claims by November 15.

Providers do not need to take any action in having their claims corrected.

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

Reassignment to Part A critical access hospitals, federally qualified health centers, and rural health clinics

Provider types affected

This *MLN Matters*[®] article is intended for critical access hospitals (CAHs), federally qualified health centers (FQHCs), and rural health clinics (RHCs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8387, which clarifies that individual physicians and non-physician practitioners can reassign benefits directly to a Part A CAH, FQHC, or RHC through their Form CMS-855A enrollment. CAHs, FQHCs, and RHCs are no longer required to submit a separate Form CMS-855B in order to receive reassigned benefits.

Background

The Centers for Medicare & Medicaid Services (CMS) previously released guidance regarding reassignments to Part A entities in CR 7864, "Revision to of the *Medicare Program Integrity Manual* (PIM), Chapter 15, Section 15.5.20, consistent with 42 Code of Federal Regulations (CFR), Section 424.80(b)(1) and (b)(2) and the *Medicare Claims Processing Manual*, Chapter 1, Sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7."

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

CR 7864 allowed for reassignments to occur to all Part A entities via the CMS-855B Medicare enrollment application.

CR 8387 clarifies that all Part A entities may obtain reassignments via Part B, except for CAHs, FQHCs, and RHCs. These three Part A entities may only obtain reassignments through the Medicare Part A CMS 855A enrollment process. Physicians and non-physician practitioners have the option to reassign their benefits to a CAH, FQHC or an RHC. This is not required. However, if the physician or non-physician practitioner wants to participate in the Medicare electronic health records (EHR) incentive program as an eligible professional (EP) and wishes to have their EHR payments sent to a CAH, FQHC, or RHC, a reassignment to that entity needs to be established with Medicare.

The entity receiving the reassigned benefits must enroll with the Part A Medicare administrative

contractor (MAC) via a Form CMS-855A, and the physician or non-physician practitioner reassigning benefits must enroll with the Part B MAC via a Form CMS-855I and Form CMS-855R. If the physician or non-physician practitioner is currently enrolled with the Part B MAC via a Form CMS-855I and wishes to solely establish a new reassignment to a CAH, FQHC or RHC, only a Form CMS-855R is required.

The Part A CAH, FQHC, and RHC, may only receive reassigned benefits, assuming that the requirements for a reassignment exception are met and that the reassignee meets all enrollment requirements.

Note that Medicare will verify that the national provider identifier (NPI) reported for physicians in the rendering or attending physician fields on CAH method II claims for payment, matches physician enrollment data in Medicare's files.

Additional information

The official instruction, CR 8387, issued to your Medicare contractor regarding this clarification, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R483PI.pdf>.

The official instruction, CR 7864, issued to your Medicare contractor regarding this revision may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R445PI.pdf>.

MLN Matters[®] article MM7864, "Revision to Chapter 15 (Section 15.5.20) of the "Medicare Program Integrity Manual" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7864.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: MM8387
Related Change Request (CR) #: CR 8387
Related CR Release Date: August 16, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R483PI
Implementation Date: January 6, 2014

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.

Open Payments: An overview for physicians and teaching hospitals

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) conducted an *MLN Connects*[™] national provider call August 8, 2013, for physicians and teaching hospitals to give an update on the Open Payments program policy, with a focus on third party payments and indirect payments as well as the physician resource toolkit. This article gives you an overview of the key points discussed.

Open Payments (Physician Payments Sunshine Act) requires manufacturers of pharmaceuticals or medical devices to publicly report payments made to physicians and teaching hospitals.

- Open Payments data collection began August 1, 2013.
- Physicians and teaching hospitals may voluntarily enroll in the Open Payments program in order to monitor their data reported by industry.

Background

This article provides an overview of the Open Payments program for physicians and teaching hospitals. This information is a summary of the final rule implementing the Open Payments program (Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests (CMS-5060-F), codified at 42 *Code of Federal Regulations* (CFR) Parts 402 and 403). This summary is not intended to override or take the place of the final rule, which is the official source for requirements and information on the program.

Relationships between industry and physicians are common

Collaborations between physicians and the medical industry can be beneficial by promoting discovery and development of new technologies that improve health and/or lower costs. However, financial relationships may also influence professional judgment and conflicts of interest can potentially arise.

Section 6002 of the Affordable Care Act requires the establishment of a transparency program, known as Open Payments, which requires manufacturers of pharmaceuticals or medical devices to publicly report payments made to physicians and teaching hospitals, creating greater transparency around the financial relationships that occur among them.

The final rule, titled "Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests," was published February 8, 2013. This rule requires manufacturers of drugs, devices, biologicals, or medical supplies covered by Medicare, Medicaid or the Children's Health Insurance Program (CHIP) to report annually to the Centers for Medicare & Medicaid Services (CMS) payments or transfers of value provided to physicians or teaching hospitals. In addition, manufacturers and group purchasing organizations (GPOs) are required to report annually physician ownership or investment interests. CMS will publish manufacturers' and GPOs' submitted payment and ownership information on a public website.

