# Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

*A Newsletter for MAC Jurisdiction 9 Providers*

April 2014


## In this issue



# 'Sequestration' mandatory payment reduction of two percent continues through March 31, 2015

For the Medicare fee-for-service (FFS) program, claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will continue to incur a two percent reduction in Medicare payment through March 31, 2015.

Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME competitive bidding program, will continue to be reduced by two percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

The claims payment adjustment will continue to be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare secondary payment adjustments. Though beneficiary payments for deductibles and coinsurance are not subject to the two percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the two percent reduction.


CMS encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries the impact of sequestration on Medicare's reimbursement. Questions about reimbursement should be directed to your *Medicare administrative contractor*.

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

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



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# About the 'Medicare B Connection'

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

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

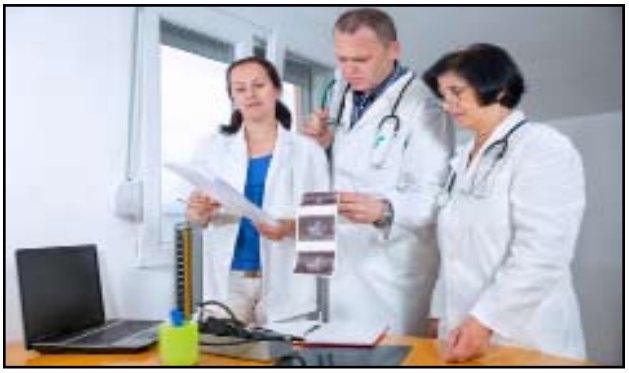
For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

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

# April 2014 update of the ambulatory surgical center payment system

***Note**: This article was revised on April 10, 2014, to reflect the revised change request (CR) 8675 issued April 10. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the March 2014 Medicare B Connection, Pages 11-13.*

### 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 (MACs)) for services to Medicare beneficiaries.

### Provider action needed

This article is based on CR 8675 and is a recurring update that describes changes to and billing instructions for various payment policies implemented in the April 2014 ASC update. Make sure billing staff are aware of the changes.

### Background

This CR includes updates to the Healthcare Common Procedure Coding System (HCPCS). The update applies to Chapter 14 of the "Medicare Claims Processing" manual (Ambulatory Surgical Centers). Make sure that your billing staffs are aware of these changes.

### Key points of CR 8675

#### New services

New services, shown below and listed in CR 8675, Attachment A, Table 1, are assigned for payment under the ASC payment system, effective April 1, 2014.

| HCPCS | Short descriptor | Long descriptor | ASC PI |
|---|---|---|---|
| C9739 | Cystoscopy prostatic imp 1-3 | Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants | G2 |
| C9740 | Cysto impl 4 or more | Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants | G2 |

### Billing for drugs, biologicals, and radiopharmaceuticals

#### a. Drugs and biologicals with payments based on average sales price (ASP), effective April 1, 2014

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 April 2014 release of the ASC DRUG file. The updated payment rates, effective April 1, 2014, are included in the April 2014 update of the ASC, Addendum BB, which will be posted on the CMS website.

#### b. HCPCS for drugs and biologicals separately payable under the ASC payment system, effective April 1, 2014

Two drugs and biologicals have been granted ASC payment status, effective April 1, 2014. These items, along with their descriptors and ASC payment indicator (ASC PI), are shown below and are listed in CR 8675, Attachment A, Table 2.

| HCPCS | Long descriptor | ASC PI |
|---|---|---|
| C9021* | Injection, obinutuzumab, 10 mg | K2 |
| C4121 | Theraskin, per square centimeter | K2 |

**Note**: The HCPCS identified with an "*" indicate that these are new codes effective April 1, 2014.

#### c. Revised ASC Payment Indicator for HCPCS Codes A9545, J1446, J7178, and Q0181

Effective April 1, 2014, the payment indicator for HCPCS code A9545 (Iodine I-131 tositumomab, therapeutic, per treatment dose) will change from K2 to Y5 because the product associated with HCPCS A9545 (brand name Bexxar) is no longer marketed.

Effective January 1, 2014, the payment indicator for HCPCS J1446 (Injection, TBO-Filgrastim, 5 micrograms) will change from Y5 for K2 to indicate that the drug will be paid separately effective January 1, 2014. Suppliers who think they may have received an incorrect payment for dates of service January 01, 2014, through March 31, 2014, may request contractor adjustment of the previously processed claims.

Effective January 1, 2014, the payment indicator for HCPCS J7178 (Injection, human fibrinogen concentrate, 1 mg) will change from N1 to K2 to indicate that the drug will

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be paid separately effective January 1, 2014. Suppliers who think they may have received an incorrect payment for dates of service January 01, 2014 through March 31, 2014, may request contractor adjustment of the previously processed claims.

Effective January 1, 2014, the payment indicator for HCPCS code Q0181 (Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as) will change from Y5 to N1.

These codes are listed below and in CR 8675, Attachment A, Table 3, along with the effective date for the revised payment indicator.

| HCPCS | Long descriptor | ASC PI | Effective date |
|---|---|---|---|
| A9545 | Iodine I-131 tositumomab, therapeutic, per treatment dose | Y5 | 4/1/2014 |
| J1446 | Injection, TBO-Filgrastim, 5 micrograms | K2 | 1/1/2014 |
| J7178 | Injection, human fibrinogen concentrate, 1 mg | K2 | 1/1/2014 |
| Q0181 | Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as | N1 | 1/1/2014 |

### d. Updated payment rate for certain HCPCS, effective April 1, 2013, through June 30, 2013

The payment rate for one HCPCS was incorrect in the April 2013 ASC Drug File. The corrected payment rate is listed below and in CR 8675, Attachment A, Table 4, and has been installed in the April 2014 ASC Drug File, effective for services furnished on April 01, 2013, through June 30, 2013. Suppliers who think they may have received an incorrect payment for dates of service April 1, 2014, through June 30, 2014, may request contractor adjustment of the previously processed claims.

| HCPCS | Short descriptor | Corrected payment rate | ASC PI |
|---|---|---|---|
| Q4127 | Talymed | $13.78 | K2 |

### e. Updated payment rate for certain HCPCS, 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 listed below and in CR 8675, Attachment A, Table 5, and has been installed in the April 2014 ASC drug file, effective for services furnished on July 01, 2013 through September 30, 2013. Suppliers who think they may have received an incorrect payment for dates of service July 01, 2013, through September 30, 2013, may request contractor adjustment of the previously processed claims.

| HCPCS | Short descriptor | Corrected payment rate | ASC PI |
|---|---|---|---|
| Q4127 | Talymed | $13.78 | K2 |

### f. Updated payment rates for certain HCPCS, effective October 1, 2013, through December 1, 2013

The payment rates for two HCPCS were incorrect in the October 2013 ASC drug file. The corrected payment rates are listed below and in CR 8675, Attachment A, Table 6, and have been installed in the April 2014 ASC drug file, effective for services furnished on October 01, 2013, through December 31, 2013. Suppliers who think they may have received an incorrect payment for dates of service October 1, 2013 through December 31, 2013, may request contractor adjustment of the previously processed claims.

| HCPCS | Short descriptor | Corrected payment rate | ASC PI |
|---|---|---|---|
| J2323 | Natalizumab injection | $12.99 | K2 |
| Q4127 | Talymed | $13.78 | K2 |

### g. Reassignment of skin substitute products that are new for 2014 from the low cost group to the high cost group

In the 2014 OPPS/ASC final rule, CMS finalized a policy to package payment for skin substitute products into the associated skin substitute application procedure. For packaging purposes, CMS created two groups of application procedures: application procedures that use high cost skin substitute products (billed using *CPT®* codes *15271-15278*) and application procedures that use low cost skin substitute products (billed using HCPCS C5271-C5278). Assignment of skin substitute products to the high cost or low cost groups depended upon a comparison of the July 2013 payment rate for the skin substitute product to $32, which is the weighted average payment per unit for all skin substitute products using the skin substitute utilization from the 2012 claims data and the July 2013 payment rate for each product. Skin substitute products with a July 2013 payment rate that was above $32 per square centimeter are paid through the high cost group and those with a July 2013 payment rate that was at or below $32 per square centimeter are paid through the low cost group for 2014. As a reminder, for 2015, CMS will follow their usual policy with regard to the specific quarterly ASP data sets used for proposed and final rule-making in that CMS will use April 2014 ASP data to establish the proposed rule low/high cost threshold and they will use July 2014 ASP data to establish the final low/high cost threshold for CY 2015.

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CMS also finalized a policy that will use the $32 per square centimeter threshold to determine mapping to the high or low cost skin substitute group for any new skin substitute products approved for payment during 2014. Any new skin substitute products without pricing information were assigned to the low cost category until pricing information becomes available. There were nine new skin substitute products that were effective January 1, 2014, and that were assigned to the low cost payment group because pricing information was not available for these products at the time of the January 2014 update. There is now pricing information available for three of these nine products. That information is listed below and in CR 8675, Attachment A, Table 7, and it shows the three new products and their low/high cost status based on the comparison of the price per square centimeter for each product to the $32 square centimeter threshold for 2014.

| HCPCS | Long descriptor | ASC PI | Low/high cost status |
|---|---|---|---|
| Q4143 | Repriza, per square centimeter | N1 | Low |
| Q4147 | Architect extracellular matrix, per square centimeter | N1 | High |
| Q4148 | Neox 1k, per square centimeter | N1 | High |

### h. Billing guidance for the topical application of mitomycin during ophthalmic surgery

This is a reminder that ASCs are not permitted to bill HCPCS code J9280 (Injection, mitomycin, 5 mg) for the topical application of mitomycin.

### 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. Carriers/MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, carriers/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 8675 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2927CP.pdf*.

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

*MLN Matters*® Number: MM8675 *Revised*
Related Change Request (CR) #: CR 8675
Related CR Release Date: April 10, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R2927CP
Implementation Date: April 7, 2014



## Incorrect overpayments and denials for some new patient visit claims

The Centers for Medicare & Medicaid Services (CMS) has identified issues related to processing of claims for new patient visits billed by the same physician or physician group within the past three years.

