Medicare B Connection

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A Newsletter for MAC Jurisdiction N Providers

July 2014

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This *MLN Matters*® special edition article is intended for all Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order or provide Medicare-covered services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Medicare requires that services provided/ordered be authenticated by the author. The method used should be a handwritten or electronic signature. Under certain circumstances, a rubber stamped signature is acceptable. If you do not have an acceptable signature on services provided/ordered, your Medicare payment may be impacted.

Caution – what you need to know

Medicare services provided/ordered must be authenticated by the author using an acceptable signature.

Go – what you need to do

Use this article as a reference to available educational resources related to signature requirements for Medicare-covered services.

Educational products for health care professionals

The *Medicare Learning Network*® (MLN®) offers a variety of educational products to help you understand signature requirements for Medicare-covered services.

1. Medicare Quarterly Compliance Newsletter

- The *Medicare Quarterly Provider Compliance Newsletter (January 2014)* highlights Comprehensive Error Rate Testing (CERT) circumstances as a result of insufficient documentation.

2. Articles

- *MM5971*: **"CR 5550 Clarification – Signature Requirements"** clarifies the instructions on signature requirements for the certification of terminal illness for hospice. It states that Medicare contractors will accept a facsimile of an original written or electronic signature in documenting the

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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 (wavier of liability statement on file).

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

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

Consolidated Billing

Clarification of billing instructions related to the home health benefit

Provider types affected

This *MLN Matters*® article is intended for physicians, home health agencies, and suppliers of durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) submitting claims to Medicare administrative contractors (MACs) for services and supplies to Medicare beneficiaries in a home health period of coverage.

Provider action needed

This article is based on change request (CR) 8775, which updates the *Medicare Claims Processing* manual, to specify the physician specialty codes that are excluded from home health consolidated billing, to make conforming changes related to the retirement of the home health advance beneficiary notice, and to make miscellaneous changes to conform term and code usage to national standards. This CR contains no new policy. Make sure your billing staffs are aware of these updates.

Background

CR 8775 makes a variety of small changes to the *Medicare Claims Processing* manual. These changes do not reflect any new policy. These changes fall into one of three categories.

1. Clarification to home health consolidated billing (HH CB) instructions: In 2003, CR 2705 made changes to Medicare systems to bypass services from home health consolidated billing (HH CB) editing when provided by a physician. CR 2705 provided a list of physician specialty codes that are used in this bypass, but the list was never included in the *Medicare Claims Processing* manual. CR 8775 adds the list to the HH CB section of Chapter 10 of the manual. It also makes some wording clarifications to better reflect how Medicare system edits currently enforce HH CB. The modifications to the manual are attached to CR 8775, and you will find a link to that CR in the *Additional information* section of this article.
2. Removal of references to the home health advance beneficiary notice (HHABN): CR 8404 described the use of the advance beneficiary notice of noncoverage (ABN) as a replacement for the HH ABN. CR 8775 makes conforming changes to Chapter 10 to remove references to the HHABN.
3. Conforming to national standards: CR 8775 makes detailed changes throughout many sections of Chapter 10 to ensure that references to type of bill and revenue code values mirror the way these values are used in the National Uniform Billing Committee's Official UB-04 Data Specifications Manual. Additionally, one remittance advice code pair is updated to comply with the Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules for code usage on remittance advices.

Note: MACs use claim adjustment reason code 97 when rejecting or denying claims due to HH CB.

Additional Information

The official instruction, CR 8775, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2977CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net work-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM8775
Related Change Request (CR) #: CR 8775
Related CR Release Date: June 20, 2014
Effective Date: September 23, 2014
ICD-10: Upon Implementation of ICD-10
Related CR Transmittal #: R2977CP
Implementation Date: September 23, 2014 ICD-10: Upon implementation of ICD-10

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Surgery

Delay in implementing NCD for single chamber and dual chamber cardiac pacemakers

On August 13, 2013, the Center for Medicare & Medicaid Services (CMS) issued a final decision memorandum regarding coverage of implanted permanent cardiac pacemakers, single chamber or dual chamber, and determined they are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. On February 6, 2014, CMS directed Medicare administrative contractors to implement national coverage determination (NCD) 20.8.3 July 7, 2014, for claims with dates of service on and after August 13, 2013, for those beneficiaries who meet the specific coverage criteria. See *MLN Matters® article MM8525*.

There is a temporary delay in implementing NCD 20.8.3. CMS will advise you of the new implementation date in the near future.

Invalidation of 140.3 – transsexual surgery

Effective date: May 30, 2014
Implementation date: June 29, 2014

Summary of changes

The purpose of this change request (CR) is to implement the Departmental Appeals Board decision consistent with 42 CFR §426.560(b)(2) by removing Section 140.3 (Transsexual Surgery) from Pub. 100-03, *Medicare National Coverage Determinations* manual. Additionally, references to transsexual surgery have been removed from Pub. 100-02, *Medicare Benefit Policy* manual.

