

C Medicare B CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

November 2014



In this issue

Hospice-related services for Medicare B.....	8
October update to the 2014 MPFSDB.....	11
Psychotherapy probe review findings.....	12
Outpatient therapy cap values for 2015.....	13
New timeframe for response to ADRs	14
Revised form to reassign Medicare benefits	18

Proper billing of outpatient drugs

Medicare uses an outpatient prospective payment system (OPPS) to pay certain outpatient claims. With this method of reimbursement, the Medicare payment is not based on the amount the provider charges; therefore, the billed charges generally do not affect the current Medicare prospective payment amounts. Billed charges usually exceed the Medicare payment amount; therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.



First Coast Service Options Inc. (First Coast) reminds providers that they are responsible for ensuring that the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and units of service are billed correctly for services rendered to Medicare beneficiaries, and claims are in accordance with coding guidelines. Providers should use the appropriate HCPCS codes,

and report units of service as the number of times that a service or procedure was performed or, if the HCPCS is associated with a drug, the number of units administered.

This article provides examples of payment errors that were identified during an audit for certain outpatient claims. Providers should carefully review this article to ensure their claims are submitted properly to Medicare.

Errors that may result in overpayments

Incorrect number of units of service

In the audit review, a provider administered 720 micrograms of filgrastim to a patient and billed for eight units of service (2,400 micrograms). Using the HCPCS description (injection, filgrastim 300 micrograms) the correct number of units to bill for 720 micrograms was three. On 19 separate occasions this type of error occurred, resulting in overpayments.

Prior to billing the claim, ensure the service is correctly represented by the true number of units. If you are unsure what constitutes one unit, per Medicare guidelines, review the [Medicare Part B drug average sales price \(ASP\)](#) files.

See **DRUGS**, Page 5



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Contents

About the Medicare B Connection

About the 'Medicare B Connection'3
 Advance beneficiary notices.....4

Coverage/Reimbursement

Durable Medical Equipment

October update of 2014 DMEPOS fee schedule6

Hospice

Hospice-related services for Medicare B.....8

Laboratory/Pathology

Reporting service location NPI on anti-markup and reference lab claims9

Medicare Physician Fee Schedule

October update to the 2014 MPFSDB..... 11

Psychiatric Services

Psychotherapy probe review findings.....12

Radiology

FDG PET for solid tumor claims13

Therapy Services

Outpatient therapy cap values for 2015.....13
 2015 annual update to the therapy code list14

General Coverage

New timeframe for response to ADRs14
 Coverage of ultrasound screening for AAA and screening fecal occult blood tests.....15
 Coverage of items and services in IDE studies16
 Quarterly provider update.....17

General Information

Revised form to reassign Medicare benefits (CMS-855R)18
 Demand letters for polysomnography claims18

Claims and Inquiry Summary Data

Top inquiries19

Top denials20
 Use self-service resources to assist with and avoid claim denials20
 Top unprocessable claims21

Local Coverage Determinations

Looking for LCDs?22
 Advance beneficiary notice22

Revisions to LCDs

Noncovered services.....23
 Paclitaxel (Taxol®).....23
 Visual field examination23

Additional Information

J3590/C9399 Vimizim™ (elosulfase alfa)....24
 Alprolix™ [Coagulation Factor IX (Recombinant), Fc Fusion Protein]24
 Cyramza™ (ramucirumab) injection24
 Eloctate™ Antihemophilic Factor (Recombinant), Fc Fusion Protein25
 Entyvio™ (vedolizumab) injection25
 Novoeight®, Antihemophilic Factor (Recombinant)26
 Tretten®, Coagulation Factor XIII A-Subunit (Recombinant)26
 Sylvant™ (siltuximab) injection.....26

Educational Resources

Upcoming provider outreach and educational events27

CMS MLN Connects™ Provider eNews

eNews for October 23, 2014.....28
 eNews for October 30, 2014.....29
 eNews for November 6, 2014.....29
 eNews for November 13, 2014.....30

Contact Information

Florida Contact Information31
 U.S. Virgin Islands Contact Information32
 Puerto Rico Contact Information33

Order Form

Medicare Part B materials34

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.

Medicare Part B 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 applicable contact section located at the end of this publication for the address in which to send written appeals requests.

Drugs and Biologicals

DRUGS

From front page

These files list the dosage per unit for most payable drugs.

Billed separately for packaged services

For selected outpatient drugs that have multiple HCPCS codes, one provider billed Medicare on two line items using a HCPCS code that Medicare pays separately, instead of a HCPCS code that Medicare does not pay separately. These line items involved two different packaged outpatient drugs. In total, the provider was paid \$25,637 for packaged drugs when the provider should have been paid \$0.

Another provider billed Medicare for the chemotherapy drug melphalan hydrochloride (J9245) rather than the chemotherapy drug carboplatin (J9045) that was actually administered. During the dates of service that the provider administered this drug, Medicare packaged carboplatin in the payment for other services and did not provide for separate reimbursement under the OPPTS. As a result, the provider was paid \$16,617 when they should have been paid \$0.

Review the services being billed prior to the claim being submitted to determine if there are any packaged services being included. It is the provider's responsibility to ensure the correct codes are being billed to represent the services being rendered and that the billing follows Medicare guidelines. For more information on packaged services, please review *CMS' "Claims Processing Manual" (Publication 100-04), Chapter 4, Section 10.4.*

Lack of supporting documentation

Four providers billed Medicare for nine line items for which the providers did not provide any documentation to support that a patient had received the drug service billed.

The Centers for Medicare & Medicaid Services' IOMs can provide specifics on billing for services and documentation that may be required for the services. Specifically, CMS provides an IOM on Drugs and Biologicals: *"Claims Processing Manual" (Publication 100-04), Chapter 17.*

Incorrect HCPCS codes

One provider used an incorrect HCPCS code on one line item, which resulted in an overpayment. The provider billed Medicare for two units of service for leuprolide acetate injections (J1950, 3.75 milligrams per unit), which is indicated for the treatment of endometriosis, uterine leiomyomas, and malignant neoplasms of the breast; however, the provider should have billed Medicare for two units of service for leuprolide acetate injection (J9217, 7.5



milligrams per unit), which is indicated for the treatment of prostate cancer and was the drug actually administered.

Again, it is the provider's responsibility to review the claim prior to submitting it to Medicare to ensure it is being billed properly. First Coast recommends that providers establish a compliance and audit program that will allow them to set up necessary checks and balances to safeguard themselves against submitting incorrect claims, resulting in future overpayments. For more information on compliance programs, review the Office of Inspector General's (OIGs) Web page on *Compliance Education Materials.*

Provider education resources

The following resources provide information that will assist you with proper billing of outpatient services.

- Medicare *Claims Processing Manual* (Publication 100-04)
 - Chapter 1 - General Billing Requirements, Section 80.3.2.2 FI Consistency Edits – <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf#page=237>
 - Chapter 12 - Physicians/Nonphysician Practitioners – <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>
 - Chapter 17 - Drugs and Biologicals, Section 70 Claims Processing Requirements - General – <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf#page=32>
 - Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.3 Use and Acceptance of HCPCS Codes and Modifiers – <https://www.cms.gov/manuals/downloads/clm104c23.pdf#page=13>

Durable Medical Equipment

October update of 2014 DMEPOS fee schedule

Note: This article was revised November 17, 2014, to reflect the revised change request (CR) 8865 issued November 13. 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 [August 2014 Medicare B Connection, Pages 16-17](#).

Provider types affected

This *MLN Matters*[®] article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including hospice & home health MACs, and durable medical equipment MACs (DME MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 8865 to alert providers and suppliers that CMS issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2014. Make sure your billing staffs are aware of these changes.

Background

CMS updates DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>.