CMS has determined that the edits, implemented in October 2013, generated incorrect overpayments and denials for some claims. CMS will be issuing refunds on any offset or recouped payments and interest in the next 90 days.

For background see *MLN Matters® article MM8165*.

## Global Surgery

# Global surgery post-operative period of 0, 10 and 90 days

First Coast Service Options Inc. (First Coast) recently conducted data analysis to evaluated procedure codes with a global period of 0, 10, and 90 days. The findings revealed that services were incorrectly paid during a global period without an appropriate modifier.

### Definition of a global surgical package

As outlined in the Centers for Medicare & Medicaid Services (CMS) Internet-only manual (IOM), Publication 100-04 Chapter 12, Sections 40.1 and 40.2, field 16 of the Medicare fee schedule database (MFSDB) provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090 and sometimes YYY. Codes with 090 in field 16 are major surgeries; codes with 000 or.010 are either minor surgical procedures or endoscopies.

CMS IOM, Publication 100-04 Chapter 12, Section 40.3 (Claims Review for Global Surgeries) includes correct coding initiative policy and computer edits that allow carriers to detect instances of fragmented billing for certain intraoperative services and other services furnished on the same day as the surgery that are considered to be components of the surgical procedure.

Prepayment edits in addition to the correct coding edits also allow carriers to detect other services included in the payment for a major or minor surgery or for an endoscopy. Prepayment edits identify services that meet the following conditions:

- Preoperative services submit on the same claim or on a subsequent claim as the surgical or endoscopy procedure.
- Same day or postoperative services submit on the same claim or on a subsequent claim as the surgical or endoscopy procedure.
- Services that were furnished within the prescribed global period of the surgical procedure.

Services within the prescribed global period of the surgical procedure including services billed without modifier, *78, 79, 24, 25*, or *57* or are billed with modifier *24* but without the required documentation.

- Services that are billed with the same provider or group number as the surgical procedure or endoscopy also, edit for any visit billed separately during the postoperative period with modifier 24 by a physician who billed for postoperative care only with modifier *55*.

### Modifiers

- Modifier *57* reports a decision to perform surgery prior to a major procedure with a 90 day global period.
- Modifier *78* reports return trips to the operating room for a related procedure or treatment for complications during a postoperative period.
- Modifier *58* is utilized to indicate a staged or related surgical procedure performed during the postoperative period of the first procedure. The physician must indicate that the services was planned prospectively or at the time of the original procedure, more extensive than the original procedure or for therapy following a diagnostic surgical procedure in which a new postoperative period begins once the next procedure in the series is billed.
- Modifier *79* reports an unrelated procedure by the same physician during a postoperative period
- Modifier *24* reports an unrelated evaluation and management service by the same physician during a postoperative period.
- Modifier 25 reports a significantly, separately identifiable evaluation and management service by the same physician on the day of a procedure for which separate payment may be made.

### First Coast's response

In response to the risk of payment errors that occur when submitting global surgery services, First Coast will be enhancing claim editing to detect incorrectly billed services.

## Laboratory/Pathology

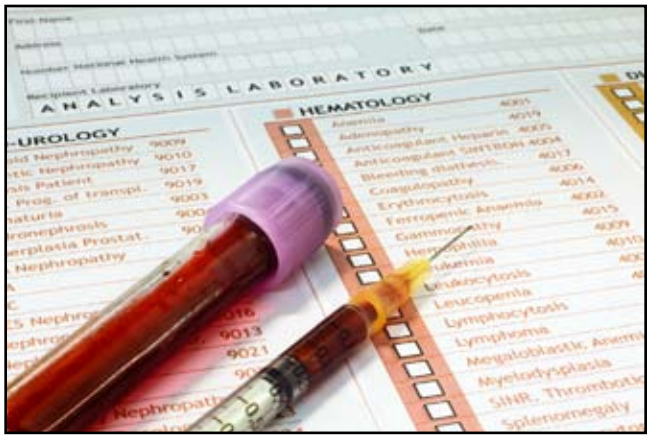
# 2014 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment – revision

### Provider types affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

### What you need to know

This *MLN Matters*® article is based on change request (CR) 8695 which provides instructions for the revised 2014 clinical laboratory fee schedule, including several codes that were inadvertently left off of the previous 2014 fee schedule files. These codes, which were intended to be included on the original 2014 clinical laboratory fee schedule file, were recently given a "QW" modifier to both identify the codes and to determine payment for tests performed by a laboratory having only a certificate of waiver under CLIA. Also, CR 8695 corrects a technical oversight that led to the misstatement of several prices on the fee schedule. Those prices reflected on this file created for CR 8695 are now correct. Be sure your billing staffs are aware of these updates.




### Background

CR 8695 provides instructions for the revised 2014 clinical laboratory fee schedule.

#### Access to data file

The revised 2014 clinical laboratory fee schedule data file will be available on or after February 28, 2014, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*.

Other interested parties, such as the Medicaid state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, will also use the Internet to retrieve the 2014 clinical laboratory fee schedule which will be available in multiple formats including Excel, text, and comma delimited.

#### Mapping information

Existing codes that have been recalculated so that their national limitation amount (NLA) and/or price for each MAC is correct. These codes are *80160, 82017, 82136, 82139, 82261, 82270, 82271, 82271*QW, *82272, 82272*QW, *82274, 82274*QW, *82379, 83013, 83080, 85576, 85576*QW, *86355, 86357, 86359, 86367*, G0123, G0328, and G0328QW.

#### Existing code pricing

- Existing code *86152* is priced at the 2013 contractor gap-filled rate.
- Existing code *86294*QW is priced at 100 percent of the midpoint in the NLA pricing.

### Additional information

Note that your MAC will not automatically adjust claims processed prior to implementation of CR 8695. However, if you have claims that need adjustment, your MAC will adjust those claims that you bring to their attention.

The official instruction, CR 8695, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2948CP.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*.

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Related CR Transmittal #: R2948CP
Implementation Date: On or before June 30, 2014

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# Approved new waived tests for 2014

## Provider types affected

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

## Provider action needed

### Stop – impact to you

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your 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.

### Caution – what you need to know

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) considers to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 8705, from which this article is taken, informs MACs about the latest new *CPT*® codes that are subject to CLIA edits.

### Go – what you need to do

Make sure that your billing staffs are aware of these CLIA-related changes for 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 8705 (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.

| *CPT*® code | Effective date | Description |
|---|---|---|
| *87880*QW | July 29, 2013 | Poly stat Strep A Flip Test |
| G0434QW | August 1, 2013 | Alere iScreen DX Multi-Drugs of Abuse Dip Test |
| G0434QW | September 10, 2013 | Alere iScreen DX Single Dip Card {The Alere iScreen DX Single Dip Card may include a maximum of four drugs in any combination of the 13 claimed drugs} |
| *85018*QW | December 12, 2013 | Alere HemoPoint H2 System |
| *87804*QW | December 13, 2013 | Sofia Analyzer and Influenza A+B FIA |
| G0434QW | February 21, 2014 | Ultimate Analysis Cup Inc. UA Cups Test Cards |
| G0434QW | February 21, 2014 | Ultimate Analysis Cup Inc. UA Cups |
| *83516*QW | February 27, 2014 | Rapid Pathogen Screening, Inc. InflammaDry |

The new *CPT*® code *83516*QW has been assigned for the immunoassay test for the visual, qualitative

detection of elevated levels of the MMP-9 protein in human tears, from patients suspected of having dry eye performed using the Rapid Pathogen Screening, Inc. InflammaDry.

MACs will not search their files to either retract payment or retroactively pay claims based on the above changes; however, they will adjust claims impacted by these changes if you bring such claims to your MAC's attention.

## Additional information

The official instruction, CR 8705, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2919CP.pdf*.

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

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Implementation Date: July 7, 2014

## Medicare Physician Fee Schedule Database

# April 2014 Medicare physician fee schedule database update

***Note**: This article was revised April 8, 2014, to reflect the revised change request (CR) 8664 issued April 4. The CR was revised to reflect the President signing into law the "Protecting Access to Medicare Act of 2014" April 1, 2014, thus averting the expiration of the 0.5 percent update to the physician fee schedule conversion factor and the 1.0 work floor GPCI, which will now remain in effect until December 31, 2014. Similar changes were made to this article. The CR release date and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in* the *March 2014 Medicare B Connection, Pages 25-27*.

## Provider types affected

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

## Provider action needed

This article is based on CR 8664 which amends the payment files that were issued to Medicare contractors based upon the 2014 MPFS, final rule and passage of the "Protecting Access to Medicare Act of 2014," which the President signed April 1, 2014. Make sure that your billing staffs are aware of these changes.

## Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

In order to reflect appropriate payment policy as included in the 2014 MPFS final rule, the MPFSDB has been updated with April changes, and those necessitated by "Protecting Access to Medicare Act of 2014," which the President signed April 1, 2014. This law extends the 0.5 percent update through December 31, 2014. Since the Act extends the MPFSDB policies to all of 2014, the April update payment files that were previously created to be effective from January 1, 2014 to March 31, 2014, can now be used by MACs to be effective from January 1, 2014, to December 31, 2014.