General information

Background

The purpose of this CR is to inform you that the Department of Health and Human Services Departmental Appeals Board (DAB) has invalidated National Coverage Determination (NCD) 140.3 "Transsexual Surgery" pursuant to Section 1869(f)(1)(A)(iii) of the Social Security Act (SSA).

(Docket #A-13-47, Decision #2576) dated May 30, 2014. As a consequence of this decision, NCD 140.3 is no longer valid. Implementation of this decision shall be June 29, 2014.

Policy

Because **the NCD is no longer valid** as of the effective date, its provisions are no longer a basis for denying claims for Medicare coverage of "transsexual surgery" under 42 CFR §405.1060. Moreover, any local coverage determinations used to adjudicate such claims may not be based on or rely on the provisions or reasoning from Section 140.3 of Pub. 100-03, *Medicare NCD* manual. In the absence of an NCD, contractors and adjudicators should consider whether any Medicare claims for these services are reasonable and necessary under §1862(a)(1)(A) of the SSA consistent with the existing guidance for making such decisions when there is no NCD.

Therefore, the Centers for Medicare & Medicaid Services will implement the DAB decision with this CR consistent with 42 CFR §426.560(b)(2). **Section 140.3 has been removed from the *Medicare NCD* manual**.

"Medicare Benefit Policy Manual

Chapter 1 – Inpatient Hospital Services Covered under Part A

120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

(Rev. 189, Issued: 06-27-14, Effective: 05-30-14, Implementation: 06-29-14)

Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" non-covered services (e.g., cosmetic surgery, noncovered organ transplants, non-covered artificial organ implants, etc.), including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay in which the noncovered service was performed, are not covered services under Medicare. Services "not related to" non-covered services are covered under Medicare.

Following are examples of services "related to" and "not related to" non-covered services while the beneficiary is an inpatient:

- A beneficiary was hospitalized for a non-covered service and broke a leg while in the hospital. Services

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TRANSSEXUAL

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related to care of the broken leg during this stay is a clear example of "not related to" services and are covered under Medicare.

- A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a non-covered transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a recommendation for a non-covered transplant or implant, the services related to the admitting condition would be covered.
- A beneficiary was admitted to the hospital for covered services related to a condition which ultimately led to identification of a need for transplant and receipt of a transplant during the same hospital stay. If, on the basis of the nature of the services and a comparison of the date they are received with the date on which the beneficiary is identified as a transplant candidate, the services could reasonably be attributed to preparation for the non-covered transplant, the services would be "related to" non-covered services and would also be non-covered.

Following is an example of services received subsequent to a non-covered inpatient stay:

After a beneficiary has been discharged from the hospital stay in which the beneficiary received non-covered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior non-covered services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous non-covered procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, complications from cosmetic surgery, removal of a non-covered bladder stimulator, or treatment of any infection at the surgical site of a non-covered transplant that occurred following discharge from the hospital.

However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered."

Source: CR 8825, *transmittal 169* & *transmittal 189*

Medically unlikely edits and bilateral procedures

Provider types affected

This *MLN Matters*® special edition article is intended for all Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare administrative contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries.

Provider action needed

Stop – impact to you

Claims filed using noncompliant coding for bilateral surgical procedures may have been paid in the past. The purpose of this article is to inform providers that MUE changes may now render those claim lines unpayable.

Caution – what you need to know

Providers and suppliers, other than ambulatory surgical centers (ASCs), are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a 50 modifier and one unit of service (UOS).

Go – what you need to do

Make sure your billing staffs examine their process for filing claims for bilateral procedures and services to ensure the 50 modifier is used in accordance with Medicare correct coding and claims submission instructions.

Background

There are several ways that claims for bilateral procedures could be coded, but different methods are only correct in specific situations. The most common methods involve reporting

- a single UOS on one line using the 50 modifier;
- one UOS on each of two lines using modifiers RT and LT; and
- two UOS on a single line with no modifier.

For Medicare claims, when reporting bilateral surgical procedures using codes where the term bilateral is not included in the descriptor, both the *Medicare Claims Processing* manual and the *National Correct Coding Initiative (NCCI)* manual specify that these bilateral surgical procedures should be reported using a single UOS and the 50 modifier. The NCCI manual goes on to warn that MUE edits are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently many bilateral procedures have an MUE value of one, and have had that MUE value for some time.

At the recommendation of the Office of the Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS) has examined its claims data relative to MUE levels and has confirmed a pattern of inappropriate billing using multiple lines to bypass the MUEs. Agreeing with the OIG that this practice overcharges both beneficiaries and the Medicare program, CMS is converting most MUEs into per day edits. The MUE adjudication indicator (MAI) indicates the type of MUE and its basis. Effective with the July 1, 2014 update, published per day

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MUE

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edits are identified on the CMS NCCI website (*http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html*) by their MAI value of two or three.

MAI of three

An MAI of three, the most common per day edit, indicates an edit for which the MUE is based on clinical information such as:

- billing patterns;
- prescribing instructions; or
- other information.