Key points of CR 8865

Splints, casts, and certain intraocular lenses (IOLs)

As part of this update, the splint and cast (SC) payment category indicator will be added to the file for the following SC Healthcare Common Procedure Coding System (HCPCS) codes reflecting payment calculated in accordance with the regulations at 42 CFR, Section 414.106 for splints and casts:

A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010, Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021, Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032, Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041, Q4042, Q4043, Q4044, Q4045, Q4046, Q4047, Q4048, Q4049

The 'IL' payment category indicator will be added to the file for V2630, V2631, and V2632 HCPCS codes for IOLs inserted in a physician's office reflecting payment calculated in accordance with the IOL payment regulations at 42 CFR, Section 414.108.



You may want to review *MLN Matters*[®] article MM8645, "April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule" at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8645.pdf>, which includes additional discussion on the establishment of national fee schedule amounts for codes for splints, casts, and IOLs.

Off-the-shelf (OTS) orthotics

Effective October 1, 2014, the following two new codes are added to the HCPCS file to describe prefabricated knee orthoses that are furnished OTS:

1. **K0901:** Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf; and
2. **K0902:** Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf.

Since these two orthotic OTS codes represent a coding explosion of the prefabricated knee orthosis codes L1843 and L1845, the fees for the above codes will be added to the DMEPOS fee schedule file and established by applying the fees for codes L1843 and L1845 to the new OTS codes K0901 and K0902, respectively. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the *Medicare Claims Processing Manual*, Chapter 23, Section 60.3.1. at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>.

Further information on the development of new

See **DMEPOS**, next page

DMEPOS

From previous page

OTS orthotic codes can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html.

Specific coding and pricing issues

1. This update also notifies that HCPCS codes K0734, K0735, K0736, and K0737 found in Attachment B of CR 6270, were discontinued; and
2. Cross walked to HCPCS codes E2622, E2623, E2624, and E2625, respectively, effective January 1, 2011.

Billing instructions for these wheelchair seat cushion items may refer to any of these codes.

Additional information

The official instruction, CR 8865, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3123CP.pdf>.

You may review Attachment B (Page 19) of CR 6270 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1630CP.pdf>.

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



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Calculate the possibilities ...



Whether you're estimating the amount of a Medicare payment, the length of an ESRD coordinating period, or the deadlines for sending an appeals request or responding to an additional development request, try the easy way to calculate the possibilities. Find everything you need to "do it yourself" in our new *Tool center*.

Hospice

Hospice-related services for Medicare B

Note: This article was revised on November 6, 2014, to make certain clarifications, mostly to change references to terminal diagnosis to terminal prognosis. This information was previously published in the *July 2013 Medicare B Connection*, Pages 12-13.

Provider types affected

This *MLN Matters*[®] special edition (SE) is intended for physicians submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries who are in a hospice period of coverage.

What you need to know

This article informs you that recovery auditors conducted automated claim reviews of medical services provided as separate services, when the Centers for Medicare & Medicaid Services (CMS) regulation or policy, or local practice dictates that they should have been billed together, rather than individual services for Medicare patients in hospice care.

Provider action needed

CMS is publishing this article to alert providers that they should identify if a beneficiary is enrolled in hospice. Providers can ask the beneficiary or his/her legal representative if he or she is enrolled in hospice. This information should be documented in the beneficiary's medical record. Providers should educate beneficiaries and their families that once the beneficiary is enrolled in hospice, they should contact the hospice provider to arrange for any care they need. If the hospice provider does not arrange the services the beneficiary needs, the beneficiary may be financially responsible for the services. The beneficiary and their family should also be aware that the beneficiary or his/her legal representative may revoke the election of hospice care at any time in writing. To revoke the election of hospice care, the beneficiary must file a document with the hospice that includes a signed statement that the beneficiary revokes the election for Medicare coverage of hospice care for the remainder of that election period and the effective date of that revocation. Note that a verbal revocation of benefits is **not** acceptable. CMS emphasizes that the revocation of the hospice election must be done in writing.

Upon revoking the election of Medicare coverage of hospice care for a particular election period, a beneficiary resumes Medicare coverage of the benefits waived when hospice care was elected. A beneficiary may at any time elect to receive hospice coverage as long as he or she continues to meet the eligibility criteria, meaning the beneficiary is entitled to Medicare Part A and has been certified as terminally ill, with a medical prognosis of six months or less. For more information regarding hospice services, please see the references listed in the *Additional information* section of this article. A beneficiary may not designate an effective date of the revocation that is earlier than the date that the revocation is made.



Services related to a hospice terminal prognosis provided during a hospice period are included in the hospice payment and are not paid separately.

For beneficiaries enrolled in hospice, MACs should deny any Part B services furnished on or after January 1, 2002, that are submitted without either GV modifier, meaning the attending physician is not employed or paid under arrangement by the beneficiary's hospice provider and professional services provided are related to the terminal prognosis, or GW modifier, meaning the service is not related to the hospice beneficiary's terminal prognosis. MACs should deny services that are submitted with the GW modifier when the service is determined to be related to the terminal prognosis. Also, MACs should deny services that are submitted with the GV modifier if it is determined that the physician services were furnished by hospice-employed physicians and nurse practitioners (NP) or by other physicians under arrangement with the hospice.

Case studies

Here are some examples to give a better understanding of the use of these modifiers:

Example 1: A beneficiary is enrolled in hospice and goes to a physician's office for closed treatment of a metatarsal fracture, *CPT*[®] code 28470.

Resolution: If the procedure is unrelated to the terminal prognosis (non-hospice related), the physician's bill should contain GW modifier (Service not related to the hospice patient's terminal condition). If this modifier is not appended, the procedure is related to the terminal prognosis and should not be reimbursed under the part B benefit. Thus, the claim is in error, since the services are considered included with payments under the hospice benefit.

Example 2: The patient is listed as being on hospice starting August 1 through August 31, 2010. Then a provider billed *CPT*[®] code 45378, diagnostic colonoscopy with no modifiers August 3, 2010, to Part B.

Resolution: The billing of 45378 would be incorrect since the beneficiary was enrolled in hospice and

See **HOSPICE**, next page

HOSPICE

From previous page

there can be no separate reimbursement unless the service was unrelated to the terminal prognosis or the attending physician was otherwise entitled to separate reimbursement, which would be reflected by GV modifier (Attending physician not employed or paid under arrangement by the patients hospice provider) or GW modifier (Service not related to the hospice patients terminal condition). MACs should also deny services that are submitted with the modifier but for which, during medical review, the service is determined to be related to the terminal prognosis.

Additional information

To review the *Hospice Payment System Fact Sheet*, go to: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospice_pay_sys_fs.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>.

To review the *Medicare Claims Processing Manual*, Chapter 11, Sections 10.40.1.3, 40.2 and 50 - Processing

Hospice Claims, visit <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf>.

To review the *Medicare Benefit Policy Manual*, Chapter 9, Sections 10, 40.1.9 - Coverage of Hospice Services Under Hospital Insurance, go to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf>.

To review *MLN Matters*® MM8142 on the Hospice Monthly Billing Requirement, go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8142.pdf>.

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Laboratory/Pathology

Reporting the service location NPI on anti-markup and reference laboratory claims

Note: This article was revised November 6, 2014, to reflect the revised change request (CR) 8806 issued November 3. The CR was revised to change the effective and implementation dates. Also, in the article, the CR release date, transmittal number, and the Web address for accessing the article are revised. All other information remains the same. This information was previously published in the *September 2014 Medicare B Connection*, Pages 17-18.