**Note**: Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

## CR 8664 summary of changes

The summary of changes for the April 2014 update consists of the following:

**Short description corrections for HCPCS codes G0416-G0419**

| HCPCS | Old short description | Revised 2014 short description |
|---|---|---|
| G0416 | Sat biopsy prostate 1-20 spc | Biopsy prostate 10-20 spc |
| G0417 | Sat biopsy prostate 21-40 | Biopsy prostate 21-40 |
| G0418 | Sat biopsy prostate 41-60 | Biopsy prostate 41-60 |
| G0419 | Sat biopsy prostate: >60 | Biopsy prostate: >60 |

**Adjust the facility and non-facility PE RVUs for HCPCS code *77293*-global and *77293*-TC via CMS update files. See Table A (Page 13).**

**HCPCS code G9361 will be added to your Medicare contractor's systems.**

| HCPCS code | G9361 |
|---|---|
| Procedure status | M |
| Short descriptor | Doc comm risk calc |
| Effective date | 01/01/2014 |
| Work RVU | 0 |
| Full non-facility PE RVU | 0 |
| Full non-facility NA indicator | (blank) |
| Full facility PE RVU | 0 |
| Full facility NA indicator | (blank) |
| Malpractice RVU | 0 |
| Multiple procedure indicator | 9 |
| Bilateral surgery indicator | 9 |
| Assistant surgery indicator | 9 |
| Co-surgery indicator | 9 |
| Team surgery indicator | 9 |
| PC/TC | 9 |

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| HCPCS code | G9361 |
|---|---|
| Site of service | 9 |
| Global surgery | XXX |
| Pre | 0.00 |
| Intra | 0.00 |
| Post | 0.00 |
| Physician supervision diagnostic indicator | 09 |
| Diagnostic family imaging indicator | 99 |
| Non-facility PE used for OPPS payment amount | 0.00 |
| Facility PE used for OPPS payment amount | 0.00 |
| MP used for OPPS payment amount | 0.00 |
| Type of service | 9 |
| Long descriptor | Medical indication for induction [Documentation of reason(s) for elective delivery or early induction (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-premature, prolonged maternal conditions complicating pregnancy/ delivery, fetal conditions complicating pregnancy/ delivery, malposition and malpresentation of fetus, late pregnancy, prior uterine surgery, or participation in clinical trial)] |

**Correct the physician supervision of diagnostic procedures indicator (Phys diag supv) for the TC's of the following codes, effective January 1, 2014.**

| HCPCS | Description | Phys diag supv | Effective date |
|---|---|---|---|
| *70450*-TC | CT head/brain w/o dye - Phys Diag Supv correction (TC) | 01 | 01/01/2014 |
| *70460*-TC | CT head/brain w/dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *70551*-TC | MRI brain stem w/o dye - Phys Diag Supv correction (TC) | 01 | 01/01/2014 |
| *70552*-TC | MRI brain stem w/dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *70553*-TC | MRI brain stem w/o & w/dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *72141*-TC | MRI neck spine w/o dye - Phys Diag Supv correction (TC) | 01 | 01/01/2014 |
| *72142*-TC | MRI neck spine w/ dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *72146*-TC | MRI chest spine w/o dye - Phys Diag Supv correction (TC) | 01 | 01/01/2014 |
| *72147*-TC | MRI chest spine w/ dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *72148*-TC | MRI lumbar spine w/o dye - Phys Diag Supv correction (TC) | 01 | 01/01/2014 |
| *72149*-TC | MRI lumbar spine w/ dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *72156*-TC | MRI neck spine w/o & w/dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *72157*-TC | MRI chest spine w/o & w/dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |

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Table A

| HCPCS | Mod | | Description | Non- Facility PE RVUs | Facility PE RVUs | Global | |
|---|---|---|---|---|---|---|---|
| *77293* | | A | Respirator motion mgmt simul | 9.96 | NA | ZZZ | Jan 1 to March 31, 2014 |
| *77293* | TC | A | Respirator motion mgmt simul | 9.16 | NA | ZZZ | Jan 1 to March 31, 2014 |
| *77293* | | A | Respirator motion mgmt simul | 10.72 | NA | ZZZ | Correction April 1, 2014 |
| *77293* | TC | A | Respirator motion mgmt simul | 9.92 | NA | ZZZ | Correction April 1, 2014 |

| HCPCS | Description | Phys diag supv | Effective date |
|---|---|---|---|
| *72158*-TC | MRI lumbar spine w/o & w/dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *72191*-TC | CT angiograph pelv w/o & w/ dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *74174*-TC | CT angio abd&pelv w/o&w/ dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *74175*-TC | CT angio abdom w/o & w/dye - Phys Diag Supv correction (TC) | 02 | 01/01/2014 |
| *93880*-TC | Extracranial bilat study - Phys Diag Supv correction (TC) | 01 | 01/01/2014 |
| *93882*-TC | Extracranial uni/ltd study - Phys Diag Supv correction (TC) | 01 | 01/01/2014 |

| HCPCS | Description | Phys diag supv | Effective date |
|---|---|---|---|
| *77001*-TC | Fluoroguide for vein device - Phys Diag Supv correction (TC) | 03 | 01/01/2014 |
| *77002*-TC | Needle localization by Xray - Phys Diag Supv correction (TC) | 03 | 01/01/2014 |
| *77003*-TC | Fluoroguide for spine inject - Phys Diag Supv correction (TC) | 03 | 01/01/2014 |

## Additional information

The official instruction, CR 8664, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2923CP.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: MM8664 *Revised*
Related Change Request (CR) #: CR 8664
Related CR Release Date: April 4, 2014
Effective Date: January 1, 2014
Related CR Transmittal #:R2923CP
Implementation Date: April 7, 2014

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Radiology

# Medicare NCD for beta amyloid positron emission tomography in dementia and neurodegenerative disease

***Note**: This article was revised April 4, 2014, to reflect the revised change request (CR) 8526 issued March 27, 2014. In the article, the CR release date, transmittal numbers, and the Web addresses for accessing the two transmittals of CR 8526 were revised. All other information remains the same. This information was previously published in the February 2014 Medicare B Connection, Pages 30-32.*

## Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who submit claims to Medicare A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries with dementia or neurodegenerative disease.

## What you need to know

Effective for claims with dates of service on or after, September 27, 2013, the Centers for Medicare & Medicaid Services (CMS) will only allow coverage for PET Aβ imaging (one PET Aβ scan per patient) through coverage with evidence development (CED) to: (1) develop better treatments or prevention strategies for Alzheimer's Disease (AD), or, as a strategy to identify subpopulations at risk for developing AD, or (2) resolve clinically difficult differential diagnoses (e.g., front temporal dementia (FTD) versus AD) where the use of PET Aβ imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

## Background

After careful consideration, effective for claims with dates of service on or after September 27, 2013, CMS believes that the evidence is insufficient to conclude that PET Aβ imaging improves health outcomes for Medicare beneficiaries with dementia or neurodegenerative disease. However, there is sufficient evidence that the use of PET Aβ imaging could be promising in certain scenarios. Therefore, Medicare will only allow coverage for PET Aβ imaging (one PET Aβ scan per patient) through CED to:

1. Develop better treatments or prevention strategies for AD, or, as a strategy to identify subpopulations at risk for developing AD, or
2. Resolve clinically difficult differential diagnoses (e.g., FTD versus AD) where the use of PET Aβ imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

Health outcomes may include the following:

1. Avoidance of unnecessary or potentially harmful treatment or tests
2. Improving, or slowing the decline of, quality of life (to include maintenance of independence) and cognitive and functional status
3. Survival

Outcomes may be short-term (e.g., related to meaningful changes in clinical management) or long-term (e.g., related to dementia outcomes).

A list of ICD-9 and corresponding ICD-10 codes for beta amyloid for dementia and neurodegenerative diseases is in the following table.

| ICD-9 codes | Corresponding ICD-10 codes |
|---|---|
| 290.0 Senile dementia, uncomplicated | F03.90 Unspecified dementia without behavioral disturbance |
| 290.10 Presenile dementia, uncomplicated | F03.90 Unspecified dementia without behavioral disturbance |
| 290.11 Presenile dementia with delirium | F03.90 Unspecified dementia without behavioral disturbance |
| 290.12 Presenile dementia with delusional features | F03.90 Unspecified dementia without behavioral disturbance |
| 290.13 Presenile dementia with depressive features | F03.90 Unspecified dementia without behavioral disturbance |
| 290.20 Senile dementia with delusional features | F03.90 Unspecified dementia without behavioral disturbance |
| 290.21 Senile dementia with depressive features | F03.90 Unspecified dementia without behavioral disturbance |
| 290.3 Senile dementia with delirium | F03.90 Unspecified dementia without behavioral disturbance |
| 290.40 Vascular dementia, uncomplicated | F01.50 Vascular dementia without behavioral disturbance |

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## NCD

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| ICD-9 codes | Corresponding ICD-10 codes |
|---|---|
| 290.41 Vascular dementia with delirium | F01.51 Vascular dementia with behavioral disturbance |
| 290.42 Vascular dementia with delusions | F01.51 Vascular dementia with behavioral disturbance |
| 290.43 Vascular dementia with depressed mood | F01.51 Vascular dementia with behavioral disturbance |
| 294.10 Dementia in conditions classified elsewhere without behavioral disturbance | F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance |
| 294.11 Dementia in conditions classified elsewhere with behavioral disturbance | F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance |
| 294.20 Dementia, unspecified, without behavioral disturbance | F03.90 Unspecified dementia without behavioral disturbance |
| 294.21 Dementia, unspecified, with behavioral disturbance | F03.91 Unspecified dementia with behavioral disturbance |
| 331.11 Pick's disease | G31.01 Pick's disease |
| 331.19 Other frontotemporal dementia | G31.09 Other frontotemporal dementia |
| 331.6 Corticobasal degeneration | G31.85 Corticobasal degeneration |
| 331.82 Dementia with Lewy Bodies | G31.83 Dementia with Lewy bodies |
| 331.83 Mild cognitive impairment, so stated | G31.84 Mild cognitive impairment, so stated |
| 780.93 Memory loss | R41.1 Anterograde amnesia R41.2 Retrograde amnesia R41.3 Other amnesia (amnesia NOS, memory loss NOS) |
| V70.7 Examination for normal comparison or control in clinical research | Z00.6 Encounter for examination for normal comparison and control in clinical research program |

Effective for claims with dates of service on or after September 27, 2013, MACs will return to provider/ return as unprocessable claims for PET Aβ imaging, through CED during a clinical trial, not containing the following:

- Condition code 30, (for institutional claims only)
- Modifier Q0 and/or modifier Q1 as appropriate
- ICD-9 dx code V70.7/ICD-10 dx code Z00.6 (on either the primary/secondary position)
- A PET HCPCS code 788.11 or 788.14
- Dx codes (see list in table above)
- Aβ HCPCS code A9586 or A9599

MACs will return as unprocessable claims for PET Aβ imaging using the following messages:

- **Claim adjustment reason code (CARC) 4**: the procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remark code (RARC) N517**: Resubmit a new claim with the requested information.
- **RARC N519**: Invalid combination of HCPCS modifiers.