It acknowledges that exceptions could occur but they would be sufficiently rare that the abnormally high units of service value should be considered to be a billing error.

Providers should carefully assess any denials based on these edits and consider the denial to be an indication of incorrect reporting due to such things as clerical errors or errors in the interpretation or application of coding instructions. It is also possible some provider reporting errors could be associated with a lack of medical necessity for the excess units, although the MUE itself does not address medical necessity, but only the medically unlikely nature of the reported value.

In the rare instance where the provider has verified all information, including the correct interpretation of coding instructions, and still believes that the correctly coded medically necessary service exceeds the MUE, the provider should submit a clearly supported appeal.

MAI of two

An MAI of two indicates an edit for which the MUE is based on regulation or subregulatory instruction ("policy"), including the instruction that is inherent in the code descriptor or its applicable anatomy.

Examples:

1. The MUE of a "per cervical vertebra" code cannot exceed seven based on anatomic considerations, that is, the number of cervical vertebrae. The MUE of seven is therefore inherent in the code descriptor, an integral part of the code set specified for use by HIPAA.
2. The MUE of a "first 15 minutes" session code for a practitioner cannot exceed one since any time beyond that would require a different "subsequent" code, and that limitation is inherent in the code descriptor and its annual incorporation by CMS.

CMS expects all claims reporting services in excess of the MUE for edits with an MAI of two will represent either clerical errors or errors in the interpretation of instructions. CMS has not identified any instances in which a higher value would be correct and payable. MACs have therefore been instructed that this subregulatory instruction is binding on the MAC for both initial determinations and redeterminations, as is all subregulatory instruction.

Request for reopening of a claim

For all MUE edit denials, including both MAI of two and three, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening to correct its billing of the claim as an alternative to filing an appeal. Providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral service because it was billed with two UOS instead of being billed with one UOS and a 50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the 50 modifier to avoid future denials and delays in payment.

Additional information

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work.

MLN Matters® Number: SE1422
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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National coverage determination (NCD) for single chamber and dual chamber permanent cardiac pacemakers

Note: *This article was revised July 11, 2014, to reflect the revised change request (CR) 8525 issued July 10. The CR was revised to state that the implementation of CR 8525 is delayed until further notice from the Centers for Medicare & Medicaid Services (CMS). As soon as an implementation date is established, this article will be updated accordingly. This information was previously published in the February 2014 Medicare B Connection, Pages 35-37*.

Provider types affected

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

Provider action needed

This article is based on CR 8525 which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for the indications outlined in the *Medicare National Coverage Determinations* manual (Chapter 1, Part 1, Section 20.8, Cardiac Pacemakers) and the *Medicare Claims Processing* manual (Chapter 32, Section 320, Billing Requirements for Cardiac Pacemakers: Single and Dual Chamber) which were revised by and included as attachments to CR 8525. CR 8525 is effective for claims with dates of service on or after August 13, 2013.

Make sure that your billing personnel know about these changes.

Background

Permanent cardiac pacemakers refer to a group of self-contained, battery operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads. Single chamber pacemakers typically target either the right atrium or right ventricle. Dual chamber pacemakers stimulate both the right atrium and the right ventricle.

The implantation procedure is typically performed under local anesthesia and requires only a brief hospitalization. A catheter is inserted into the chest, and the pacemaker's leads are threaded through the catheter to the appropriate chamber(s) of the heart. The surgeon then makes a small "pocket" in the pad of the flesh under the skin on the upper portion of the chest wall to hold the power source. The pocket is then closed with stitches.

On August 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD). In this NCD, CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion).

The following indications are covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction.
2. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block.

The following indications are non-covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block.
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest.
5. Ineffective atrial contractions (e.g., chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia.
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes are prolonged or electrophysiological studies have demonstrated that the block is at or beyond the level of the His Bundle (a component of the electrical conduction system of the heart).
7. Syncope of undetermined cause.
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block.
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.
11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia.
12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

MACs will determine coverage under the Social Security Act (Section 1862(a)(1)(A); see *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm*) for any other indications for the implantation and use of single chamber or dual chamber cardiac pacemakers that are not specifically

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addressed in this NCD.

Note: MACs will accept the inclusion of the KX modifier on the claim line(s) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia (symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion)).