Manufacturers and group purchasing organizations began to collect the required data August 1, 2013, and will report the data to CMS by March 31, 2014.

Open Payments objectives and roles

The objectives of the program are to:

- Make financial relationships transparent on a national scale; and
- Give consumers the information needed to ask questions and make more informed decisions about their healthcare professionals.

CMS' role

- Remain neutral and present the data on a public website
- Ensure reporting and disclosures are complete, accurate, and clear

Industry's role

- Collect information on payments and other transfers of value, as well as ownership or investment interests held by physicians and their immediate family members
- Register and submit 2013 data to CMS in the first Quarter of 2014
- Report required annually to CMS
- Correct disputed information

Physicians' role

- Voluntarily keep track of payments and transfers of value made to them and be mindful of ownership and investment interests held by themselves or immediate family
- Voluntarily register with CMS in order to receive notifications and information submitted by industry
- Voluntarily review information for accuracy prior to public posting and dispute potentially inaccurate data

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Open (*continued*)

Impact on physicians or teaching hospitals

Under the Open Payments program, a “physician” is any of the following types of professionals that are legally authorized by the state to practice, regardless of whether they are Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) providers:

- Doctor of medicine
- Doctor of osteopathy
- Doctor of dentistry
- Doctor of dental surgery
- Doctor of podiatry
- Doctor of optometry
- Doctor of chiropractic medicine

Note: Medical residents are excluded from the definition of physicians for the purpose of this program, but fellows are not excluded.

Under the Open Payments program, “teaching hospitals” are hospitals that received payment for Medicare direct graduate medical education (GME), inpatient prospective payment system (IPPS) indirect medical education (IME), or psychiatric hospital IME programs during the last calendar year for which this information is available and on the list posted annually by CMS. The teaching hospital list for Open Payments 2013 is posted at <http://go.cms.gov/openpayments> and will be updated annually.

As mentioned, industry will submit to CMS information on payments and other transfers of value, as well as ownership or investment interests held by physicians and their immediate family members. Ownership or investment interest generally includes: stock, stock options other than those received as compensation, until they are exercised; partnership shares; limited liability company memberships; and loans, bonds, or other financial instruments that are secured with an entity’s property or revenue or a portion of that property or revenue.

The ownership or investment interest may be direct or indirect and through debt, equity, or other means. Certain exceptions apply (See Section 403.902 Definitions in the final rule.).

Ownership or investment interests of an immediate family member of a physician can also trigger reporting. Immediate family member of a physician is a spouse; natural or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother-, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

Track and review your information

Physicians should track all interactions they have with industry involving payments or transfers of value to

ensure accuracy. Physicians and teaching hospitals are not required to register with the program. However, voluntary registration will allow physicians and teaching hospitals to review their data prior to public release. They will also be able to dispute any data thought to be incorrect.

Physicians and teaching hospitals can register and nominate an authorized representative. The information needed to register is undergoing public review and comment through the Paperwork Reduction Act (PRA) process. The information will be finalized and officially released after completion of the PRA process.

Physicians, teaching hospitals, and authorized representatives will be able to review and dispute information. Registration starts early 2014 and will remain open.

Physicians may initiate data disputes to correct inaccurate information any time before the end of the calendar year in which the information was publicly available. If the manufacturer or GPO can’t resolve the dispute with the physician or teaching hospital and correct the data in the initial 45-day or subsequent 15-day period, the manufacturer or GPO and physician or teaching hospital should continue to seek a resolution. Corrections from disputes initiated after 45 days may not be reflected in the initial public data. Data from unresolved disputes will still be posted publicly but will be marked as “disputed.” CMS will monitor the dispute and resolution process and will update the public data at least once annually.

Here is the specific physician information that is reported by the industry:

- Full legal name (as it appears in national plan and provider enumeration system (NPPES))
- Primary practice and specialty
- Primary business address
- National provider identifier (NPI) as it appears in NPPES
- State professional license number(s)
- E-mail address
- Information about the covered product: name(s) of the related covered drug, device, biological, or medical supply
- Information about the payment: amount, date, form, and nature of payment or other transfer of value; number of payments; and, if designated or assigned to a third party, the name of individual or entity the physician assigns the payment to
- How the payment was made (“form of payment”): Cash or cash equivalent; in kind items or services; stock or stock options or any other ownership interest; dividend, profit or other return on

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Open *(continued)*

investment indicated to receive the payment.