For claims with dates of service on or after September 27, 2013, Medicare will deny/reject claims for more than one PET Aβ scan; HCPCS code A9586 or A9599, in a patient's lifetime.

MACs will line-item deny claims for PET Aβ, HCPCS code A9586 or A9599, where a previous PET Aβ, HCPCS code A9586 or A9599 is paid in history using the following messages:

- **CARC 149**: "Lifetime benefit maximum has been reached for his service benefit category."
- **RARC N587**: "Policy benefits have been exhausted."
- **Group code: PR**, assigning financial liability to the beneficiary if a claim is received with occurrence code 32 indicating a signed ABN is on file, or occurrence code 32 is present with modifier GA.
- **Group code: CO**, assigning financial liability to the provider if a claim is received with a GZ modifier indicating no signed ABN is on file.

Note that MACs will not automatically adjust claims processed prior to implementation of CR 8526, but they will adjust such claims that you bring to their attention.

**Note**: Each new beta amyloid radiopharmaceutical will require a separate code. Therefore, for the interim period, HCPCS code A9599 (Radiopharmaceutical for beta-amyloid positron emission tomography (PET) imaging, diagnostic, per study dose) shall be used

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with an effective date of January 1, 2014. After a new beta amyloid radiopharmaceutical is approved for a separate, individual HCPCS code, a subsequent CR will be issued to update this NCD policy.

**Note**: Contractors should refer to the business requirements in CR 8526 well as general clinical trial billing requirements at Pub. 100-03, Chapter 1, Section 310, and Pub. 100-04, Chapter 32, section 69. See Pub. 100-03, *NCD Manual*, Chapter 1, Section 220.6.20, for the coverage of beta amyloid PET in neurodegenerative disease and dementia, and Pub. 100-04, *Claims Processing Manual*, chapter 13, section 60.12, for claim processing instructions.

### Additional information

The official instruction, CR 8526, is in two transmittals issued to your A/B MAC. The first transmittal updates the *National Coverage Determinations* anual and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R164NCD.pdf*. The second transmittal updates the *Medicare Claims Processing* manual and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2915CP.pdf*.

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

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## General Coverage

# 'Medicare Benefit Policy' manual clarifications regarding use of antigens

**Effective date:** January 1, 2001
**Implementation:** date: May 12, 2014

### Summary of changes

This change request serves to make the *Medicare Benefit Policy* manual provisions consistent with regulatory requirements. Additionally, revisions are being made to Chapter 13 of the *Medicare Program Integrity* manual to accurately reflect CMS's plan to implement Section 731 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (*transmittal 510*).

### General information

#### Background

Section 1861(s)(2)(G) the Social Security Act (the Act) authorizes Medicare coverage of "antigens (subject to quantity limitations prescribed in regulations by the Secretary)". Implementing regulations were established at 42 CFR 410.68 to identify a reasonable supply of antigens is considered to be not more than a 12-month supply.

#### Policy

This change request serves to make the *Medicare Benefit Policy* manual provisions regarding a reasonable supply of antigens consistent with the regulatory requirements mentioned above.

### *Medicare Benefit Policy Manual*

#### *Chapter 15 – Covered Medical and Other Health Services*

***50.4.4.1 – Antigens***

***(Rev. 186, Issued: 04-16-14, Effective: 01-01 01, Implementation: 05-12-14)***

*Payment may be made for a reasonable supply of antigens that have been prepared for a particular patient if: (1) the antigens are prepared by a physician who is a doctor of medicine or osteopathy, and (2) the physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen.*

*Antigens must be administered in accordance with the plan of treatment and by a doctor of medicine or osteopathy or by a properly instructed person (who could be the patient) under the supervision of the doctor. The associations of allergists that CMS consulted advised that a reasonable supply of antigens is considered to be not more than a 12-month supply of antigens that has been prepared for a particular patient at any one time. The purpose of the reasonable supply limitation is to assure that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient. (See §§20.2 and 50.2.)*

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# CLARIFICATION

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***90 – Routine Services and Appliances***

***(Rev. 186, Issued: 04-16-14, Effective: 01-01 01, Implementation: 05-12-14)***

*Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations are not covered.*

*The routine physical checkup exclusion applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury; and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.*

*The routine physical checkup exclusion does not apply to the following services (as noted in section 42 CFR 411.15(a)(1)):*

- *Screening mammography,*
- *Colorectal cancer screening tests,*
- *Screening pelvic exams,*
- *Prostate cancer screening tests,*
- *Glaucoma screening exams,*
- *Ultrasound screening for abdominal aortic aneurysms (AAA),*
- *cardiovascular disease screening tests,*
- *diabetes screening tests,*
- *screening electrocardiogram,*
- *Initial preventive physical examinations,*
- *Annual wellness visits providing personalized prevention plan services, and*
- *Additional preventive services that meet the criteria specified in 42 CFR 410.64.*

*If the claim is for a diagnostic test or examination performed solely for the purpose of establishing a claim under title IV of Public Law 91-173, "Black Lung Benefits," the service is not covered under Medicare and the claimant should be advised to contact their Social Security office regarding the filing of a claim for reimbursement under the "Black Lung" program.*

*The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physicians' services (and services incident to a physicians' service) performed in conjunction with an eye disease, as for example, glaucoma or cataracts, or to post-surgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. Such prosthetic lens is a replacement for an internal body organ - the lens of the eye. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §120).*

*Expenses for all refractive procedures, whether performed by an ophthalmologist (or any other physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage.*

### *A. Immunizations*

*Vaccinations or inoculations are excluded as immunizations unless they are either:*

- *Directly related to the treatment of an injury or direct exposure to a disease or condition, such as antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. (In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as smallpox, polio, diphtheria, etc., is not covered.); or*
- *Specifically covered by statute, as described in the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.2.*

### *B. Antigens*

*Prior to the Omnibus Reconciliation Act of 1980, a physician who prepared an antigen for a patient could not be reimbursed for that service unless the physician also administered the antigen to the patient. Effective January 1, 1981, payment may be made for a reasonable supply of antigens that have been prepared for a particular patient even though they have not been administered to the patient by the same physician who prepared them if:*

- *The antigens are prepared by a physician who is a doctor of medicine or osteopathy, and*
- *The physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen.*

*A reasonable supply of antigens is considered to be not more than a 12-month supply of antigens that has been prepared for a particular patient at any one time. The purpose of the reasonable supply limitation is to assure that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.1)*

**Source**: *CR 8665, transmittal 186*

# 'Medicare Program Integrity' manual update – deletion of Section 13.14 from Chapter 13

**Effective date:** January 1, 2001
**Implementation:** date: May 12, 2014

## Summary of changes

This change request serves to make the "Medicare Benefit Policy" manual provisions consistent with regulatory requirements (*transmittal 186*). Additionally, revisions are being made to Chapter 13 of the *Medicare Program Integrity* manual to accurately reflect CMS's plan to implement Section 731 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

## General information

### Background

This request is to ensure Chapter 13 of the *Medicare Program Integrity* manual accurately reflects CMS's plan to implement Section 731 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Therefore, Section 13.14 of Chapter 13 of the "Medicare Program Integrity" manual is being deleted.

### Policy

Section 731 of the MMA called for the Secretary to establish a plan to evaluate new local coverage determinations (LCDs) for national coverage. CMS currently has in place a more efficient process to evaluate new and current LCDs that includes extensive engagement and collaboration through conference calls, face to face meetings and open communication with and among the Medicare administrative contractors (MACs) and CMS central office. The MACs evaluate LCDs and the evidence supporting the LCDs using the various tools CMS has available. Under this paradigm, LCDs, where appropriate, are becoming more consistent across MACs.

**Source**: *CR 8665, transmittal 510*

# Manual medical review of therapy services ends

Effective April 15, 2014, First Coast discontinued manual medical review for therapy claims.

This does not apply to claims for 2013 dates of services.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) established a requirement for mandatory manual medical review of therapy services for dates of service October 1 through December 31, 2012, for physical therapy/speech-language pathology or occupational therapy services above $3,700. The Center for Medicare & Medicaid Services requires Medicare administrative contractors to notify providers by posting to their website when they have stopped conducting the reviews. This article serves as that notification.

For additional information on the pre-approval process, refer to *change request 8036* and related *MLN Matters® article MM8036*.

**Source**: CR 8036

# RARC and CARC, MREP, and PC Print update

## Provider types affected

This *MLN Matters*® article is for physicians, providers, and suppliers sending claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.


## Provider action needed

This article is based on change request (CR) 8703, which updates the claims adjustment reason code (CARC) and remittance advice remark code (RARC) lists and also instructs Medicare systems maintainers to update the *Medicare Remit Easy Print* (MREP) and *PC Print* by July 1, 2014. Make sure that your billing staffs are aware of these updates and that they obtain the updated MREP or PC Print software if you use that software.

## 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 CARCs and appropriate RARCs 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).

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or use another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. CARC and RARC code sets are updated three times a year on a regular basis. CR 8703 lists only the changes that have been approved since the last code update (CR 8561, transmittal 2855, issued on January 10, 2014, with the related *MLN Matters*® article available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8561.pdf*), and does not provide a complete list of codes for these two code sets.

### Changes in CARC list since CR 8561

The following tables list the changes in the CARC database since the last code update in CR 8561. The full CARC list is available from the Washington Publishing Company (WPC) website at *http://wpc-edi.com/Reference*.

**New codes – CARC**

| Code | Narrative | Effective date |
|---|---|---|
| 259 | Additional payment for Dental/ Vision service utilization. | 01/26/2014 |
| 260 | Processed under Medicaid ACA Enhanced Fee Schedule. | 01/26/2014 |

**Modified codes – CARC**

| Code | Modified narrative | Effective date |
|---|---|---|
| 257 | The disposition of the claim/ service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/ service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA) **Notes**: To be used for months 2 and 3 in the grace period. | 01/26/2014 |

**Deactivated codes – CARC**

| Code | Current narrative | Effective date |
|---|---|---|
| A7 | Presumptive Payment Adjustment | 07/01/2015 |

### Changes in RARC list since CR 8561

The following tables list the changes in the RARC database since the last code update in CR 8561. The full RARC list is available from the WPC website at *http://wpc-edi.com/Reference*.