Other key notes for billing

- MACs will pay professional claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains at least one of the *CPT*® codes of *33206, 33207*, or *33208* **and** one of the following ICD-9-CM/ICD-10-CM diagnostic codes, and only when the claim is submitted with the KX modifier:
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*® codes and at least one of the diagnosis codes listed above along with the KX modifier:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block o 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia
- Contractors will return claim lines if the KX modifier is not present using the following message:
  - **Claim adjustment reason code (CARC) 4**: The procedure code is inconsistent with the modifier used or a required modifier is missing.
  - **Remittance advice remarks code (RARC) N517**: Resubmit a new claim with the requested information.
- Effective for claims with dates of service on or after August 13, 2013, MACs will pay outpatient institutional claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, (codes C1785, C1786, C2619, or C2620) provided the claim contains the KX modifier, and contains at least one of the *CPT*® codes *33206, 33207*, or *33208*, **and** one of the following ICD-9-CM/ICD-10-CM diagnostic codes :
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6
- MACs will return outpatient institutional claims for implanted permanent cardiac pacemakers that do not meet the preceding requirements.
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*® codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia
- Effective for claims with dates of service on or after August 13, 2013, MACs will pay inpatient claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains one of the following ICD-9/ICD-10 diagnosis **and** procedure codes:
  - 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, or 37.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, **and**
  - 426.0/I44.2, 426.12/I44.1,
  - 426.13/I44.1, 427.81/I49.5, or
  - 746.86/Q24.6
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*® codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block

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- o 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
- o 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia

In addition, be aware of the following:

- MACs will deny claims for implanted dual chamber for one of the following *CPT*® codes: *33206, 33207*, or *33208* and contains at least one of the following ICD-9-CM/ICD-10-CM diagnosis codes (even if submitted with at least one of the acceptable diagnosis codes listed above):
  - o 426.11/I44.0
  - o 427.31/I48.1/I48.2/I48.91
  - o 427.32/I48.2/I48.3/I48.4/ or I48.91
  - o 427.89/I49.8/ R00.1
  - o 780.2/R55

MACs will use the following messages when denying claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following HCPCS and/or *CPT*® codes: *C1785, C1786, C2619, C2620, 33206, 33207*, or *33208*, and at least one diagnosis code from the list of ICD-9/ICD-10 diagnosis codes above:

- **CARC 96**: Non-covered charge(s).
- **RARC N569**: Not covered when performed for the reported diagnosis.
- **Group code CO** (contractual obligation), if claim received with GZ modifier indicating no signed advance beneficiary notice (ABN) is on file or group code PR (patient responsibility) if occurrence code 32 indicating a signed ABN is on file or occurrence code 32 with modifier GA is present.

NCDs are binding on all MACs and contractors with the federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See the Social Security Act, Section 1869(f)(1)(A)(i), at *http://www.ssa.gov/OP_Home/ssact/title18/1869.htm*.

Additional information

The official instruction, CR 8525, was issued to your MACs regarding this change via two transmittals. The first is the transmittal that updates the *NCD* manual and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R170NCD.pdf*. The second transmittal updates the *Medicare Claims Processing* manual and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2986CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM8525 *Revised*
Related Change Request (CR) #: CR 8525
Related CR Release Date: July 10, 2014
Effective Date: August 13, 2013
Related CR Transmittal #: R170NCD and R2986CP
Implementation Date: To be determined

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

Quarterly provider update

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

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

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

General Coverage

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certification of terminal illness hospice.

- *MM6100*: **"Physician signature requirements for Diagnostic Tests"** notes that a physician's signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

- *MM6261*: **"Signature and date stamps for DME supplies – certificates of medical necessity (CMNs) and DME MAC information Forms (DIFs)"** alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions regarding signature requirements for CMNs and DIFs. It states signature and date stamps are not acceptable for use on CMNs and DIFs. Medicare contractors will only accept hand written, facsimiles of original written and electronic signatures and dates on medical documentation for medical review purposes on CMNs and DIFs.
- *MM6698*: **"Signature guidelines for medical review purposes"** outlines the new rules for signatures and adds language of e-Prescribing beginning on or after April 16, 2010. The article covers signature logs and attestation statements. A helpful table summarizing examples where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit a signature log or attestation statement.
- *MM7337*: ***Hospice Benefit Policy* manual update: new certification requirements and revised conditions of Participation"** states, if the narrative is part of the certification or recertification form it must be located immediately above the physician's signature. If the narrative is an addendum to the form, (in addition to the physician's signature on the certification or recertification form) the physician must also sign immediately following the narrative in the addendum. In addition, it must include a statement directly above the physician's signature attesting that (by signing), the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient.
- *MM8219*: **"Use of rubber stamp for signature"** highlights the exception for the use of rubber stamps in accordance with the Rehabilitation Act of 1973 in the case of the author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. Under this circumstance, by affixing the rubber stamp, the provider is certifying that they have reviewed the document.
- *SE1219*: **"A physician's guide to Medicare's home health certification, including the face-to-face encounter"** includes a short section on signature requirements for face-to-face documentation.
- *SE1308*: **"Physicians delegation of tasks in skilled nursing facilities (SNFs) and nursing facilities (NFs)"** addresses the authority of nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) to sign orders, certification, and recertification in SNFs and NFs.
- *SE1405*: **"Documentation requirements for home health prospective payment system (HH PPS) face-to-face encounter"** notes that the homebound status of the patient and his/her need for skilled services must be written in a brief narrative, signed by a physician, titled "Home Health Face-to-Face Encounter", and dated.