Provider types affected

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

Provider action needed

This article is based on CR 8806, which provides guidance for physicians and suppliers billing anti-markup and reference laboratory claims. Effective for anti-markup and reference laboratory claims submitted with a receipt date on and after April 1, 2015, billing physicians and suppliers are required to report the name, address, ZIP code, and the national provider identifier (NPI) of the performing physician or supplier when the performing physician or supplier is enrolled in a different contractor's jurisdiction. Make sure your billing staffs are aware of this update.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all covered health care entities follow the same standard for submitting and processing electronic claims transactions. According to the instructions for use of the American National Standards Institute (ANSI) x12 837 professional electronic claim transaction, suppliers must submit the NPI that matches the name and address of the servicing provider/supplier identified on the claim.

On anti-markup and reference laboratory claims, physicians and other suppliers are required to identify the supplier's name, address, and ZIP code in Item 32 of the CMS-1500 claim, or the corresponding loop and segment of the ANSI x12 837 professional electronic claim format. The NPI of the physician or supplier who actually performed the service is required in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the ANSI x12 837 professional electronic claim transaction.

However, prior to the implementation of the provider enrollment, chain, and ownership system (PECOS), MACs used systems that were specific to each MAC and did not allow MACs from one state to view provider enrollment information from another state. This systems limitation prevented MACs from being able to share information

See **LAB**, next page

LAB

From previous page

about existing providers/suppliers, and increased the potential for fraud. As a result, physicians and suppliers that were enrolled in another MAC's jurisdiction could not validate the NPI in Item 32a of the CMS-1500 claim form or on the ANSI x12 837 professional electronic claim format, because the function was not available in PECOS.

Since the NPI of the physician/supplier that actually performed the test may not be available to the billing physician or supplier, the *Medicare Claims Processing Manual* currently instructs physicians and suppliers to submit their own NPI with the name and address of the actual performing physician or supplier in Item 32a (and its electronic equivalent) when billing for reference laboratory services, or services subject anti-markup, when the performing physician or supplier is enrolled in another contractor's jurisdiction.

Effective April 1, 2015, changes to PECOS will allow MACs the ability to verify all physician and supplier NPIs, regardless of the jurisdiction in which they are enrolled. Therefore, beginning with claims received on or after April 1, 2015, physicians and suppliers billing anti-markup and reference laboratory claims must report the NPI of the physician or supplier who actually performed the service in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the American National Standards Institute (ANSI) x12 837 professional electronic claim format. This new requirement applies to all claims, including claims for services where the performing physician/supplier is out of the processing MAC's jurisdiction.

Anti-markup claims will be identified by the presence of the "Yes" indicator in Item 20 of the CMS-1500 or its electronic equivalent. Reference laboratory claims will be identified by the presence of 90 on any service line.

MACs will return as unprocessable a claim:

- Where the NPI in Item 32a (or its electronic equivalent) does not belong to the entity whose name and address are identified in Item 32 (or its electronic equivalent)
- For a reference laboratory or anti-markup service that is performed outside the MAC's billing jurisdiction when submitted without the name, address, and ZIP code of the performing physician/supplier in Item 32, and the NPI of the performing physician/supplier in Item 32a of the CMS-1500 claim form, or on the ANSI x12 837 professional electronic claim format, in the appropriate loops/segments
- For a reference laboratory or anti-markup service performed outside the contractor's billing jurisdiction when the NPI in Item 32A (or its electronic equivalent) does not match the name and address of a valid



servicing physician/supplier identified on the existing table in PECOS.

MACs use the following codes for claims returned as unprocessable:

- Claim adjustment reason code (CARC) 16 – Claim/service lacks information which is needed for adjudication.
- For reference lab claims, remittance advice remarks code (RARC) N270 – Missing/incomplete/invalid other provider primary identifier.
- For anti-markup claims, RARC N283 – Missing/incomplete/invalid purchased service provider identifier.
- Group code – contractual obligation (CO)

Additional information

The official instruction, CR 8806, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3103CP.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> under - How Does It Work.

MLN Matters® Number: MM8806 *Revised*

Related Change Request (CR) #: CR 8806

Related CR Release Date: November 3, 2014

Effective Date: April 1, 2015

Related CR Transmittal #: R3103CP

Implementation Date: Claims with a receipt date on or after April 1, 2015

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Medicare Physician Fee Schedule

October update to the 2014 Medicare physician fee schedule database

Note: This article was revised October 24, 2014, to reflect the revised change request (CR) 8888 issued October 20. The CR was revised to correct the type of service indicator of HCPCS code G0471 to "5." In this article, the CR release date, transmittal number and the Web address for accessing CR 8888 are revised. All other information remains the same. This information was previously published in the *September 2014 Medicare B Connection, Pages 21-22.*

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

Provider action needed

CR 8888 informs MACs about changes to payment files that were originally issued to contractors based upon the 2014 Medicare physician fee schedule (MPFS) final rule. This change request amends those payment files, effective October 1, 2014. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to MACs based upon rates in the 2014 MPFS final rule, published in the *Federal Register* December 10, 2013, which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html>, as modified by Section 101 of the "Pathway for SGR Reform Act of 2013" to be effective for services furnished between January 1, 2014, and March 31, 2014. On April 1, 2014, the President signed the "Protecting Access to Medicare Act of 2014," which extends those rates through December 31, 2014.

In order to reflect appropriate payment policy as included in the 2014 MPFS final rule, the Medicare physician fee schedule database (MPFSDB) has been updated with October changes. These rates are effective through December 31, 2014.

The table below summarizes the addition of federally qualifying health centers (FQHCs) Healthcare Common Procedure Coding System (HCPCS) codes G0466, G0467, G0468, G0469, and G0470.

HCPCS	Short descriptor	Procedure status
G0466	FQHC visit, new patient	X
G0467	FQHC visit, estab pt	X
G0468	FQHC visit, IPPE or AWW	X
G0469	FQHC visit, MH new pt	X
G0470	FQHC visit, MH estab pt	X

In addition, note the following changes:

- For HCPCS 55970 and 55980, CMS will change their procedure status codes from "N"= "Noncovered service by Medicare" to "C"= "Carrier Priced", and their global surgery codes from "XXX" to "YYY", effective May 30, 2014 (All other indicators should remain the same.).
- For HCPCS code A9586, CMS will change its procedure status code changed from "N"= "Noncovered service by Medicare" to "C"= "carrier priced", and its global surgery code from "XXX" to "YYY", effective September 27, 2013. (All other indicators should remain the same. See CR 8526.).
- HCPCS code G0471 "Ven blood coll SNF/HHA" is added to the MPFS with a procedure status code of X, effective April 1, 2014.
- HCPCS code 02757 "Perq lamot/lam lumbar" is revised to the 2014 physician fee schedule with a procedure status code of "R"="restricted", effective January 9, 2014 (See CR 8757).
- CMS is changing the short descriptor for G9361 to read "Med Ind for induction", effective January 1, 2014.

MACs need not search their files to either retract payment for claims already paid or to retroactively pay claims and which were impacted by the above changes. However, they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 8888 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3097CP.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> under - How Does It Work.

MLN Matters® Number: MM8888 *Revised*
 Related Change Request (CR) #: CR 8888
 Related CR Release Date: October 20, 2014
 Effective Date: October 1, 2014
 Related CR Transmittal #: R3097CP
 Implementation Date: October 6, 2014

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Psychiatric Services

Psychotherapy probe review findings

First Coast Service Options Inc. (First Coast) recently conducted post payment provider specific probes reviews in response to data aberrancies identified for *Current Procedural Terminology*® (CPT®) code 90834 (psychotherapy, 45 minutes with patient and/or family member). Post payment medical reviews resulted in high error rates. Services were denied because submitted medical records did not meet documentation requirements as outlined in the *Psychiatric Diagnostic Evaluation and Psychotherapy Services* local coverage determination (LCD) (L33128). Specifically the medical records were missing one or more of the following documentation requirements for each date of service:

- Documentation of measurable goals on the treatment plan;
- Detailed summary of the psychotherapy sessions, including descriptive documentation of therapeutic interventions;
- Degree of patient participation and interaction with the therapist;
- Reaction of the patient to the therapy sessions;
- Documented progress toward measurable goals since the last sessions; and changes or lack of changes in the patient's symptoms or behavior;
- Documentation of adjustments in the treatment plan that reveal the dynamics of treatment;
- Treatment plan was not updated and did not support the medical necessity of each psychotherapy session.