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**New codes – RARC**

| Code | Narrative | Effective date |
|---|---|---|
| N699 | Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program. | 3/1/2014 |
| N700 | Payment adjusted based on the Electronic Health Records (EHR) Incentive Program. | 3/1/2014 |
| N701 | Payment adjusted based on the Value-based Payment Modifier. | 3/1/2014 |
| N702 | Decision based on review of previously adjudicated claims or for claims in process for the same/similar ype of services | 3/1/2014 |
| N703 | This service is incompatible with previously adjudicated claims or claims in process. | 3/1/2014 |
| N704 | **Alert**: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted. | 3/1/2014 |
| N705 | Incomplete/invalid documentation. | 3/1/2014 |
| N706 | Missing documentation. | 3/1/2014 |
| N707 | Incomplete/invalid orders. | 3/1/2014 |
| N708 | Missing orders. | 3/1/2014 |
| N709 | Incomplete/invalid notes. | 3/1/2014 |
| N710 | Missing notes. | 3/1/2014 |
| N711 | Incomplete/invalid summary. | 3/1/2014 |
| N712 | Missing summary. | 3/1/2014 |
| N713 | Incomplete/invalid report. | 3/1/2014 |
| N714 | Missing report. | 3/1/2014 |
| N715 | Incomplete/invalid chart | 3/1/2014 |
| N716 | Missing chart. | 3/1/2014 |
| N717 | Incomplete/Invalid documentation of face-to-face examination | 3/1/2014 |
| N718 | Missing documentation of face-to-face examination. | 3/1/2014 |
| N719 | Penalty applied based on plan requirements not being met. | 3/1/2014 |
| N720 | **Alert**: The patient overpaid you. You may need to issue the patient a refund for the difference between the patient's payment and the amount shown as patient responsibility on this notice. | 3/1/2014 |
| N721 | This service is only covered when performed as part of a clinical trial. | 3/1/2014 |
| N722 | Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item. | 3/1/2014 |
| N723 | Patient must use Liability set-aside (LSA) funds to pay for the medical service or item. | 3/1/2014 |
| N724 | Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item. | 3/1/2014 |
| N725 | A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis. | 3/1/2014 |
| N726 | A conditional payment is not allowed. | 3/1/2014 |
| N727 | A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis. | 3/1/2014 |
| N728 | A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis. | 3/1/2014 |

**Modified codes – RARC**

| Code | Modified narrative | Effective date |
|---|---|---|
| MA50 | Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number. Start: 01/01/1997. Last modified: 03/01/2014. **Notes**: (Modified 2/28/03, 3/1/2014) | 3/1/2014 |
| M77 | Missing/incomplete/invalid/ inappropriate place of service. **Start**: 01/01/1997. **Last Modified**: 03/01/2014. **Notes**: (Modified 2/28/03, 3/1/2014) | 3/1/2014 |
| N29 | Missing documentation/orders/ notes/summary/report/chart. Start: 01/01/2000 \| Stop: 03/01/2016 \| Last Modified: 03/01/2014. **Notes**: (Modified 2/28/03, 8/1/05, 3/1/2014) Related to N225, Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016. | 3/1/2014 |

See **CARC,** next page

## CARC

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| Code | Modified narrative | Effective date |
|---|---|---|
| N225 | Incomplete/invalid documentation/orders/ notes/ summary/report/ chart. **Start**: 08/01/2004 \| **Stop**: 03/01/2016 \| **Last Modified**: 03/01/2014. **Notes**: (Modified 8/1/05, 3/1/2014) Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016. | 3/1/2014 |

**Deactivated codes – RARC (there are none)**

### Additional information

The official instruction, CR 8703, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2920CP.pdf*.

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

*MLN Matters*® Number: MM8703
Related Change Request (CR) #: CR 8703
Related CR Release Date: April 4, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R2920CP
Implementation Date: July 7, 2014



# Implementation of Phase III CORE 360 CARCs and RARCs rule – version 3.0.3

***Note**: This article was revised March 19, 2014, to reflect a new change request (CR). The CR was revised to include two attachments for V3.0.3 and V 3.0.4 of the Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE), Mandated CARC/RARC Code Combination List. Version 3.0.4, published January 31, 2014, must be implemented no later than May 1, 2014. The attachment of document V 3.0.3 shows the changes made between version 3.0.2 and 3.0.3. The attachment of document V 3.0.4 shows the changes made between V 3.0.3 to V 3.0.4. Additionally, the implementation date for V 3.0.4 for Part A and Part B MACs has been delayed to May 5, 2014. The CR release date, transmittal number and link to the CR were also change. All other information remains the same. This information was previously published in the December 2013 Medicare B Connection, Pages 22-23*.

### Provider types affected

CR 8518, from which this article is taken, instructs Medicare contractors to report only the code combinations that are listed in the current version of the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of CARC and RARC Rule. The spreadsheet attached to CR 8518 (which is available also at *http://www.caqh.org/CORECodeCombinations.php*) shows the change log for CORE Code Combination version 3.0.3 updates published on October 1, 2013.

### Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C – Administrative Simplification – to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently, and to achieve greater uniformity in the transmission of health information.

More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to electronic data interchange (EDI) from paper has been slow and disappointing. 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. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE published code combination version 3.0.3 October 1, 2013. This update is based on July, 2013 CARC and RARC updates as posted at the WPC website. You may review these updates at: *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

See **CORE,** next page

# Implementation of operating rules for electronic funds transfers

***Note**: This article was revised on April 8, 2014, to add a link to MM8619 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8619.pdf), which provides additional information regarding healthcare electronic fund transfers. All other information is unchanged. This information was previously published in the March 2014 Medicare B Connection, Pages 36-38.*

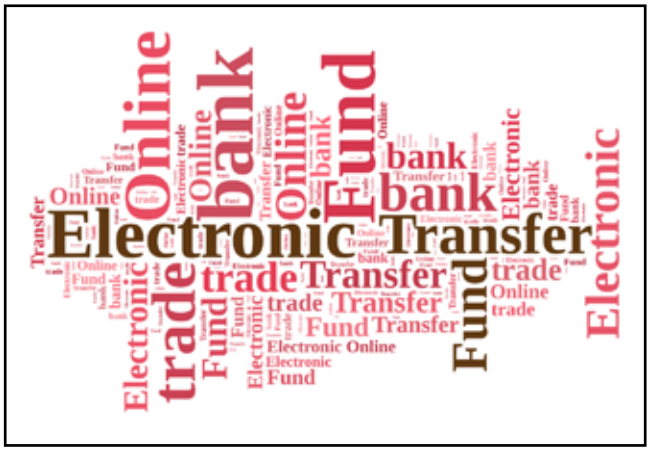
## Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs) and durable medical equipment Medicare administrative contractors (DME/MACs) for services to Medicare beneficiaries.

## What you need to know

This article is based on change request (CR) 8629 which informs MACs that they must comply with NACHA operating rules that are applicable to initiators of health care payments. CR 8629 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) Network with electronic health care payments. The overarching goals of the requirements of CR 8629 are to assure that providers receiving health care payments via EFT will receive a "trace number" that facilitates automatic re-association of the EFT health care payment with its associated remittance advice.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider's financial institution regarding the health care EFT payment




may change as per these requirements. Specifically, the company entry description and the TRN segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR 8629. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of CR 8629 can be accommodated by your accounting processes and systems.

## Background

In support of Health Insurance Portability & Accountability Act of 1996 (HIPAA) operating rules for health care EFT and remittance advice transactions adopted by HHS, NACHA – The Electronic Payments Association

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## CORE

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### Additional information

The official instruction, CR 8518, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1360OTN.pdf*.

In CR 8365, released August 16, 2013, CMS instructed Medicare contractors to implement this updated rule set by January 6, 2014. You can find the associated *MLN Matters*® article, MM8365 "Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule – Update from CAQH CORE" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8365.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: MM8518 *Revised*
Related Change Request (CR) #: CR 8518
Related CR Release Date: March 18, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R1360OTN
Implementation April 7, 2014 (See "Note" below title)

*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.*

# EFT

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has adopted its own operating rules that apply to ACH transactions that are health care payments from health plans to providers. NACHA manages the development, administration and governance of the ACH network used by all types of financial networks and represents more than 10,000 financial institutions.

A new NACHA standard for electronic healthcare claim payments went into effect September 20, 2013, impacting all originators and receivers of EFT used to pay healthcare claims. This healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the healthcare EFT standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The healthcare EFT standard requires the following:

- Company entry description of "HCCLAIMPMT" to identify the payment as healthcare
- Company name should be the health plan or third party administrator paying the claim
- An addenda record must be included with a record type code of "7" and an addenda type code equal to "05"
- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association trace number) data segment that is included on the electronic remittance advice

Healthcare providers will utilize the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. See "Healthcare EFT Standard Format" in the Medicare IOM for more information.

Example:

TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, segment terminator

* data element separator

The following table explains this example:

| Element | Element name | Mandatory or optional | Data content |
|---|---|---|---|
| TRN | Reassociation trace number | M | ASC X12 835 segment identifier. This is always "TRN". |
| TRN01 | Trace type code | M | Trace type code is always a "1". |
| TRN02 | Reassociation information | M | This data element must contain the EFT trace number. |
| TRN03 | Origination company ID | M | A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's tax identification number (TIN). |
| TRN04 | Reference identification | O | This data element is required when information beyond the originating company Identifier in TRN03 is necessary for the payee to identify the source of the payment. |
| Segment | Segment terminator | M | The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\". |

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## Additional information

For information on the NACHA operating rules that apply to health care payments, particularly with regard to requirements for originators, see *https://healthcare.nacha.org/healthcarerules*.The official instruction, CR 8629 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1349OTN.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: MM8629 *Revised*
Related Change Request (CR) #: CR 8629
Related CR Release Date: February 21, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R1349OTN
Implementation Date: July 7, 2014



# 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.

# Appeals for canceled claims related to Medicare beneficiaries classified as "unlawfully present" in the United States

In some cases, claims submitted for beneficiaries determined to be unlawfully present in the United States were reprocessed without offering appeal rights on the resulting overpayments. See *MLN Matters® article MM8009*, "New Informational Unsolicited Response (IUR) Process to Identify Previously Paid Claims for Services Furnished to Medicare Beneficiaries Classified as "Unlawfully Present" in the United States." In addition, in some cases where appeal rights were offered on the reprocessed claims, appeals were not processed appropriately.