3. Fact sheets:

- *ICN 905063*: **"Power mobility devices: complying with documentation and coverage requirements"** discusses the need for a signature on both the prescription and the detailed product description from the supplier by the treating

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physician.

- *ICN 905364*: **"Complying with Medicare signature requirements"** provides answers to questions, as well as a list of resources, about Medicare signature requirements.
- *ICN 905064*: **"Continuous and bi-level positive airway pressure (CPAP/BPAP) devices: complying with documentation and coverage requirements"** states the order/prescription must be signed by the treating physician who ordered the device. The description may be written by someone else, but the treating physician must sign the order.

Additional information

To review detailed Medicare signature requirements read Chapter 3 of The *Medicare Program Integrity* manual located at *http://www.cms.gov/Regulations-and-Guidance / Guidance/Manuals/Downloads/pim83c03.pdf*.

For more information about provider compliance, visit *http://www.cms.gov/Outreach-and-Education/ Medicare-Learning-Network-MLN/MLNProducts/ ProviderCompliance.html*.

MLN Matters® Number: SE1419
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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Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2014, must be paid before the end of business March 31, 2014.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *http://fms.treas.gov/prompt/rates.html* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 2 percent is in effect through December 31, 2014.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

Source: Publication 100-04, Chapter 1, Section 80.2.2

Medicare Learning Network®

The *Medicare Learning Network*® (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/ Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/ index.html*.

EDI enrollment form will not allow ERA future-date requests

Effective July 21, 2014, the EDI enrollment form will be updated to no longer allow future date requests for 835 (electronic remittance advice) changes. Once the form has been received and processed the remittance request will be effective the next business day. The current form will be retired as of July 20, 2014, and only the current form will be accepted on and after July 21, 2014.

Please remember that the authorized official original signature and title must be included on all applications, and signing this section confirms that you have read and agree with the Agreement, Centers for Medicare & Medicaid Services (CMS) obligations, and Attestation sections on Pages 3 and 4.

Reminders

- It is highly recommended that you keep a copy of your completed enrollment form(s) for your records.
- EDI forms are processed in the order in which they are received.
- All forms received after 2:00 p.m. ET, will have the date of the receipt of the next business day.

Implementation of phase III CORE 360 CARCs and RARCs rule – version 3.1.0

***Note**: This article was revised July 9, 2014, to reflect the revised change request (CR) 8711 issued June 25. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are changed. Also, the CAQH CORE version number in the above title is revised to 3.1.0. All other information remains the same. This information was previously published in the May 2014 Medicare B Connection, Page 18*.

Provider types affected

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

What you need to know

This article is based on CR 8711, which instructs the MACs to update the Committee on Operating Rules for Information Exchange (CORE) 360 uniform use of claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) rule. If you use Medicare's PC Print or Medicare Remit Easy Print (MREP) software, you will need to obtain the new version after it is updated October 6, 2014. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act.

Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security 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.

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 will publish the next version of the Code Combination List on or about June 1, 2014. This update is based on March 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. (Visit *http://www.wpc-edi.com/* reference for CARC and RARC updates and *http://www.caqh.org/ CORECode Combinations.php* for CAQH CORE defined code combination updates.)

Note: Per the Affordable Care Act mandate, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/group fode for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 8711, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1392OTN.pdf*.

MLN Matters® Number: MM8711 *Revised*
Related Change Request (CR) #: CR 8711
Related CR Release Date: June 25, 2014
Effective Date: September 2, 2014
Related CR Transmittal #: R1392OTN
Implementation Date: September 2, 2014