The documentation for psychotherapy services should include on a periodic basis the patient's capacity to participate and benefit from psychotherapy. Such periodic documentation should include the estimated duration of treatment in terms of number of sessions required and the target symptoms, measurable and objective goals of therapy related to changes in behavior, thought processes and/or medications, methods of monitoring outcome, and why the chosen therapy is an appropriate modality either in lieu of or in addition to another form of psychiatric treatment. For an acute problem, there should be documentation that the treatment is expected to improve the mental health status or function of the patient. For chronic problems, there must be documentation indicating that stabilization of mental health status or function is expected. Documentation will reflect adjustments in the treatment plan that reveals the dynamics of treatment.



It is expected that the treatment plan for a patient receiving outpatient psychotherapy (i.e., measurable and objective treatment goals, descriptive documentation of therapeutic intervention, frequency of sessions, and estimated duration of treatment) will be updated on a periodic basis, generally at least every three months.

The medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy session and include the following:

- The presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to alter baseline functioning; and
- A detailed summary of the session, including descriptive documentation of therapeutic interventions such as examples of attempted behavior modification, supportive interaction, and discussion of reality; and
- The degree of patient participation and interaction with the therapist, the reaction of the patient to the therapy session, documentation toward goal oriented outcomes and the changes or lack of changes in patient symptoms and/or behavior as a result of the therapy session.
- The rationale for any departure from the plan or extension of therapy should be documented in the medical record. The therapist must document patient/therapist interaction in addition to an assessment of the patient's problem(s).

First Coast recommends providers be familiar with medical necessity indications and documentation requirements for psychotherapy services as indicated in the *Psychiatric Diagnostic Evaluation and Psychotherapy Services* LCD. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

Radiology

Claim hold extended for FDG PET for solid tumors

Issue

Claims for fluorodeoxyglucose (FDG) positron emission tomography (PET) for solid tumors submitted October 6 through November 30 will be held to ensure Medicare systems can accurately calculate payments. Specifically, these are claims containing Healthcare Common procedure Coding System (HCPCS) A9552 for all oncologic conditions. See [MLN Matters® article MM8739](#) for additional information.

Resolution

The common working file (CWF) will disable the edits that

were to be implemented with CR 8739.

Status/date resolved

Open. This release of these claims began December 1.

Provider action

No action is required by providers

Current processing issues

Here is a link to a table of [current processing issues](#) for both Part A and Part B.

Therapy Services

Outpatient therapy cap values for 2015

Provider types affected

This [MLN Matters®](#) article is intended for physicians, therapists, and other providers, submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs, for outpatient rehabilitation services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8970 informs MACs about changes to outpatient therapy caps for 2015. For physical therapy and speech-language pathology combined, the therapy cap will be \$1,940. For occupational therapy, the cap for 2015 will be \$1,940. Make sure that your billing staffs are aware of these changes.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as "therapy caps." The therapy caps are updated each year based on the Medicare Economic Index. An exceptions process to the therapy caps for reasonable and medically necessary services was required by Section 5107 of the Deficit Reduction Act of 2005. The exceptions process for the therapy caps has been continuously extended several

times through subsequent legislation. Most recently, Section 103 of the Protecting Access to Medicare Act of 2014 extended the therapy caps exceptions process through March 31, 2015.



Additional information

The official instruction, CR 8970, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3120CP.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> under - How Does It Work.

MLN Matters® Number: MM8970

Related Change Request (CR) #: CR 8970

Related CR Release Date: November 14, 2014

Effective Date: January 1, 2015

Related CR Transmittal #: R3120CP

Implementation Date: January 5, 2015

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2015 annual update to the therapy code list

Provider types affected

This *MLN Matters*® article is intended for physicians, therapists, and other providers who submit claims to Medicare administrative contractors (MACs), including home health & hospice MACs, for outpatient rehabilitation therapy services that are provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8985 updates the therapy code list for 2015 by adding two “sometimes therapy” codes, and deleting two current codes. The update to the therapy code list reflects those made in the 2015 Healthcare Common Procedure Coding System and *Current Procedural Terminology*®, Fourth Edition (HCPCS/CPT®-4). Make sure your billing staff are aware of these changes.

Background

The Social Security Act (Section 1834(k)(5)) (see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/*Current Procedural Terminology*®, 2015 Edition (HCPCS/CPT®-4) is the coding system used for the reporting of these services.

CR 8985 updates the list of codes that sometimes, or always, describe therapy services. The additions, changes,

and deletions to the therapy code list reflect those made in the 2014 and 2015 Healthcare Common Procedure Coding System and *Current Procedural Terminology, Fourth Edition*® (HCPCS/CPT®-4).

The therapy code listing can be found at <http://www.cms.gov/Medicare/Billing/TherapyServices/index.html>.

Specifically, CR 8985 updates the code list by adding HCPCS codes 97607 (Neg press wnd tx) and 97608 (Neg press wound tx >50 cm) to the “sometimes therapy” codes and deleting HCPCS codes G0456 and G0457 from the 2015 therapy code list. Code 97608 replaces current code G0457 effective January 1, 2015, and 97607 replaces current code G0456 effective January 1, 2015.

Additional information

The official instruction, *CR 8985*, issued to your MAC regarding this change, is available on the CMS website.

MLN Matters® Number: MM8985

Related Change Request (CR) #: CR 8985

Related CR Release Date: November 14, 2014

Effective Date: January 1, 2015

Related CR Transmittal #: R3121CP

Implementation Date: January 5, 2015

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General Coverage

New timeframe for response to additional documentation requests

Provider types affected

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

What you need to know

This article is based on change request (CR) 8583, which instructs MACs and zone program integrity contractors (ZPICs) to produce *pre-payment review* additional documentation requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. **Failure to respond within 45 days of a prepayment review ADR will result in denial** of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.



Background

In certain circumstances, CMS review contractors (MACs, ZPICs, recovery auditors, the comprehensive error rate testing contractor and the supplemental medical review contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare’s common working file (CWF).

In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an ADR. The requirements for additional documentation are as follows:

- The Social Security Act, Section 1833(e) – Medicare contractors are authorized to collect medical

See **ADR**, next page

ADR

From previous page

documentation. The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.

- According to the *Medicare Program Integrity Manual*, Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions), when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within **45** calendar days of the request. **Reviewers shall deny claims for which the requested documentation was not received by day 46.**

Additional information

The official instruction, CR 8583, issued to your MAC

Coverage of ultrasound screening for AAA and screening fecal occult blood tests

Provider types affected

This *MLN Matters*® article is intended for physicians, physician assistants, nurse practitioners, and clinical nurse specialists submitting claims to Medicare administrative contractors (MACs) for ultrasound screening for abdominal aortic aneurysms (AAA) and screening fecal occult blood tests (FOBT) ordered for Medicare beneficiaries.

Provider action needed

Effective for dates of service on and after January 27, 2014, MACs shall pay claims for ultrasound screening for AAA and screening FOBTs, per the modified requirements in 42 *Code of Federal Regulations* (CFR) 410.19 and 410.37. See the details of the changes in the *Background* section. Make sure that your billing staffs are aware of these changes.

Background

Medicare Part B coverage of screening FOBTs and ultrasound screening for AAA is covered for certain beneficiaries that meet eligibility requirements as described in regulations. As part of the 2014 physician fee schedule final rule, the Centers for Medicare & Medicaid Services (CMS) revised the Medicare Part B coverage requirements for ultrasound screening for AAA (42 CFR 410.19) and screening FOBT (42 CFR 410.37).

regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R554PI.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> under - How Does It Work.