Providers and suppliers are entitled to file appeals for these reprocessed claims, and appeals should be processed on these claims even if appeal rights were not initially offered. Providers and suppliers are entitled to submit a request for redetermination within 120 calendar days from the later of either (a) the date of receipt of the remittance advice indicating recovery of payment for such services, or (b) April 1, 2014.

In cases where a request for redetermination of such services was refused, providers and suppliers are entitled to resubmit their request within 120 calendar days from the later of either (a) the date of receipt of the letter or notice from their Medicare administrative contractor (MAC) refusing to process the appeal, or (b) April 1, 2014.

If the request for redetermination of such services resulted in a dismissal notice from their MAC, providers and suppliers may request that the dismissal be vacated. Requests to vacate the dismissal must be filed with their MAC within six months of the later of (a) the date of receipt of the dismissal notice, or (b) April 1, 2014, provided a request for review of the dismissal was not filed with the qualified independent contractor (QIC). Any requests pending before the QIC will be processed by the QIC.

In cases where a redetermination request for such services was processed by their MAC, providers and suppliers are entitled to request a reopening of the redetermination decision within the later of either (a) one year of the date of receipt of the redetermination notice, or (b) October 1, 2014, if they disagree with the redetermination decision, provided a request for reconsideration has not been filed with the QIC. Any requests pending before the QIC will be processed by the QIC.

For any appeal request, request to reopen an appeal decision, or a request to vacate a dismissal where the original claim was cancelled, providers must submit a paper claim that replicates the original cancelled claim with their appeal or reopening request. Failure to submit a paper claim with the appeal or reopening request will result in delays in effectuating favorable appeal decisions.

# Adjustments to claims previously reduced due to the electronic prescribing (eRx) initiative

Medicare contractors are required to adjust claims that were previously reduced due to the E-Prescribing initiative, when the Centers for Medicare & Medicaid Services (CMS) furnishes a file to contractors that shows that a provider is a successful ePrescriber. Recently First Coast Service Options (First Coast) received such a file from CMS of claims that require adjustments.

Medicare providers will start to receive payments and statements referencing these adjustments. The internal control numbers (ICNs) for the applicable adjustments will begin with 48 or 96. It is not necessary for providers to call the contact center about these payments.

To determine if a claim was adjusted due to the eRx initiative, providers can simply compare the previous allowed amount on their claim with the new allowed amount on their adjustment remittance notice. If the previous allowed amount is between 1 percent and 2 percent less than the new allowed amount, then the adjustment was made to reimburse the provider for the reduction that was taken on their claim when the claim was initially processed.


For more information on the eRx Incentive Program please access: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html*.

# Updating beneficiary information with the benefits coordination and recovery center

***Note**: This article replaces article SE1205.* ***There are no changes to the processes that were described in SE1205**. The key change is that the coordination of benefits contractor (COBC) is now known as the benefits coordination and recovery center (BCRC) and there is new contact, address, and Web address information at the end of this article that is associated with this process and the BCRC.*

## Provider types affected

This *MLN Matters*® special edition article is intended for physicians, other providers, and suppliers who provide products or services to Medicare beneficiaries with insurance in addition to Medicare. It updates *MLN Matters*® article SE1205 to provide information regarding the benefits coordination and recovery center (BCRC), which has replaced the former coordination of benefits contractor.

## Provider action needed

### Stop – impact to you

A new Medicare secondary payer (MSP) initiative will affect how you may update beneficiary information to the BCRC.

### Caution – what you need to know

This article describes initiatives that both the Centers for Medicare & Medicaid Services (CMS) and the BCRC are undertaking to maintain the most up-to-date and accurate beneficiary MSP information on Medicare's common working file (CWF).

### Go – what you need to do

You should make sure that your appropriate staffs are aware of these options for updating a beneficiary's MSP information and that they are aware of new contact information at the end of this article for the BCRC.

## Background

There has been considerable discussion about the accuracy of beneficiary Medicare secondary payer (MSP) information on the CWF and who is responsible for keeping that information updated. Further, providers have stated that the update is not accepted when they attempt to update beneficiary information with the BCRC by phone. Therefore (as noted below), CMS and the BCRC are both undertaking initiatives to resolve the issue and maintain the most up-to-date and accurate beneficiary information with regard to MSP.

### CMS initiatives

In compliance with Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (known as Section 111 of the MMSEA), CMS has implemented a process through which private insurers (both group health plans (GHP) and non-group health plans (NGHP)) submit coverage information to the BCRC when they also provide coverage to a Medicare beneficiary. A private GHP insurer reporting under Section 111 is known as a responsible reporting entity (RRE), and the BCRC receives Section 111 data input files from approximately 1,500 GHP insurers, and each file can include large numbers of individual coverage records. This information permits CMS to more accurately determine who (either the private insurer or Medicare) has primary, or secondary, claims coverage responsibility.

Occasionally, information submitted to the BCRC from any number of sources, including GHP RREs, service providers, and beneficiaries themselves can conflict with MSP information previously reported to the BCRC. To reduce such conflicts in the future, CMS has developed and implemented a data management "reporting hierarchy" process, which the BCRC administers (effective April 1, 2011). An explanation of the Hierarchy rules can be found within the MMSEA Section 111 GHP user guide available at *http://go.cms.gov/MIRGHPUserGuide*.

### BCRC initiatives

The BCRC works closely with GHP RREs and other reporters in order to reduce "hierarchy" conflicts in future reporting. The following steps are in place to help providers update MSP records:

**Provider attempting update with the beneficiary in the office**

The first time a call is made to update the record after April 4, 2011, it will be updated via the telephone call. For any subsequent calls made to update the record after April 4, 2011, no update will be made on the call, but two options are available: 1) Proof of information can be faxed or mailed on the insurer or employer's company letterhead, and the update will be made in 10-15 business days; or 2) You can contact the insurer or employer organization that last updated the record.

**Provider attempting update when the beneficiary is not in the office**

**No update will be made from a telephone call**. The provider has three options to have the record updated:

1) Have the beneficiary contact BCRC
2) Contact the beneficiary's insurer to resolve the issue
3) Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days

**Provider with new information**

The BCRC will take new information for a beneficiary, but if the new information requires changes to an existing record, two options are available:

1) The beneficiary will need to call to close out the record; or
2) Fax or mail proof of information on the insurer or

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employer's company letterhead and the update will be made in 10-15 business days.

**Provider update for deceased beneficiary**

A **single** update can be made by **one** provider for a deceased beneficiary, once the date of death has been confirmed. Any subsequent updates would need to be handled by a family member with the appropriate documentation, including a death certificate.

### Additional information

An explanation of the GHP RRE hierarchy rules can be found within the MMSEA Section 111 GHP user guide at http://go.cms.gov/MIRGHPUserGuide. General information about GHP mandatory insurer reporting is available at http://go.cms.gov/mirghp.

The BCRC's contact information is:

**Telephone**: 1-855-798-2627 (8 AM to 8 PM ET)

**Fax**: 1-405-869-3307 (address the fax to Medicare- MSP General Correspondence)

**Mailing address**

Medicare – MSP General Correspondence
P.O. Box 138897
Oklahoma City, OK 73113-8897

*MLN Matters*® Number: SE1416
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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# Updating beneficiary information with the coordination of benefits contractor

***Note**: This article was rescinded and replaced by MLN Matters® article SE1416 April 3, 2014. That article is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1416.pdf. This information was previously published in the February 2012 Medicare B Connection, Pages 58-59.*

*MLN Matters*® Number: SE1205 *Rescinded*
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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# CMS sets new ICD-10 compliance date for October 1, 2015