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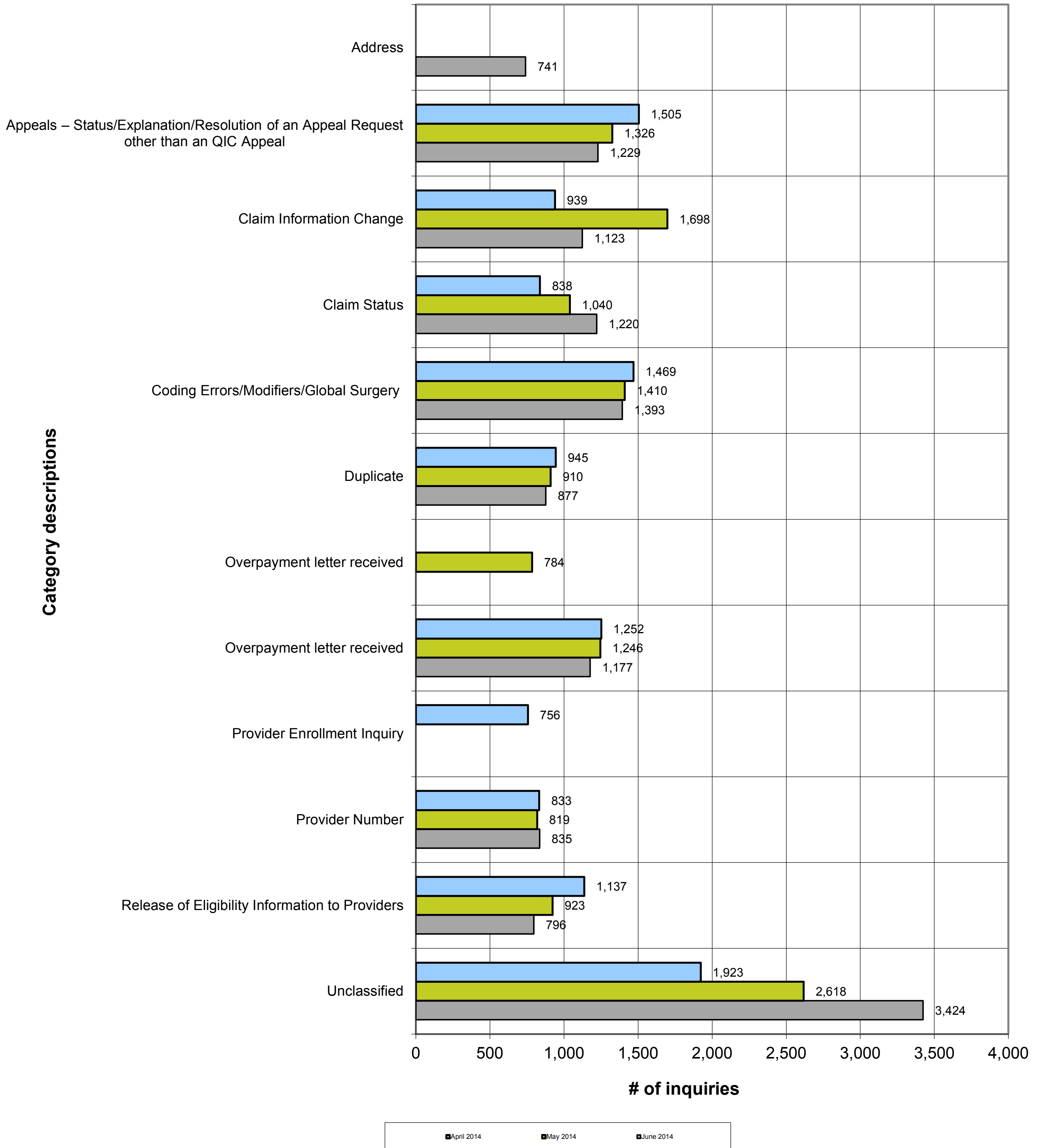
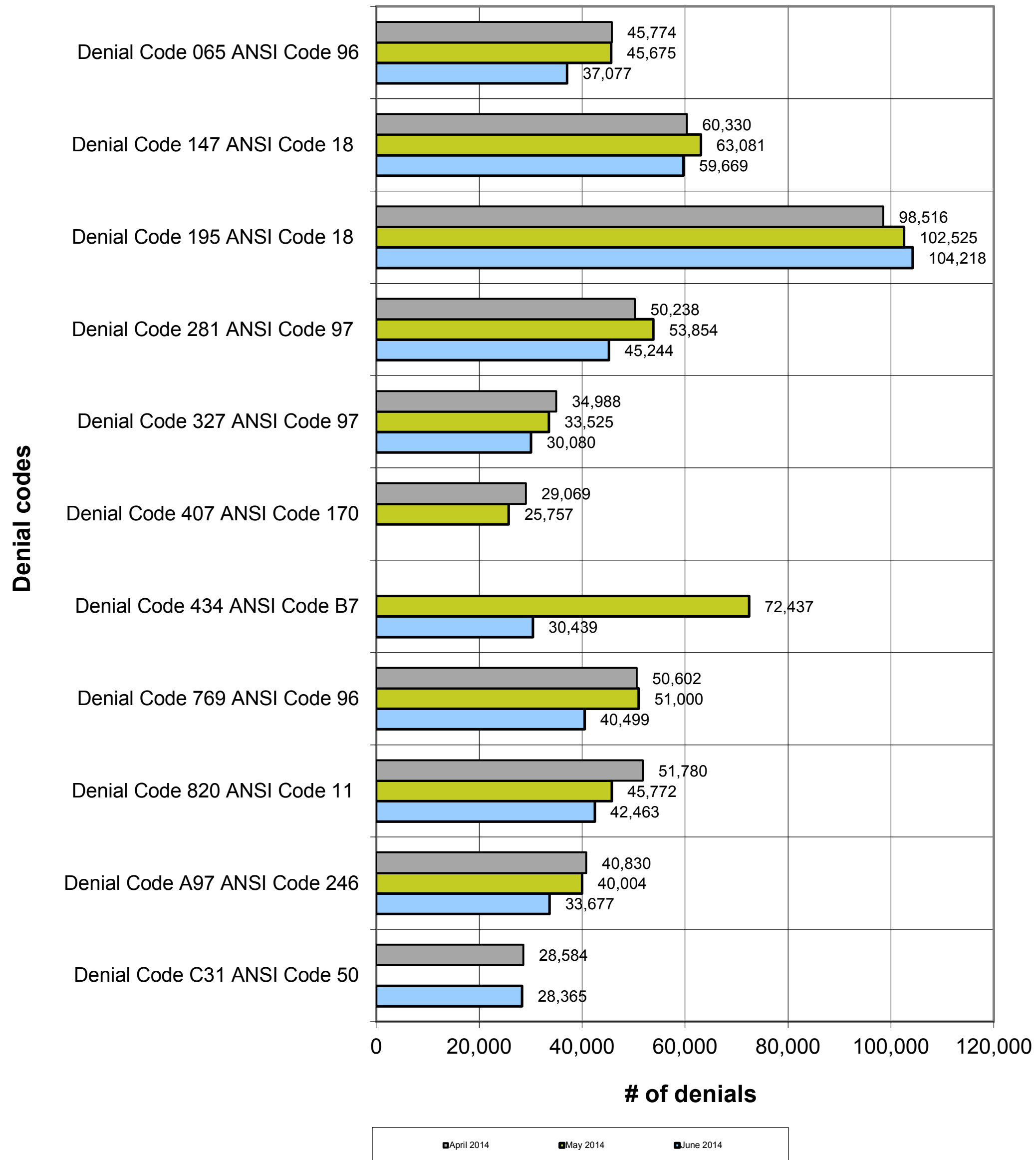
Claims and Inquiry Summary Data