In addition, the industry must report why the physician or teaching hospital received the payment (“nature of payment”), e.g.:

- Charitable contribution
- Compensation for services other than consulting
- Consulting fees
- Current or prospective ownership or investment interest
- Direct compensation for serving as faculty or as a speaker for a medical education program (accredited and non-accredited programs)
- Education
- Entertainment
- Food and beverage
- Gifts
- Grant
- Honoraria
- Research
- Royalty or license
- Space rental or facility fees
- Travel and lodging

Types of payments in the Open Payments program

This program captures payments or other transfers of value:

- Paid directly to physicians and teaching hospitals (known as “direct payments”)
- Paid indirectly to physicians and teaching hospitals (known as “indirect payments”)
- Payments **designated by physicians or teaching hospitals** to be paid to another party (known as third-party payments)

Direct payments are payments or other transfers of value provided by the applicable manufacturer or applicable group purchasing organization directly to covered recipients or physicians holding an ownership or investment interest. Here are examples of direct payments: to be paid to another party (known as third-party payments)

1. University Teaching Hospital accepts a \$10,000 grant paid by check from ABC drug manufacturer August 5, 2013. The manufacturer reports:
 - University Teaching Hospital name, address, and TIN from the teaching hospital list published annually by CMS; and
 - Payment information: form of payment, date of payment, and nature of payment.

2. Root Canal Specialty, LLC, contracts with Dr. Jane White to speak at three dental school lectures on the 5th of August, September, and October in 2013 for \$5,000 per lecture. During the discussion, Dr. White will market Root Canal Specialty’s prescription toothpaste, SparkleRx. The manufacturer reports:
 - Dr. Jane White information: name, business address, NPI, license number, primary and specialty type; and
 - Payment information: Form of payment, date of payment, amount of payment, nature of payment, drug information, and marketed name of the covered drug (SparkleRx).

Indirect payments are those payments or other transfers of value made by a manufacturer (or GPO) to a physician or teaching hospital through an intermediary. The manufacturer (or GPO) requires, instructs, directs, or otherwise causes the third party to provide the payment to a physician or teaching hospital. Information about the intermediary will not be reported under this program. Here are examples of indirect payments:

1. Root Canal Specialty, LLC, provides \$10,000 to a dental specialty society on October 12, 2013, requesting the award to be split between the two dentists, chosen by the dental specialty society. The manufacturer reports the following information about the two dentists:
 - Name, address, NPI, license number, specialty (\$5,000 will be attributed to each dentist that receives the award); and
 - Payment information: form of payment, date of payment, and nature of payment.
2. Asthma Relief, LLC, contracts with an advertisement agency to create a newsletter valued at \$35, regarding cutting edge treatments for asthma. The newsletter is targeted toward top prescribers of Asthma Relief, LLC, drugs, and is provided December 7, 2013.

The manufacturer reports the following information about top prescribers:

- Name, address, NPI, license number, specialty (\$35 will be attributed to two medical doctors that are provided the newsletter); and
- Payment information: Form of payment, date of payment, and nature of payment.

Third-party payments are payments or other transfer of value provided to a third party at the request of or designated on behalf of a physician or teaching hospital. Here is an example of a third-party payment:

Asthma Relief, LLC, provides Dr. Henry Jones with a \$500 check for serving as a speaker at a round table discussing easybreathingRx and runfreeRx
(continued on next page)

Open *(continued)*

August 5, 2013. Dr. Jones requests that Asthma Relief, LLC provide the compensation to a charity. The manufacturer reports the following information about the doctor:

- Dr. Henry Jones information: name, address, NPI, license number, specialty (\$500 will be attributed Dr. Henry Jones);
- Payment information: form of payment, date of payment, and nature of payment, indication that the payment was designated to an entity and that the entity was a charity, as well as the name of the entity; and
- Drug information: the marketed name of the covered drugs (easybreathingRx, runfreeRx).

Compensation for speaking at a CME program is not required to be reported, if all of the following conditions are met:

- The program meets the accreditation or certification requirements and standards of the Accreditation Council for Continuing Medical Education (ACCME), the American Academy of Family Physicians (AAFP), the American Dental Association’s continuing education recognition program (ADA CERP), the American Medical Association (AMA), or the American Osteopathic Association (AOA);
- The manufacturer does not directly pay the physician speaker; and
- The manufacturer does not select the physician speaker nor does it provide the third-party vendor with a distinct, identifiable set of individuals to be considered as speakers for the accredited or certified continuing education program.

Other indirect payments associated with CME programs include meals, travel and lodging, tuition fees, educational materials included in CME tuition fees, and educational materials not included in CME tuition fees.

For certified or accredited programs:

- For physician-attendees: report meals, travel and lodging, and educational materials not included in CME tuition fees. Do not report tuition fees and educational materials included in CME tuition fees.
- For physician-faculty/speakers: do not report meals, travel and lodging, tuition fees, educational materials included in CME tuition fees, and educational materials not included in CME tuition fees.

For non-accredited or non-certified programs:

For physician-attendees and for physician-faculty/speakers: report meals, travel and lodging, tuition fees, educational materials included in CME tuition fees, and educational materials not included in CME tuition fees.

Items that directly benefit patients or are intended to

be used by or with patients, including the value of a manufacturer’s services to educate patients regarding a covered drug, device, biological, or medical supply, are not required to be reported. (See Section 403.904 Reports of payments or other transfers of value to physician or teaching hospitals of the final rule.) Here are two examples of educational materials:

- A manufacturer or GPO transfers a textbook to a physician or teaching hospital. This is reportable in the Open Payments program because it does not directly benefit patients.
- Manufacturer or GPO transfers a wall model or anatomical model to a physician or teaching hospital. This is not reportable in the Open Payments program because it directly benefits patients.