### ICD-10 compliance date

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

### July 2014 ICD-10 end-to-end testing canceled: additional testing planned for 2015

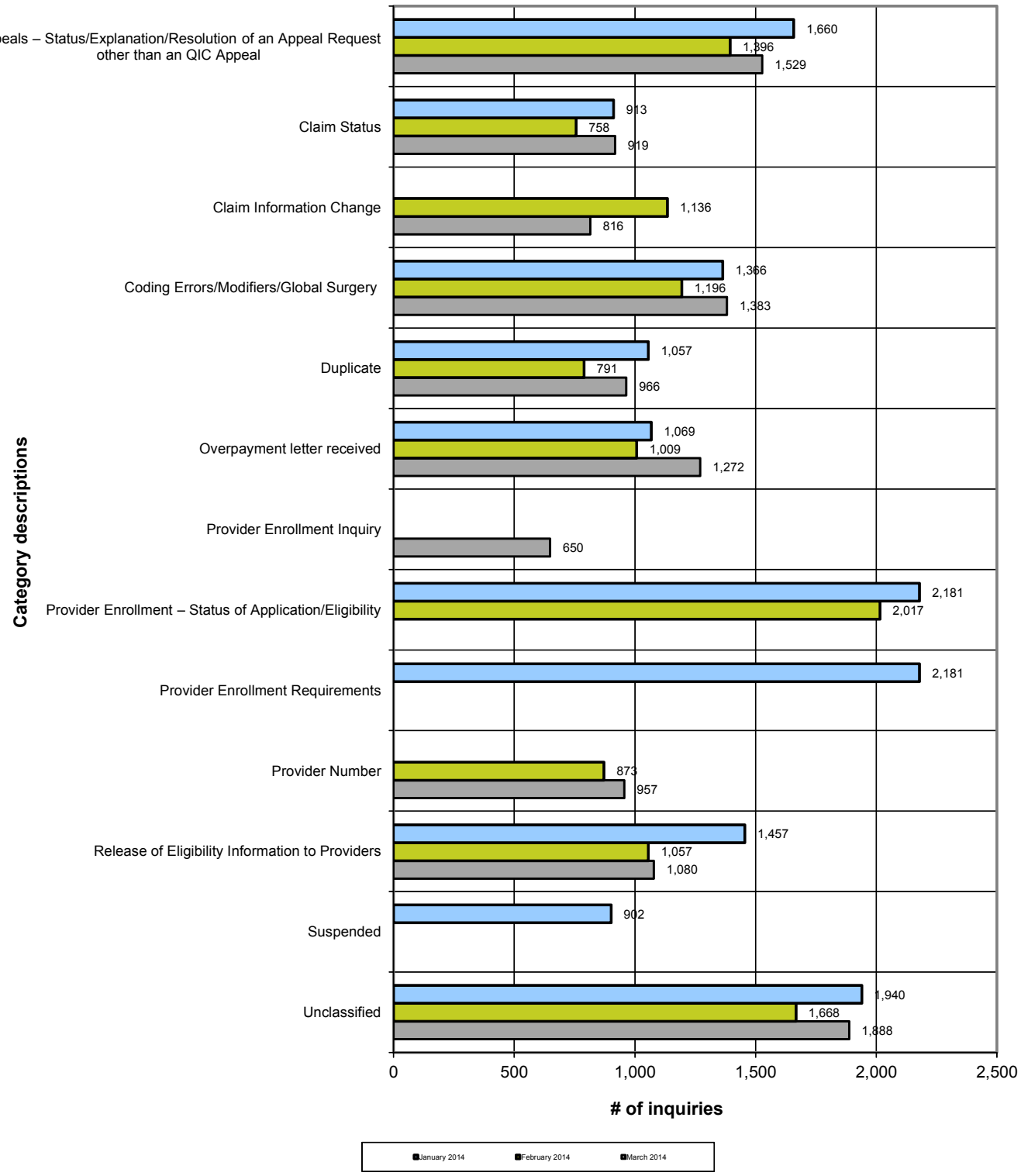
CMS planned to conduct ICD-10 testing during the week of July 21-25, 2014, to give a sample group of providers the opportunity to participate in end-to-end testing with Medicare administrative contractors (MACs) and the common electronic data interchange (CEDI) contractor. The July testing has been canceled due to the ICD-10 implementation delay. Additional opportunities for end-to-end testing will be available in 2015.

# Top inquiries, denials, and return unprocessable claims

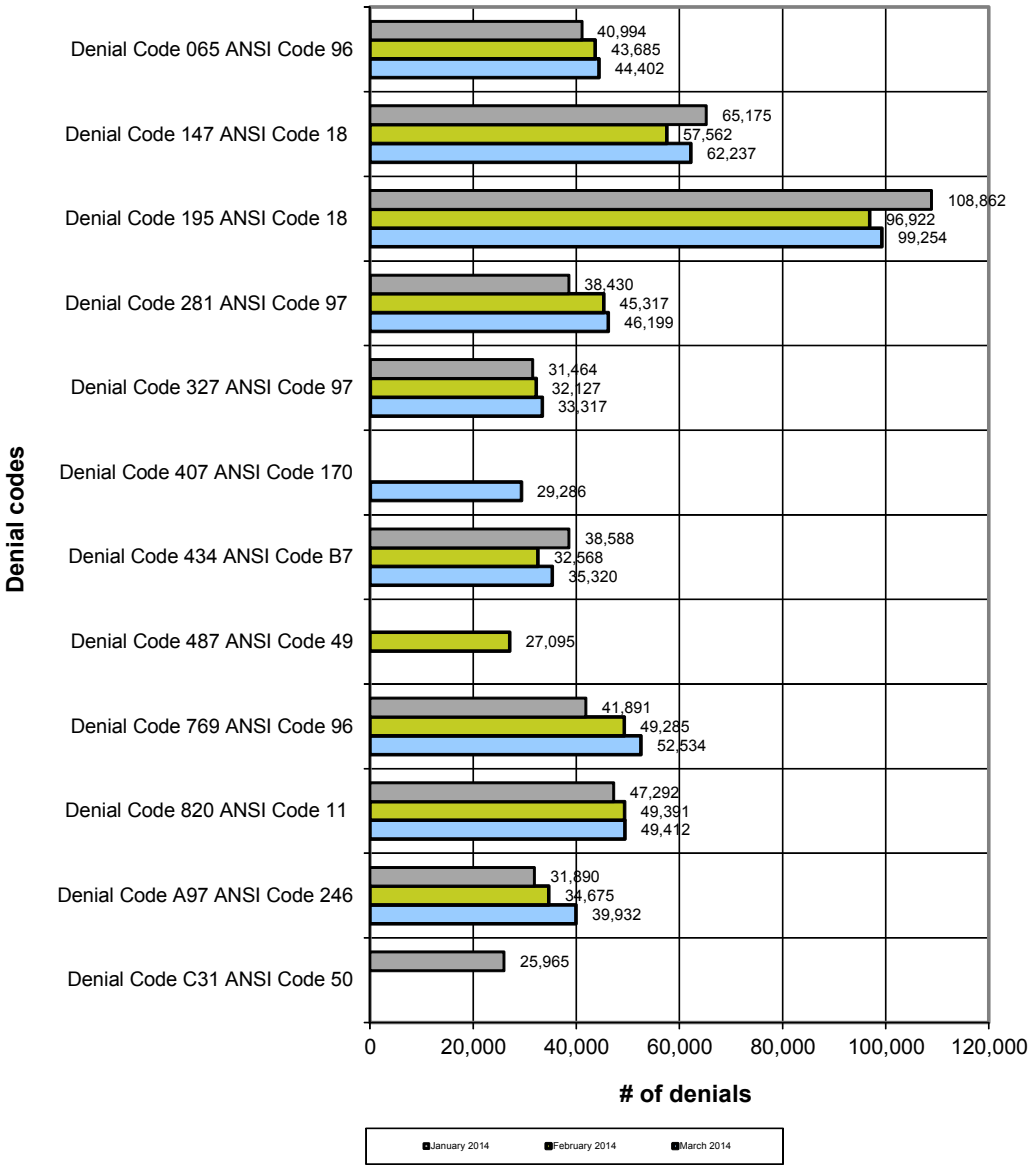
The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during January-March 2014.

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 January-March 2014**



**Part B top denials for January-March 2014**




# What to do when your claim is denied

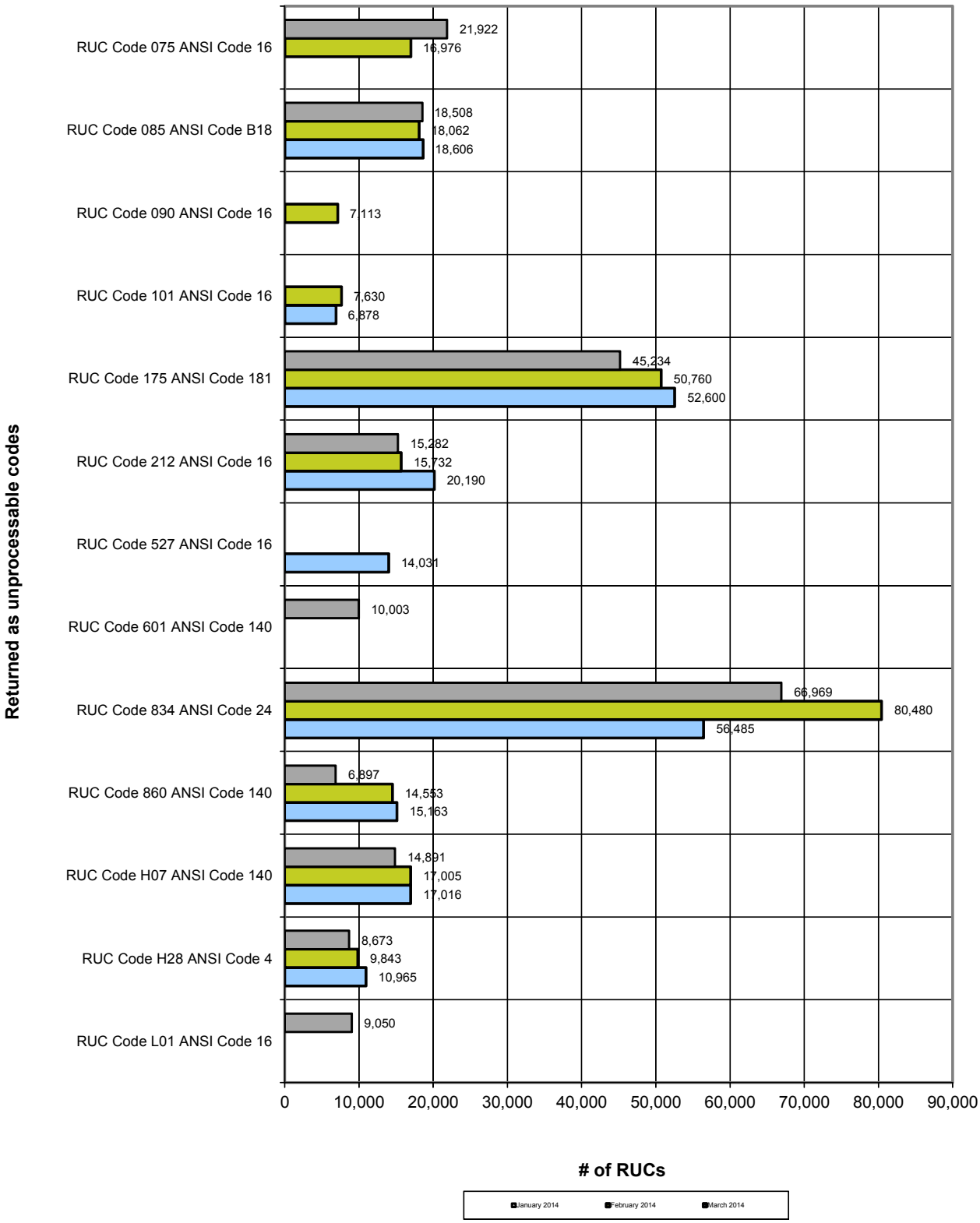
Before contacting customer service, check claim status though the IVR. The IVR will release necessary details around claim denials.