Top inquiries, rejects, 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 April-June 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.*





What to do when your claim is denied

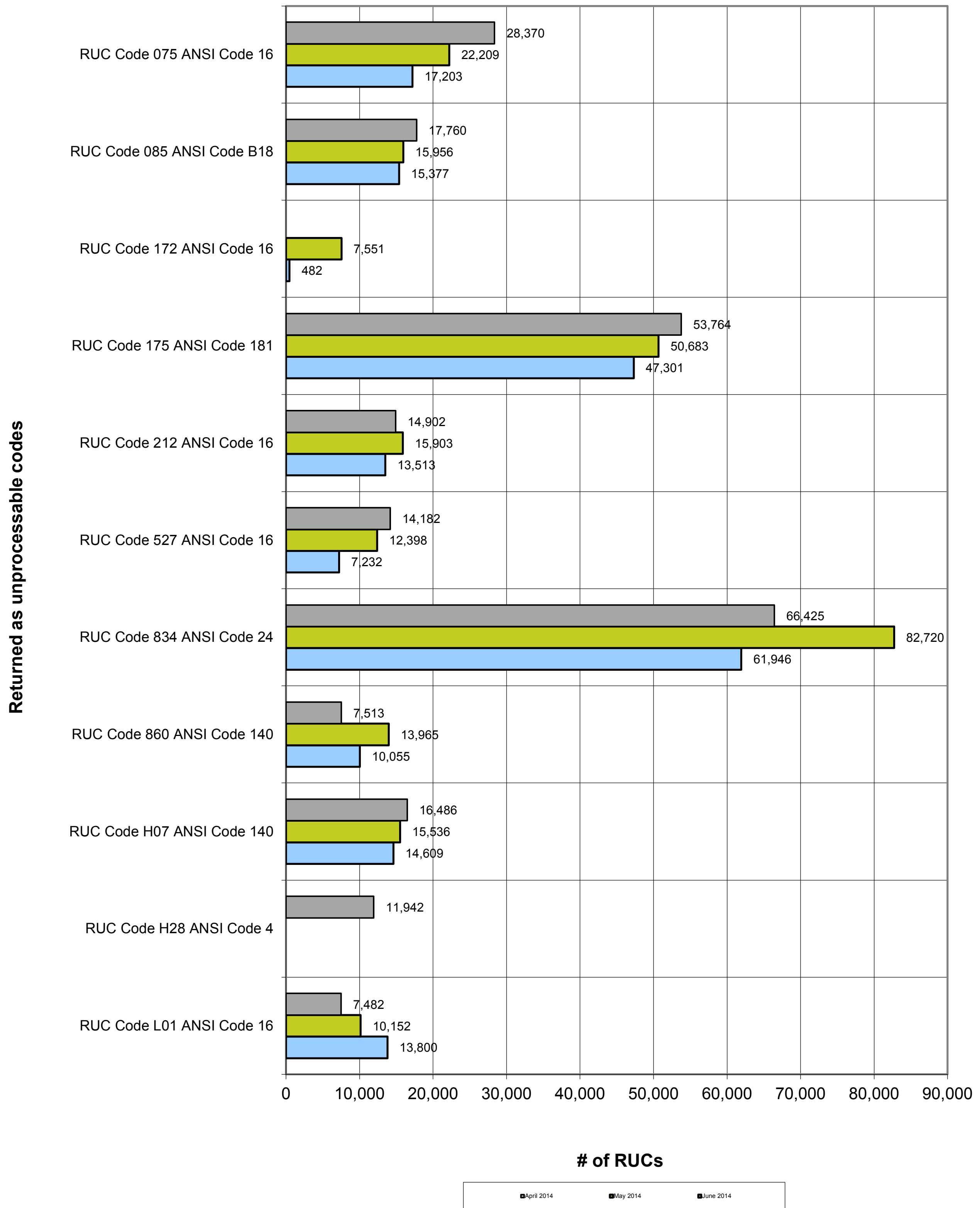
Before contacting customer service, check claim status though the IVR. The IVR will release necessary details around claim denials.