MLN Matters® Number: MM8583
 Related Change Request (CR) #: CR 8583
 Related CR Release Date: November 14, 2014
 Effective Date: April 1, 2015
 Related CR Transmittal #: R554PI
 Implementation Date: April 6, 2015

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As a result of CR 8881, the following policy changes are effective for dates of service on and after January 27, 2014:

- Ultrasound screening for AAA:** Coverage of AAA screening is modified by eliminating the one year time limit with respect to the referral for this service. This modification allows coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the initial preventive physical examination (IPPE, also commonly known as the "Welcome to Medicare Preventive Visit"). The beneficiary need only obtain a referral from their physician, physician assistant, nurse practitioner, or clinical nurse specialist. All other coverage requirements for this service remain unchanged, per 42 CFR 410.19.
- Screening FOBTs:** In addition to the beneficiary's attending physician, the beneficiary's attending physician assistant, nurse practitioner, or clinical nurse specialist may furnish written orders for screening FOBTs, per section 42 CFR 410.37(b). All other coverage requirements for this service remains unchanged, per 42 CFR 410.37.

Additional information

The official instruction, CR 8881, consists of three transmittals issued to your MAC. These transmittals update

See **TESTS**, next page



Coverage of items and services in Category A and B investigational device exemption studies

Provider types affected

This *MLN Matters*[®] article is intended for providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8921, which announces changes effective on and after January 1, 2015, to Medicare coverage requirements and review procedures related to items and services in Food and Drug Administration (FDA) approved Category A and B IDE studies. CR 8921 makes changes to the following Medicare manuals:

- *Medicare Benefit Policy Manual*, Chapter 14;
- *Medicare Benefit Policy Manual*, Chapter 16, Section 10; and
- *Medicare Claims Processing Manual*, Chapter 32, Section 68.

Make sure that your billing staffs are aware of these changes.

Background

Section 1862(m) of the Social Security Act and regulations at 42 CFR 405 Subpart B allows for payment of routine costs of care furnished to Medicare beneficiaries in category A IDE studies and authorizes the Secretary to establish criteria to ensure that category A IDE studies conform to appropriate scientific and ethical standards. Additionally, the regulations allowed Medicare contractors to make coverage decisions for category B IDE devices and routine care services in their review of claims for payment for these items and services.

Category A (experimental) device refers to a device for which “absolute risk” of the device type has not been established (that is, initial questions of safety and

effectiveness have not been resolved) and the FDA is unsure whether the device type can be safe and effective.

Category B (non-experimental/investigational) device refers to a device for which the incremental risk is the primary risk in question (that is, initial questions of safety and effectiveness of that device type have been resolved), or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained FDA premarket approval or clearance for that device type.

The FDA notifies the Centers for Medicare & Medicaid Services (CMS) when it notifies the IDE study sponsor (i.e. manufacturer) that the device is categorized as either category A or category B.

As part of the 2014 physician fee schedule rule, CMS modified its regulations at 42 CFR 405 subpart B, related to Medicare coverage of routine care items and services in category A and B IDE studies and Medicare coverage of category B IDE devices, effective January 1, 2015. For purposes of Medicare coverage in category A and B IDE studies, these regulatory modifications define Medicare coverage requirements, Medicare coverage IDE study criteria, and establish a centralized review process for approval of category A and B IDE studies.

Effective for category A and B IDE studies approved by the FDA on or after January 1, 2015, interested parties (i.e. study sponsors) that wish to seek Medicare coverage must submit a request for review and approval to CMS. Revised Chapter 14 of the *Medicare Benefit Policy Manual* contains detailed instructions on seeking CMS approval of category A and B IDE studies for purposes of Medicare coverage. Additional information regarding submission of category A and B IDE study review requests, along with the list of CMS-approved studies is available on the CMS Coverage Website at <http://www.cms.gov/Medicare/Coverage/IDE/index.html>.

See **IDE**, next page

TESTS

From previous page

the *Medicare Claims Processing Manual*, the *Medicare Benefit Policy Manual*, and the *Medicare National Coverage Determinations Manual*. These transmittals are available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3096CP.pdf>, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R196BP.pdf>, and <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R176NCD.pdf>, respectively.

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](http://www.cms.gov/MLNNetwork/MLNMattersArticles/index.html) under - How Does It Work.

MLN Matters[®] Number: MM8881

Related Change Request (CR) #: CR 8881

Related CR Release Date: October 17, 2014

Effective Date: January 27, 2014

Related CR Transmittal #: R3096CP, R176NCD, and R196BP

Implementation Date: November 18, 2014

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IDE

From previous page

Medicare claims for routine care items and services related to category A or B IDE studies and category B IDE devices should be submitted to MACs that will identify routine costs for which Medicare payment is made for each related claim.

Note: IDE studies approved by MACs prior to January 1, 2015, will continue to be administered by the MAC. Study sponsors do not have to submit the protocol to CMS if the participating study investigator sites have already received approval from their MAC. Study sponsors should continue to follow the process established by the MAC for any site additions or protocol changes.

Additional information

The official instruction, CR 8921, issued to your MAC regarding this change, via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3105CP.pdf>. The second updates the *Medicare Benefit Policy Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R198BP.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> under - How Does It Work.



MLN Matters® Number: MM8921
Related Change Request (CR) #: CR 8921
Related CR Release Date: November 6, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3105CP and R198BP
Implementation Date: January 5, 2015

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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.

Revised form to reassign Medicare benefits (CMS-855R)

Provider types affected

This *MLN Matters*[®] special edition (SE) is intended for physicians, non-physician practitioners, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) and who choose to reassign their benefits or accept reassigned benefits of those claims.

Provider action needed

Stop – impact to you

Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS-855R (Reassignment of Benefits) application, beginning June 1, 2015.

Caution – what you need to know

The revised CMS-855R application will be available for use on the CMS.gov website as of December 29, 2014. MACs may accept both the current and revised versions of the CMS-855R through May 31, 2015, after which the revised CMS-855R application will be required to be submitted.

After May 31, 2015, MACs will return any newly submitted CMS-855R applications on the previous version (07/11) to the provider/supplier with a letter explaining that the CMS-855R has been updated and the current version of the CMS-855R (11/12) must be submitted.

Go – what you need to do

Make sure your billing staffs are aware of these changes.

Background

Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS-855R application starting June 1, 2015. The revised CMS-855R has been streamlined and some sections have been re-ordered for clarity. The revised form includes an optional section for primary practice location address. This information is shared with other programs such as “Physician Compare” to help beneficiaries identify where their physicians are primarily practicing. This address must be one that is affiliated with the individual/organization where the benefits are being reassigned.

Additional information

Visit the “Medicare Provider Supplier Enrollment” Web page for more information about Medicare enrollment, available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>.

MLN Matters[®] Number: SE1432

Related Change Request (CR) #: NA

Related CR Release Date: N/A

Effective Date: June 1, 2015

Related CR Transmittal #: N/A

Implementation Date: May 31, 2015

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.

Demand letters for polysomnography claims

In June, Medicare administrative contractors (MACs) began to demand and recover what the Centers for Medicare & Medicaid Services (CMS) initially considered to be identified overpayments associated with an Office of Inspector General study on polysomnography claims.

In August, this activity was suspended. Providers should not appeal these overpayments, as all claim denials will be reversed. Any recouped money will be refunded, including interest. No action is required by providers.

Get ready for ICD-10

On October 1, 2015, the health care industry will transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures.

This transition is going to change how you do business—from registration and referrals to superbills and software upgrades. But that change doesn't have to be overwhelming.

The Centers for Medicare & Medicaid Services has the following resources to help your practice prepare for the transition.