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

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

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

## Part B top return as unprocessable claims for January-March 2014



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


## 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.

## 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.

**Find out first: Subscribe to First Coast eNews**

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

## Retired LCDs

# Tositumomab and iodine I 131 tositumomab (Bexxar®) therapy – retirement of the Part B LCD

**LCD ID number: L29291 (Florida)**
**LCD ID number: L29400 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for tositumomab and iodine I 131 tositumomab (Bexxar®) therapy was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9. Currently, based on change request (CR) 8675 (April 2014 Update of Ambulatory Surgical Center (ASC) Payment System), the ASC payment indicator for HCPCS code A9545 (Iodine I131 tositumomab, therapeutic, per treatment dose) changed to Y5 (nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) because the product associated with HCPCS code A9545 (brand name Bexxar®) is no longer manufactured. Therefore, the LCD is being retired.

### Effective date

This LCD retirement is effective for services rendered **on or after April 1, 2014**. 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

# Bortezomib (Velcade®) – revision to the Part B LCD

**LCD ID number: L29087 (Florida)**
**LCD ID number: L29102 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for bortezomib (Velcade®) was most recently revised April 12, 2012. Since that time, the "Indications and Limitations of Coverage and / or Medical Necessity" section of the LCD was revised to add the off-label indication of systemic light chain amyloidosis, and the "ICD-9 Codes that Support Medical Necessity" section of the LCD was updated to add the correlating diagnosis code 277.30. In addition, the "Sources of Information and Basis for Decision" section was updated.

### Effective date

This LCD revision is effective for services rendered **on or after April 10, 2014**. 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*.

# Intravenous immune globulin – revision to the Part B LCD

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

The local coverage determination (LCD) for intravenous immune globulin was most recently revised January 1, 2014. Since that time, the LCD was revised under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add ICD-9-CM diagnosis code 357.89 (Other inflammatory and toxic neuropathy). In addition, based on the 2014 healthcare common procedure coding system (HCPCS) annual update, new HCPCS code J1556 (Injection, immune globulin [Bivigam] 500 mg) was added to the LCD, therefore, HCPCS codes J1599 (Injection, immune globulin, intravenous, non-lyophilized [e.g. liquid], not otherwise specified, 500 mg) and J3490 (Unclassified drugs) are being removed from the "*CPT*/HCPCS Codes" section of the LCD.

### Effective date

This LCD revision for the addition of ICD-9-CM diagnosis code 357.89 is effective for services rendered **on or after April 22, 2014**. The LCD revision for the removal of HCPCS codes J1599 and J3490 is effective for claims processed **on or after April 22, 2014**, for services rendered **on or after January 1, 2014**. 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*.

# Psychiatric diagnostic evaluation and psychotherapy services – revision to the Part B LCD

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

The local coverage determination (LCD) for psychiatric diagnostic evaluation and psychotherapy services became effective for services rendered on or after June 4, 2013. Since that time, the "Documentation Requirements" section of the LCD and the "Coding Guidelines" attachment were revised to provide clarification on psychotherapy as an "incident to" service and clarification on prolonged services.

### Effective date

The LCD revision is effective for services rendered **on or after April 1, 2014**. 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*.

# Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – revision to the Part B LCD

### LCD ID number: L30366 (Florida/Puerto Rico/ U.S. Virgin Islands)

This local coverage determination (LCD) for stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) was most recently revised November 29, 2012. Since that time, the "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add the diagnosis code 198.7 (Secondary malignant neoplasm of other specified sites, adrenal gland) for procedure codes *77373*, G0339, and G0340 for SBRT making the ICD-9-CM coding congruent with the text of the LCD.

### Effective date

This LCD revision is effective for claims processed **on or after April 10, 2014**, for services rendered **on or after October 5, 2009**. 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 urisdiction 9 (J9), please *click here*.

## Additional Information

# Independent diagnostic testing facility (IDTF) – revision to the Part B LCD "Coding Guidelines" attachment

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

The "Coding Guidelines" attachment to the independent diagnostic testing facility (IDTF) local coverage determination (LCD) was revised based on external correspondence requests for clarification on the Medicare physician supervision of diagnostic procedures status indicator "9" (concept does not apply) pertaining to certain diagnostic procedures listed in the "Credentialing Matrix" section. The "Physician Supervision of Diagnostic Procedures" section has been revised to provide clarification that the minimal level of physician supervision is "general supervision," with certain exceptions listed in the regulation (CFR 410.33). In addition, based on change request (CR) 8664 April Update to the 2014 Medicare Physician Fee Schedule Database (MPFSDB), the "Credentialing Matrix" section has been revised to correct the level of supervision indicators for the following *Current Procedural Terminology*® (*CPT*®) codes: *70450, 70460, 70551, 70552, 70553, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72191, 74174, 74175, 77002, 77003, 93880*, and *93882*.

### Effective date

The revision to the "Coding Guidelines" attachment related to clarification on the Medicare physician supervision of diagnostic procedures status indicator "9" is effective for services rendered **on or after April 22, 2014**. The revision to the "Coding Guidelines" attachment related to CR 8664 is effective for claims processed **on or after April 7, 2014**, for services rendered **on or after January 1, 2014**. 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*.

# Educational Events

## Provider outreach and educational events – June 2014

***Advance beneficiary notice of non-coverage***

**When:** Wednesday, June 11 **Type of event:** Webcast
**Time:** 1:30-3:00 p.m.
*http://medicare.fcso.com/Events/267732.asp*

***Internet-based PECOS class***

**When:** Thursday, June 19 **Type of event:** Face-to-face
**Time:** 1:00-5:00 p.m.
*http://medicare.fcso.com/Events/266996.asp*

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

### Two easy ways to register

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

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

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

**Please Note:**

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

### Never miss a training opportunity

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

### Take advantage of 24-hour access to free online training

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

# Medicare Speaks — Fort Lauderdale July 22-23

**Fort Lauderdale Marriott North, 6650 North Andrews Avenue, Fort Lauderdale, FL 33309**

Learn what's trending now in Medicare. Join First Coast Service Options (First Coast) for our new educational event, Medicare Speaks 2014, in Fort Lauderdale, FL on July 22-23. The event features 20 classes focused on reducing documentation and claim errors, and minimizing payment delays. First Coast is also offering seminars on July 21 on PC-ACE Pro32™; Medicare's free billing software and Centers for Medicare & Medicaid Services (CMS) initiative the Physician Quality Reporting System (PQRS) program.

Participants will benefit from data-driven content based on the latest Medicare changes that you need to know to bill Medicare the right way, the first time. Best of all, providers can interact with their peers as well as Medicare experts from First Coast.

## Highlights

- 20 Part A and B classes chosen by your peers – *view agenda*
- Participation from First Coast's medical director and leaders from Medical Review, Provider Enrollment, Customer Service and Provider Outreach and Education departments
- Seminar on July 21 regarding PC-ACE Pro32™ and PQRS program

- Participants can select four classes per day, or tailor the schedule to meet your needs
- Medicare experts available to answer your questions at "Ask the Contractor" tables
- Continuing education credits offered

For additional information regarding the event, including logistics and registration, view our *Medicare Speaks 2014 Fort Lauderdale* brochure.

***Register now***

**Note**: If you do not have a training account, please click here to learn how to create one.

MLN Connects®

# CMS MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*™ Provider eNews is an official *Medicare Learning Network*® (*MLN*®) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate.

To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to the latest e-News:

"MLN Connects™ Provider eNews': April 3, 2014 – *http://go.usa.gov/KJRh*

"MLN Connects™ Provider eNews': April 10, 2014 – *http://go.usa.gov/kgMH*

"MLN Connects™ Provider eNews': April 17, 2014 – *http://go.usa.gov/kkfk*

"MLN Connects™ Provider eNews': April 24, 2014 – *http://go.usa.gov/kPsH*

# 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, 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 profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

### Change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

and

Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

## Provider education

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

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

## Limiting charge issues:

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

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

## Medicare claims for Railroad retirees:

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

## Fraud and abuse

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

# Phone numbers

## Providers

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

### Interactive Voice Response (IVR):

1-877-847-4992

**Email address:** *AskFloridaB@fcso.com*

**FAX**: 1-904-361-0696

**Beneficiary**
**Toll-Free:** 1-800-MEDICARE

Hearing Impaired: 1-800-754-7820

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

## Education event registration (not toll-free):

1-904-791-8103

## Electronic data interchange

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

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

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

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

### Provider enrollment

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

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

and

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

### Durable medical equipment (DME)

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

### Redeterminations

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

### Redetermination overpayment

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

### Freedom of Information Act requests (FOIA)

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

### Congressional inquiries

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

### Provider education

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

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

### Medicare claims for railroad retirees

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

### Fraud and abuse

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

### Local coverage determinations

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

### Post pay medical review

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

### Overnight mail and/or other special courier services

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

# 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**
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*

# 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

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

### Flu vaccinated list

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

## Local coverage determinations

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

## Debt collection

Overpayments, questions about Medicare as a secondary payer, cash management

First Coast Service Options Inc.
P.O. Box 45040
Jacksonville, FL 32232-5040

## Overnight mail and other special handling postal services

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

## Other Medicare contractors and intermediaries

### Durable Medical Equipment Regional Carrier (DMERC)

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

### *Regional Home Health &* Hospice Intermediary

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

### Railroad Medicare

Palmetto 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

# Medicare Websites

### 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 | | |
| **2014 fee schedule –** The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2014, 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.<br><br>**Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication. | 40300270 | $12 | | |
| Language preference: **English** [ ] **Español** [ ] | | | | |
| | | | | |
| | | ***Please write legibly*** | Subtotal | $ |
| | | | Tax (***add % for your area***) | $ |
| | | | Total | $ |

**Mail this form with payment to:**

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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