Physician tools & resources

CMS’ goals include creating awareness about the Open Payments program among physicians, providing useful and easy to understand information about Open Payments and providing resources that will support physicians.

CMS is creating awareness about the Open Payments through:

- Hosting national provider calls – see the schedule of calls at <http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html>;
- Keeping national professional associations abreast of program developments; and
- Leveraging national publications, the *Medicare Learning Network*® and existing CMS contractors educational and outreach efforts.

Mobile applications

Two free mobile applications (apps) to aid physicians and industry in tracking data collected for Open Payments are available for Apple (iOS) and Android:

- Open Payments mobile for physicians
- Open Payments mobile for industry

See *MLN Matters*® special edition article, SE1329, for details on these apps. SE1329 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1329.pdf>.

CME modules

CME modules are accessible via MedScape. They are accredited by the Accreditation Council for Continuing Medical Education. A link to CME modules is available at <http://go.cms.gov/openpayments>.

- **CME activity #1:** Are You Ready for the National Physician Payment Transparency Program?

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- **CME activity #2:** The Physician Payment Transparency Program and Your Practice.

Educational brochures

Brochures are available for physicians and patients about Open Payments. They are available on the Open Payments Web page at <http://go.cms.gov/openpayments>.

- **Pub #11709-P:** *Information Physicians Can Use on: Open Payments (Physician Payments Sunshine Act)*
- **Pub #11710:** *Information Patients Can Use on: Open Payments*

Other publications

- *MLN Matters*® SE1303 “Information on the National Physician Payment Transparency Program: Open Payments,” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf>.

- “The Sunshine Act — Effects on Physicians,” Agrawal, et. al., *New England Journal of Medicine*, NEJM 2013; 368:2054-2057, is available at <http://www.nejm.org/doi/full/10.1056/NEJMp1303523>.

For more information, contact the Help Desk at openpayments@cms.hhs.gov or visit us at <http://go.cms.gov/openpayments>.

MLN Matters® Number: SE1330
 Related Change Request (CR) #: Not Applicable (N/A)
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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

Note: This article was revised September 4 and September 16, 2013, respectively, to reflect a revised change request (CR) 8182 issued August 30 and add reference to MM8365 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8365.pdf>) for business scenarios, descriptions, and updates related to rule 3. This information was previously published in the May 2013 *Medicare B Connection*, Pages 22-24.

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 (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 you can find 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 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)

(continued on next page)

Remittance (continued)

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
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 (CARC), and remittance advice remark codes (RARC)) 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.

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.O.

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 MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1291OTN.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” as an attachment.

If you have any questions, please contact your 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: MM8182 *Revised*
Related Change Request (CR) #: CR 8182
Related CR Release Date: August 30, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1291OTN
Implementation Date: October 7, 2013, except January 6, 2014, for claims processed by DME MACs

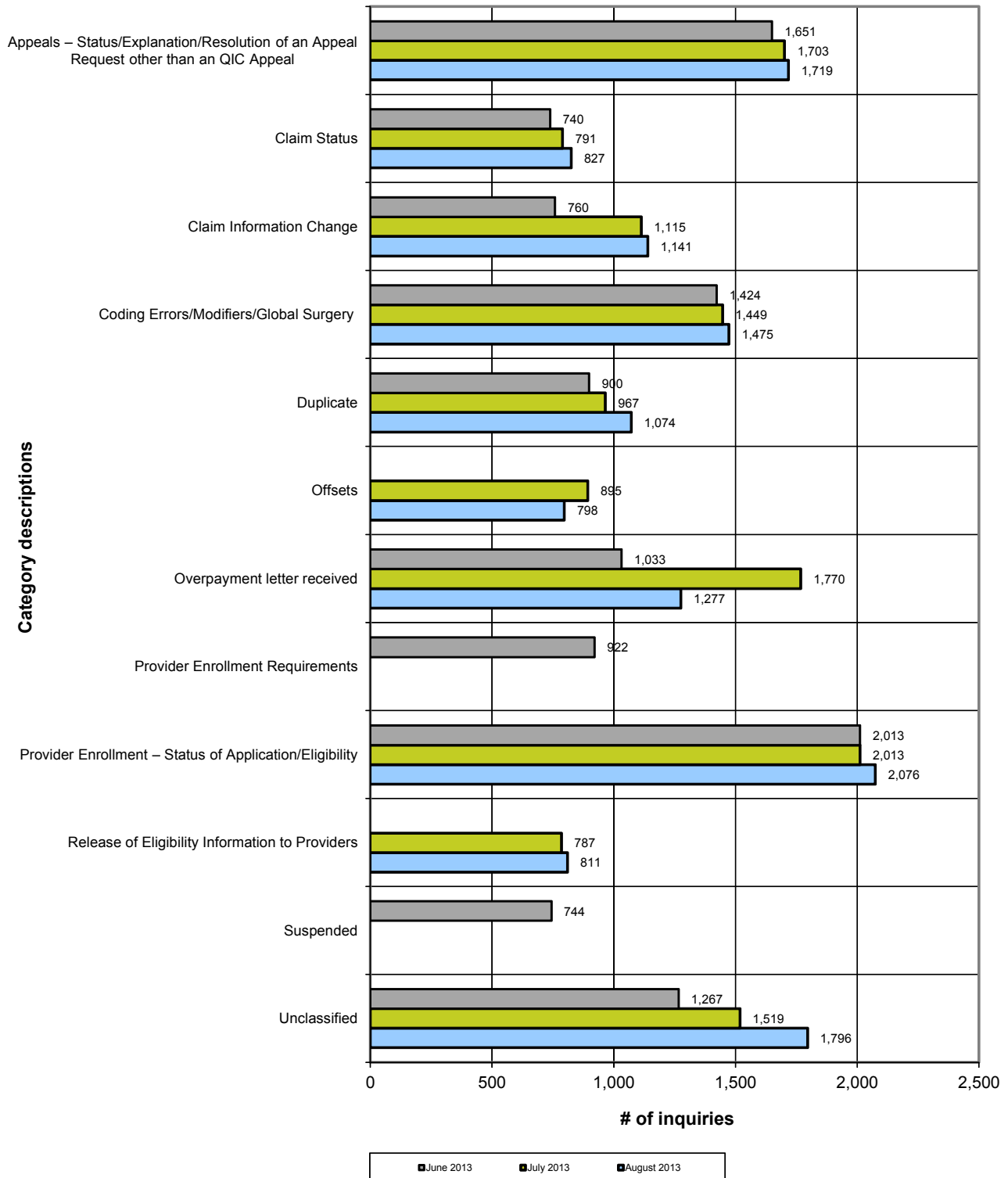
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Top inquiries, denials, and return unprocessable claims