Online ICD-10 guide

ICD-10 basics for large medical practices



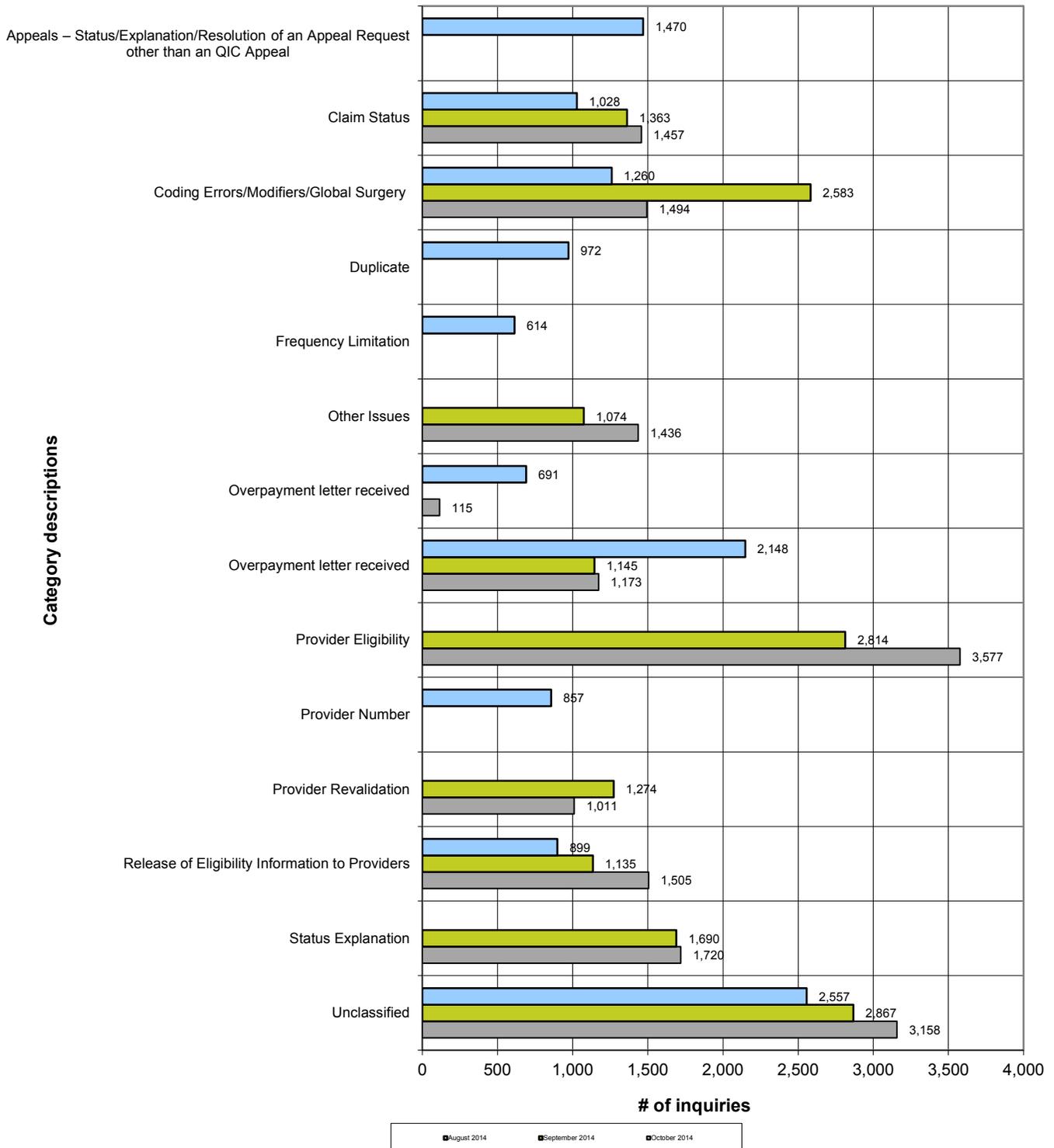
Claims and Inquiry Summary Data

Top inquiries, rejects, and return unprocessable claims

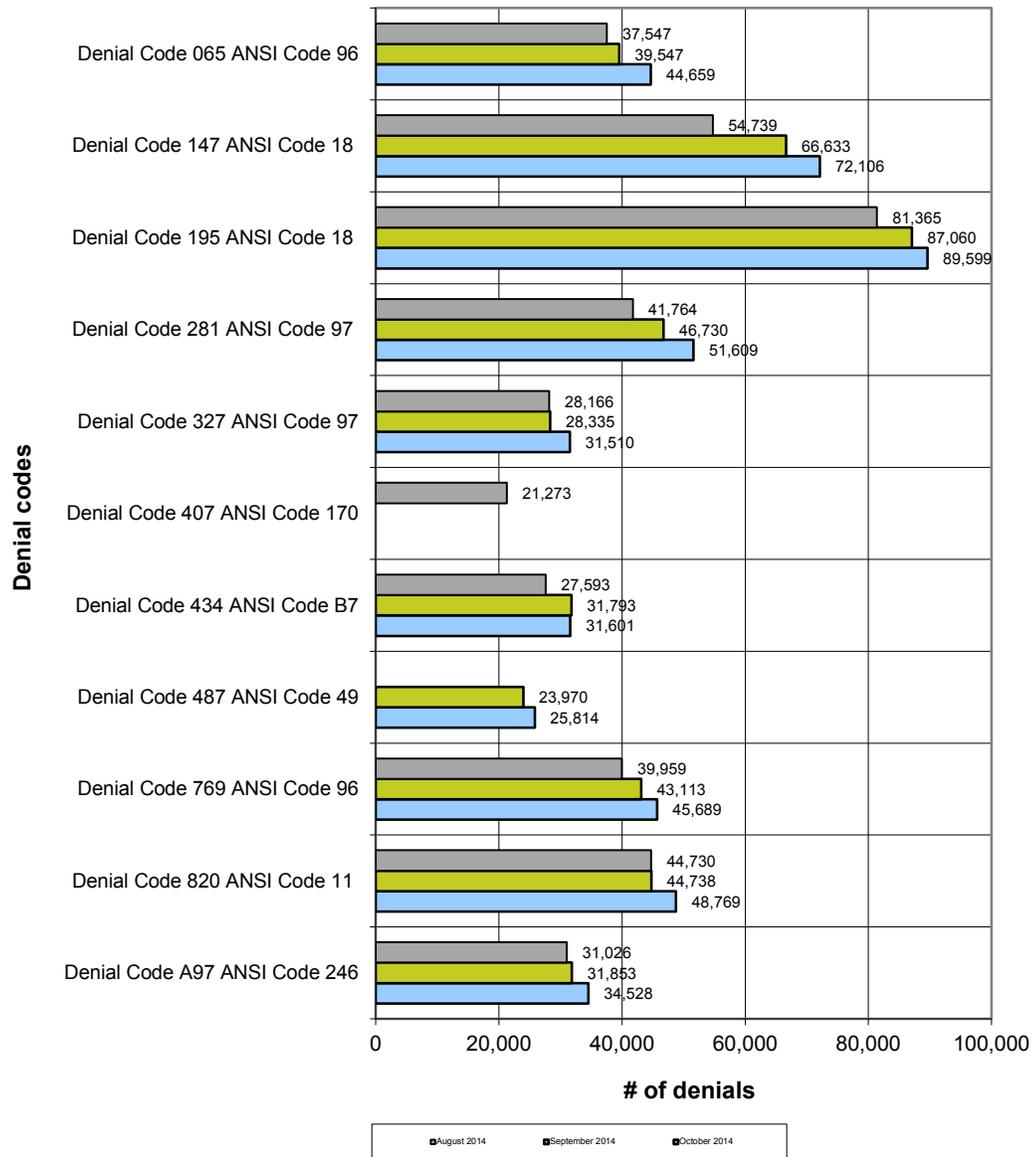
The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands August-October 2014.