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 April-June 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 N (JN) 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.*

Revisions to LCDs

Molecular pathology procedures – revision to the LCD

LCD ID number: L33703 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on the 2014 American Medical Association (AMA) Errata, the descriptor for *Current Procedural Terminology®* (*CPT®*) code *81405* was revised. Therefore, the "*CPT®*/HCPCS codes" section of the molecular pathology procedures local coverage determination (LCD) was updated to reflect the revised descriptor for *CPT®* code *81405*.

Effective date

This revision to the LCD is effective for claims processed **on or after July 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, please *click here*.

Polysomnography and sleep testing – revision to the LCD

LCD ID number: L29949 (Florida)
LCD ID number: L29951 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for polysomnography and sleep testing was revised to include Accreditation Commission for Health Care (ACHC) as an acceptable accreditor for sleep labs. The "Indications and Limitations of Coverage and /or Medical Necessity" and "Documentation/Credentialing Requirements" sections of the LCD were revised to add this language. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

The LCD revision is effective for services rendered **on or after July 8, 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, please *click here*.

Dialysis (AV fistula and graft) vascular access maintenance – revision to the Part B LCD

LCD ID number: L32828 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on the 2014 American Medical Association (AMA) Errata, the descriptors for *Current Procedural Terminology®* (*CPT®*) codes *37236* and *37237* were revised. Therefore, the "*CPT®*/HCPCS codes" section of the dialysis (AV fistula and graft) vascular access maintenance local coverage determination (LCD) was updated to reflect the revised descriptors for *CPT®* codes *37236* and *37237*.

Effective date

The LCD revision is effective for claims processed **on or after July 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, please *click here*.

Revisions to Draft LCD

Noncovered services – revision to the Part B draft LCD

LCD ID number: DL29288 (Florida)
LCD ID number: DL29398 (Puerto Rico/U.S. Virgin Islands)

The Medical Policy & Procedure Department evaluated the procedure for insertion of implantable transprostatic tissue retractor system (prostatic urethral lift) (e.g. UroLift® system) and determined that it is considered not medically reasonable and necessary at this time based on current available published evidence (e.g., peer-reviewed medical literature, and published studies). Therefore, Healthcare Common Procedure Coding System (HCPCS) codes C9739 (Cystourethroscopy with insertion of transprostatic implant; 1 to 3 implants) and C9740 (Cystourethroscopy with insertion of transprostatic implant; 4 or more implants) were added to the noncovered services local coverage determination (LCD). First Coast Service Options Inc. (First Coast) inadvertently omitted the outpatient procedure codes that represent this service when performed in a physician's office. Therefore, procedure codes *53899* [Insertion of implantable transprostatic tissue retractor system (prostatic urethral lift) (e.g. UroLift® System)], *55899* [Insertion of implantable transprostatic tissue retractor system (prostatic urethral lift) (UroLift® system)], and L8699 (Transprostatic implant) will be added to the noncovered services LCD to represent this service when performed in a physician's office. **Due to this oversight, the 45-day comment period for the noncovered services draft will be extended to August 9, 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.

To review active, future, and retired LCDs, please *click here*.

Take the time to 'chat' with the website team

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

Provider outreach and educational events – August 2014

Internet-based PECOS class

When: Thursday, August 21 **Type of event:** Face-to-face
Time: 1:00-5:00 p.m.
http://medicare.fcso.com/Events/266999.asp

Medicare Medicare "Ask-the-Contractor" teleconference (ACT): Effects of benefit periods on claims (A/B)

When: Wednesday, August 27 **Type of event:** Webcast
Time: 1:00 -3:00 p.m.
http://medicare.fcso.com/Events/271605.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: ______________________________

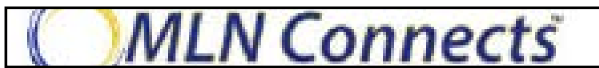
Keep checking our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

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.



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': July 3, 2014 – *http://go.cms.gov/1mKmUD3*

"MLN Connects™ Provider eNews': July 10, 2014 – *http://go.usa.gov/Xn9x*

"MLN Connects™ Provider eNews': July 17, 2014 – *http://go.cms.gov/1wviJAT*

"MLN Connects™ Provider eNews': July 24, 2014 – *http://go.usa.gov/5UTw*

"MLN Connects™ Provider eNews': July 31, 2014 – *http://go.cms.gov/1nTYqxJ*

Find out first: Subscribe to First Coast *eNews*

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

***Medicare Learning Network*®**

The *Medicare Learning Network*® (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

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 JN

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 N 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. **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:
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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)