The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during June-August 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.

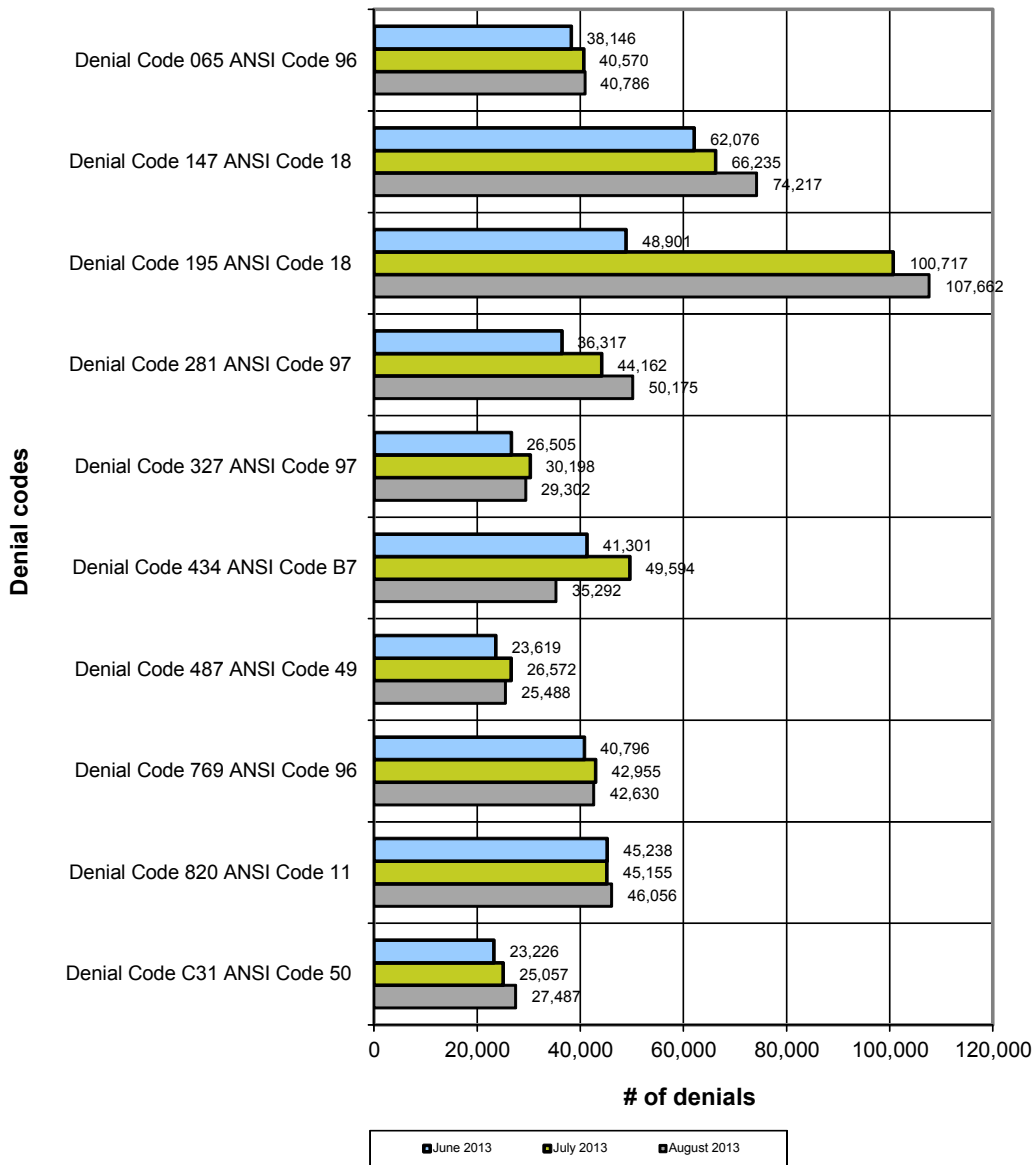
Part B top inquiries for June-August 2013