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 August-October 2014



Part B top denials for August-October 2014



Use self-service resources to assist with and avoid claim denials

Before contacting customer service, check claim status through the SPOT (Secure Provider Online Tool) or the Part B interactive voice response (IVR) system. The SPOT and 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.

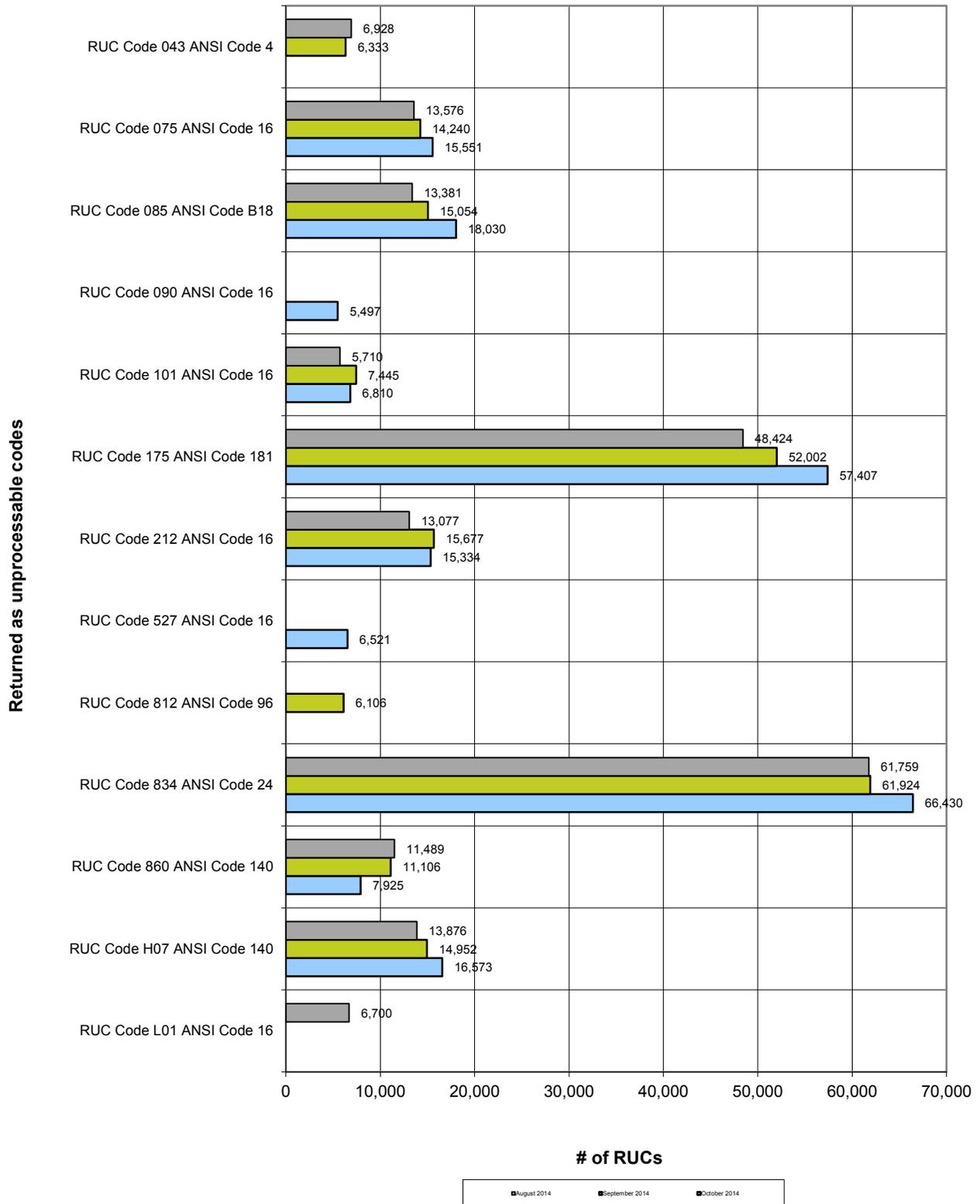
For assistance with denied claims and how to correct them, the following frequently asked questions are

available the First Coast Medicare provider website:

- [Claims completion](#)
- [Denials](#)
- [Billing issues](#)
- [Unprocessable claims](#)

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

Part B top return as unprocessable claims for August-October 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.*

Revised LCD

Noncovered services– revision to the Part B LCD

LCD ID number: L29288 (Florida)

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

Based on change request (CR) 5432, *Current Procedural technology (CPT®)* code 37799 (stenting of the vertebral and cerebral arteries) was removed from the “Unlisted Procedure Codes-Procedures” section of the LCD. Also, *CPT®* code 37799 (percutaneous transluminal angioplasty [PTA] of the vertebral and cerebral arteries) was removed from the “Procedures” section of the LCD “Coding Guidelines” attachment.

Effective date

This LCD/“Coding Guidelines” attachment revision is effective for claims processed **on or after November 3, 2014**, for services rendered **on or after November 6, 2006**.

Based on CR 6185, *CPT®* codes 0052T (*Replacement or repair of thoracic unit of a total replacement heart*

system [artificial heart]) and 0053T (*Replacement or repair of implantable component or components of total replacement heart system (artificial heart), excluding thoracic unit*) were removed from the “Devices” section of the LCD “Coding Guidelines” attachment.

Effective date

This LCD “Coding Guidelines” attachment revision is effective for claims processed **on or after November 3, 2014**, for services rendered **on or after May 1, 2008**.

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](#).

Paclitaxel (Taxol®) – revision to the Part B LCD

LCD ID number: L29249 (Florida)

LCD ID number: L29460 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for paclitaxel (Taxol®) has been revised based on a reconsideration request. Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, for off-labeled indications, anaplastic thyroid carcinoma was added. Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, ICD-9-CM code 193 (Malignant neoplasm of thyroid gland) was added. In addition, the “Sources of Information and Basis for

Decision” section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after November 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, please [click here](#).

Visual field examination – revision to the Part B LCD

LCD ID number: L29308 (Florida)

LCD ID number: L29487 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for visual field examination was revised based on the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Edits, Chapter XI, medically unlikely edits. The “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD was updated. Additionally, a “Coding Guideline” has been developed and attached to the LCD.

Effective date

This LCD revision is effective 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, please [click here](#).

Additional Information**J3590/C9399 Vimizim™ (elosulfase alfa)**

Vimizim™ (elosulfase alfa) injection, for intravenous use is a hydrolytic lysosomal glycosaminoglycan (GAG) specific enzyme indicated for patients with Mucopolysaccharidosis type IVA (MPS IVA: Morquio A syndrome). Vimizim™ was approved by the Food and Drug Administration (FDA) February 14, 2014.

Vimizim™ is supplied as a concentrated solution for infusion in a 5mg/5ml (1mg/mL) single-use vial requiring dilution. As approved by the FDA the recommended dose is 2mg per kg administered intravenously over a minimum range of 3.5 to 4.5 hours, based on infusion volume, once every week. Pre-treatment with antihistamines with or

without antipyretics is recommended 30-60 minutes prior to the start of the infusion.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The patient's medical record must also support the diagnosis of Mucopolysaccharidosis, type IVA (MPS IVA; Morquio A syndrome using the appropriate ICD-9-CM code(s) of 277.5 (Mucopolysaccharidosis) and FDA guidance for use as well as the administration.

Alprolix™ [Coagulation Factor IX (Recombinant), Fc Fusion Protein]

Alprolix™ [Coagulation Factor IX (Recombinant), Fc Fusion Protein] Lyophilized powder for solution for intravenous injection is a recombinant DNA derived, coagulation Factor IX concentrate indicated in adults and children with hemophilia B for: control and prevention of bleeding episodes, perioperative management, and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. Alprolix™ was approved by the Food and Drug Administration (FDA) on March 28, 2014.