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Top (continued)

Part B top denials for June-August 2013



What to do when your claim is denied

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

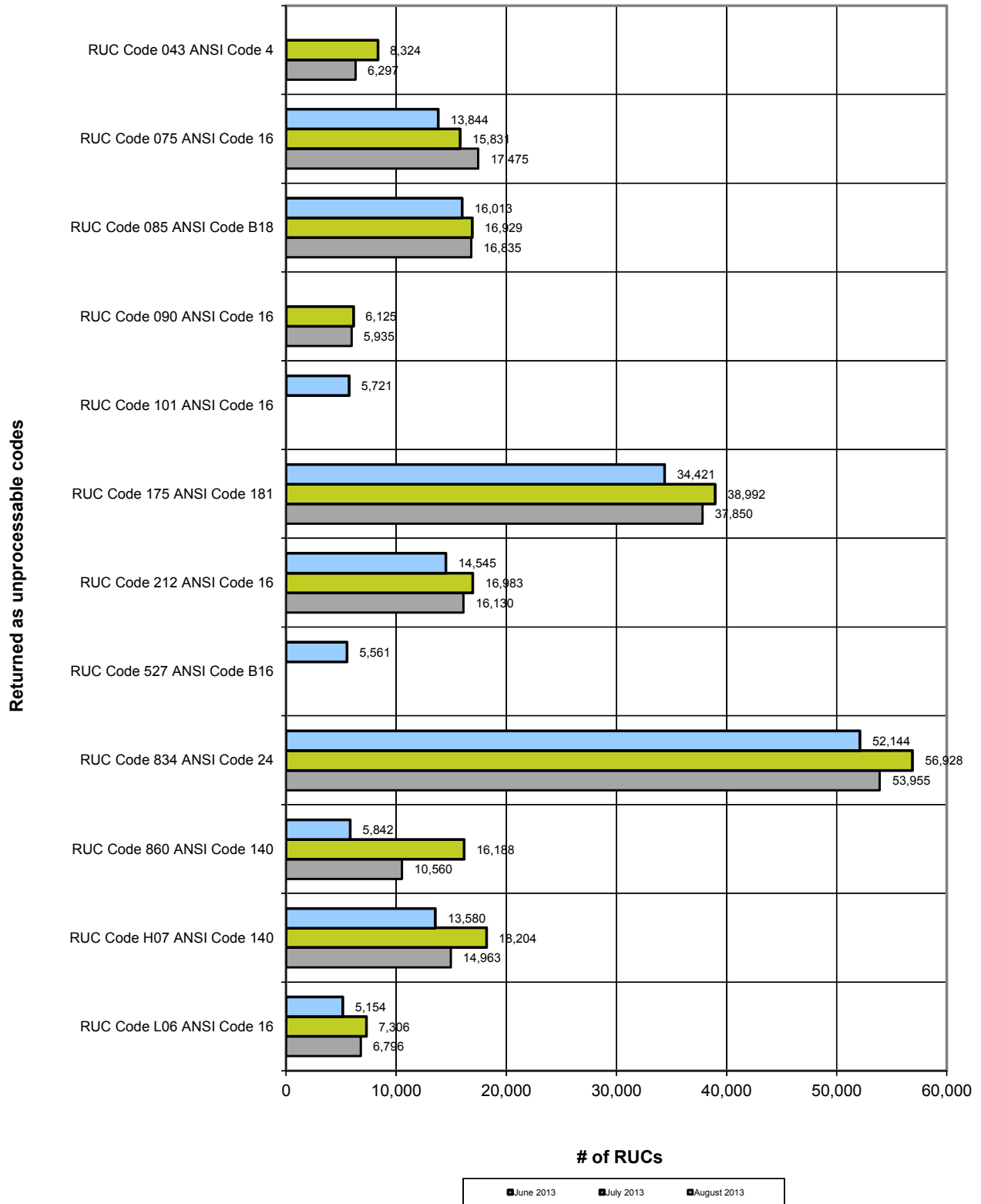
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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

You may also refer to the [Top Part B claim denials](#) and [RUCs](#) tip sheets for tips and resources on correcting and avoiding certain claim denials.

Top (continued)

Part B top return as unprocessable claims for June-August 2013



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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

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Advance beneficiary notice

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

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

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

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

Looking for LCDs?

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

New LCDs

Psychological and neuropsychological tests – New LCD

LCD ID number: L33688 (Florida/Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) has been developed as a result of the medical review issues identified in the documentation associated with claims for psychiatric services regarding unnecessary and incorrect billing for psychological and neuropsychological tests (*Current Procedural Terminology*® (CPT®) codes 96101-96125 and HCPCS code G0451). The documentation reviewed consisted mostly of evaluations of the mental status that can be performed within the psychiatric diagnostic evaluation (e.g., CPT® codes 90791, 90792). In conclusion, the contractor recognized the need to create this LCD because the documentation reviewed consisted mainly of services that should not be classified separately as psychological or neuropsychological tests and should have been coded as part of the psychiatric/psychological clinical exam or interview.

This new LCD was developed to address the indications and limitations of coverage and/or medical necessity, procedure and diagnosis codes, documentation requirements, and utilization guidelines for psychological and neuropsychological tests.

Effective date

This new LCD is effective for services rendered **on or after October 14, 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

Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the LCD

LCD ID number: L32100 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was most recently revised July 1, 2013. Since that time, a revision was made under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD to add the new Food and Drug Administration (FDA) label indication for treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity. Also, a revision was made under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, subtitled “HCPCS Codes J0897 (Xgeva®)” to add diagnosis code 238.0 (Neoplasm of uncertain behavior of bone and articular cartilage).

In addition, the “Documentation Requirements”, “Utilization Guidelines”, “Sources of Information and Basis for Decision” sections of the LCD and “Coding Guidelines” attachment were updated.

Effective date

The LCD revision is effective for claims processed **on or after October 14, 2013**, for services rendered **on or after June 13, 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](#).

Noncovered services – revision to the LCD

LCD ID number: L29288 (Florida)

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

The local coverage determination (LCD) for noncovered services was most recently revised August 5, 2013. Since that time, the following revisions have been made to the LCD:

- Based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8249 and the approval by the Food and Drug Administration (FDA), *Current Procedural Terminology (CPT®)* code 90685 was removed from the “Drugs and Biologicals” section of the LCD. This LCD revision is effective for claims processed **on or after October 7, 2013**, for services rendered **on or after June 7, 2013**.
- In addition, based on the Centers for Medicare & Medicaid Services (CMS) CR 8249, *CPT®* codes 90653, 90687, 90688, and 90739 have been removed from the “Drugs and Biologicals” section of the LCD as they will be denied as not approved by the Food and Drug Administration (FDA) versus not medically reasonable and necessary. This LCD revision is effective for claims processed **on or after October 7, 2013**, for services rendered **on or after January 1, 2013**.
- Although *CPT®* codes 90666, 90667, and 90668 were not included in CR 8249, they are also being removed from the “Drugs and Biologicals” section of the LCD to be consistent with denying as not FDA approved versus not medically reasonable and necessary. This LCD revision is effective for services rendered **on or after October 7, 2013**.
- A new LCD (Transcranial Magnetic Stimulation for Major Depressive Disorder) was developed and includes *CPT®* codes 90867, 90868, and 90869, which is currently in a 45-day notice period to become effective October 7, 2013. Therefore, *CPT®* codes 90867, 90868, and 90869 have been removed from the “Procedures” section of the LCD. This LCD revision is effective for services rendered **on or after October 7, 2013**.
- *CPT®* codes 31660, 31661, and 90586 were evaluated and a decision was made to remove these codes from the “Procedures” section of the LCD. This LCD revision is effective for services rendered **on or after October 7, 2013**.
- For all claims submitted with *CPT®* codes 31660 and 31661 medical record documentation will be requested and reviewed on an individual consideration basis. Of note, when an item or service is removed from the noncovered services LCD, it does not imply a positive coverage statement and coverage by Medicare. Therefore, claims billed for *CPT®* codes 31660 and 31661 (assuming all other requirements of the program are met) would always need to meet the medically reasonable and necessary threshold for coverage in a prepayment or post payment audit of the official record.
- Any time there is a question whether Medicare’s medical reasonableness and necessity criteria would be met, we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed HCPCS codes. Please note that services leading up to or associated with non-covered services are also not covered.



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](#).

Peripheral nerve blocks – revision to the LCD

LCD ID number: L29258 (Florida)

LCD ID number: L29466 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for peripheral nerve blocks was most recently revised October 1, 2009. Since that time, the LCD has been revised under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD to align with the National Correct Coding Initiative (NCCI) policy revised January 1, 2013. NCCI indicates *Current Procedural Terminology*[®] (CPT[®]) codes 64400-64530 (Peripheral nerve blocks-bolus injection or continuous infusion) may be reported on the date of surgery if performed for post-operative pain management only if the operative anesthesia is general anesthesia, subarachnoid injection or epidural injection and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block. Peripheral nerve blocks codes should not be reported separately on the same date of service as a surgical procedure if used as the primary anesthetic technique or as a supplement to the primary anesthetic technique.



Effective date

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

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.



Educational Events

Upcoming provider outreach and educational events October 2013

Encore First Coast's provider contact center presents: "How can we say it better" campaign

When: Tuesday, October 29
Time: 11:30 a.m.-1:00 p.m.

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, medicare.fcsou.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 MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) MLN Connects™ Provider eNews (previously “CMS Medicare FFS 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 eNews to their membership as appropriate. To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels. The following are links to the latest eNews:

- ‘MLN Connects™ Provider eNews’: August 22, 2013 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-22-eNews.pdf>
- ‘MLN Connects™ Provider eNews’: August 29, 2013 – <https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-29-eNews.pdf>
- ‘MLN Connects™ Provider eNews’: September 5, 2013 – <https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-05-enews.pdf>
- ‘MLN Connects™ Provider eNews’: September 12, 2013 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-12-Enews.pdf>
- ‘MLN Connects™ Provider eNews’: September 19, 2013 – <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-19-enews.pdf>

Source: CMS PERL 201308-08, 201308-08, 201309-01, 201309-02, 201309-03

‘Transitioning to ICD-10’ video slideshow now available

On June 20, the Centers for Medicare & Medicaid Services (CMS) regional offices hosted webinars on “Transitioning to ICD-10.” These webinars are now available as video slideshows on the CMS YouTube Channel and cover the background and impact of ICD-10 on industry, CMS ICD-10 implementation, how CMS is working with the states, how CMS is partnering with industry, best practices, frequently asked questions, resources, and contact information. The change to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act and will take place on October 1, 2014.

The *Eastern event* external.gif was specifically for healthcare professionals, coders and organizations operating within the CMS regions I, II, III and IV which include the following states: AL, CT, DC, DE, FL, GA, KY, LA, MA, MD, ME, MS, NC, NH, NJ, NY, PA, RI, SC, TN, VA, VT, and WV.

Information contained within this article was previously released in an edition of the weekly “CMS MLN Connects™ Provider e-News.”

The answer is right at your fingertips

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



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/prevaling charges or fee schedule:

Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:

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

Limiting charge issues:

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

Refund verification:

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

Medicare claims for Railroad retirees:

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

Fraud and abuse

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

Phone numbers

Providers

Toll-Free

Customer Service:
1-866-454-9007

Interactive Voice Response (IVR):

1-877-847-4992

Email address: AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary

Toll-Free:

1-800-MEDICARE

Hearing Impaired:

1-800-754-7820

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

Education event

registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services

www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange (EDI)

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

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

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

Provider enrollment

Where to mail provider/supplier applications

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

Provider change of address

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

and

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

Durable medical equipment (DME)

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

Redeterminations

First Coast Service Options Inc.
P. O. Box 45024
Jacksonville, FL 32232-5091

Redetermination overpayment

First Coast Service Options Inc.
P. O. Box 45091
Jacksonville, FL 32232-5091

Freedom of Information Act requests (FOIA)

First Coast Service Options Inc.
P. O. Box 45073
Jacksonville, FL 32232-5073

Congressional inquiries

First Coast Service Options Inc.
Attn: Carla-Lolita Murphy
P. O. Box 2078
Jacksonville, FL 32231-0048

Provider education

Educational purposes and review of customary/prevaling charges or fee schedule:

Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services

www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

Email address:

AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE

Hearing Impaired:

1-800-754-7820

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

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC

1-866-270-4909

Medicare Part A

Toll-Free:

1-888-664-4112

Addresses

Claims

Additional documentation

General mailing

Congressional mailing

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

Redeterminations

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

Redeterminations on overpayment

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

Post-payment medical exams

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

Freedom of Information Act (FOIA) related requests

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

Medicare fraud and abuse

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

Provider enrollment

Mailing address changes

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

Electronic Data Interchange (EDI)

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

Flu vaccinated list

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

Local coverage determinations

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

Debt collection

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

Overnight mail and other special handling postal services

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

Other Medicare contractors and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary

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

Railroad Medicare

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

Phone numbers

Providers

Customer service – free of charge

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

For the hearing and speech impaired (TDD)

1-888-216-8261

Interactive voice response (IVR)

1-877-847-4992

Beneficiary

Customer service – free of charge

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

Hearing and speech impaired (TDD)

1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number

1-904-361-0407

Website for Medicare

Providers

First Coast – MAC J9

medicare.fcso.com
medicareespanol.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services

www.medicare.gov

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to First Coast Service Options Inc. account # (use appropriate account number). Do not fax your order; it must be mailed.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at http://medicare.fcso.com/Publications_B/index.asp (English) or http://medicareespanol.fcso.com/Publicaciones/ (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2013 through September 2014.	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 []				
<i>Please write legibly</i>			Subtotal	\$
			Tax (add % for your area)	\$
			Total	\$

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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



Medicare B Connection

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

Attention Billing Manager