Alprolix™ is supplied as a lyophilized powder in a single use vial containing nominally 500, 1000, 2000, or 3000 international units (IU.). As approved by the FDA the recommended dose and duration of treatment depend on

the severity of the Factor XI deficiency, the location and extent of bleeding, and the patient's clinical condition.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The patient's medical record must support the diagnosis hemophilia B disorder using the appropriate ICD-9-CM code 286.1 (congenital L factor XI disorder), when provided by a supplier a valid prescription, a valid invoice, shipment ticket and FDA guidance for use as well as the administration.

Cyramza™ (ramucirumab) injection

Cyramza™ (ramucirumab) injection, for intravenous use is a human vascular endothelial growth factor receptor 2 (VEGFR2) antagonist indicated for the treatment of advanced gastric cancer or gastro-esophageal junction adenocarcinoma, as a single agent after fluoropyrimidine or platinum-containing chemotherapy. Cyramza™ was approved by the Food and Drug Administration (FDA) April 21, 2014.

Cyramza™ is supplied in a single-dose vial as a sterile, preservative-free solution as a concentrated solution for infusion in a 5mg/5ml (1mg / mL) single-use vial requiring dilution. As approved by the FDA the recommended dose is eight mg/kg every two weeks administered as an intravenous infusion over 60-minutes.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly document the patient's prior chemotherapy regimens and must also support the diagnosis of advanced gastric cancer or gastro-esophageal junction adenocarcinoma using the appropriate ICD-9-CM code(s) of 150.0-150.9 (Malignant neoplasm of esophagus), 151.0-151.9 (Malignant neoplasm of stomach), 235.5 (Other and unspecified digestive organs) and FDA guidance for use as well as the administration.

Eloctate™ Antihemophilic Factor (Recombinant), Fc Fusion Protein

Eloctate™, Antihemophilic factor (Recombinant) Fc Fusion Protein, Lyophilized powder for solution for intravenous injection is a recombinant DNA derived, Antihemophilic factor indicated for use in adults and children with hemophilia A (congenital factor VIII deficiency) for: Control and prevention of bleeding episodes; perioperative management and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. Eloctate™ is not indicated for the treatment von Willebrand disease.

Eloctate™ was approved by the Food and Drug Administration (FDA) June 6, 2014.

Eloctate™ is supplied as a lyophilized powder in single use vials of containing nominally, 250, 200, 1000, 1500, 2000, and 3000 international units pf Factor VIII potency. As approved by the FDA the recommended dose and

duration of treatment depend on the severity of the Factor VIII deficiency, the location and extent of bleeding, and the patient's clinical condition. Careful monitoring and replacement therapy is necessary in cases of major surgery or life-threatening bleeding episodes.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The patient's medical record must support the diagnosis of congenital factor VIII deficiency using the appropriate ICD-9-CM code 286.0. (Congenital deficiency of other clotting factors), when provided by a supplier a valid prescription, a valid invoice, shipment ticket and FDA guidance for use as well as the administration.

Entyvio™ (vedolizumab) injection

Entyvio™ (vedolizumab) injection, for intravenous use is an integrin receptor antagonist indicated for the treatment of adult patients with moderately to severely active ulcerative colitis (UC) who have had an inadequate response with, lost response to, or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator; or had an inadequate response with, were intolerant to, or demonstrated dependence or corticosteroids:

- Inducing and maintaining clinical response
- Inducing and maintaining clinical remission
- Improving endoscopic appearance of the mucosa
- Achieving corticosteroid-free remission

Entyvio™ is also indicated for treatment of adult patients with moderately to severely active Crohn's disease (CD) who have had an inadequate response with, lost response to, or were intolerant to a TNF blocker or immunomodulator; or had an inadequate response with, were intolerant to; or demonstrated dependence on corticosteroids:

- Achieving clinical response
- Achieving clinical remission
- Achieving corticosteroids-free remission



Entyvio™ was approved by the Food and Drug Administration (FDA) May 20, 2014.

Entyvio™ is supplied in sterile 20 mL single-use glass vials, containing 300mg of vedolizumab as a white to off-white cake. As approved by the FDA the recommended dose in patients with ulcerative colitis and Crohn's disease is 300 mg infused intravenously over approximately 30 minutes at zero, two, and six weeks, then every eight weeks thereafter. Entyvio™ should be discontinued in patients who do not show evidence of therapeutic benefit by week 14.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly document the patient's inadequate response, loss of response or intolerant to a TNF blocker

or immunomodulator or had an inadequate response, intolerance or demonstrated dependence on corticosteroids. The medical record must clearly document evidence that the patients has had therapeutic benefit the record must also support the diagnosis of UC or CD .a (using the appropriate ICD-9-CM code(s) of 556.0-556.3 or 556.5-556.9 (Ulcerative colitis), 555.0-555.9 (Regional enteritis) and FDA guidance for use as well as the administration.

Novoeight[®], Antihemophilic Factor (Recombinant)

Novoeight[®], Antihemophilic factor (Recombinant), Lyophilized powder for solution for intravenous injection is indicated for use in adults and children with hemophilia A (congenital factor VIII deficiency or classic hemophilia) for: Control and prevention of bleeding episodes; perioperative management and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. Novoeight[®] is not indicated for the treatment von Willebrand's disease.

Novoeight[®] was approved by the Food and Drug Administration (FDA) October 15, 2013.

Novoeight[®] is supplied as a lyophilized powder in single use vials of 250, 200, 1000, 1500, 2000, and 3000 international units. As approved by the FDA the recommended dose is determined using the following formula: Dosage required (IU)= body weight(kg) x desired

factor VIII increase (IU/dl or percent normal) x 0.5 (IU/dl). Frequency of Novoeight[®] administration is determined by the type of bleeding episode and recommendation of the treating physician.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The patient's medical record must support the diagnosis of congenital factor VIII deficiency using the appropriate ICD-9-CM code 286.0 (Congenital deficiency of other clotting factors), when provided by a supplier a valid prescription, a valid invoice, shipment ticket and FDA guidance for use as well as the administration.

Tretten[®], Coagulation Factor XIII A-Subunit (Recombinant)

Tretten[®], [Coagulation Factor XIII A-Subunit (Recombinant), Lyophilized powder for solution for intravenous injection is indicated for routine prophylaxis of bleeding in patients with congenital factor XIII-A-Subunit deficiency.

Tretten[®] was approved by the Food and Drug Administration (FDA) December 24, 2013.

Tretten[®] is supplied as a lyophilized powder in a single use vial along with the diluent (Sterile Water for injection) vial. As approved by the FDA the recommended doses 35 international units per kilogram body weight once monthly

to achieve target trough level of FXIII activity at or above 10 percent using a validated assay.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The patient's medical record must support the diagnosis of congenital factor XIII A-Subunit deficiency using the appropriate ICD-9-CM code 286.3 and FDA guidance for use as well as the administration.

Sylvant[™] (siltuximab) injection

Sylvant[™] (siltuximab) injection, for intravenous use is an interleukin-6 (IL-6) antagonist indicated for the treatment of patients with multicentric Castleman's disease (MCD) who is human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV) negative. Sylvant[™] was approved by the Food and Drug Administration (FDA) April 22, 2014.

Sylvant[™] is supplied in a single-use vial containing 100mg or 400mg of lyophilized powder. As approved by the FDA the recommended dose is 11mg/kg given over one hour by intravenous infusion every three weeks until treatment failure.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting.

The medical record must clearly document the patient's HIV and HHV-8 status; the medical record must include the patient's hematology laboratory test for the first 12 months of treatment and every three dosing cycles thereafter. The record must also support the diagnosis of Multicentric Castleman's disease using the appropriate ICD-9-CM code(s) of 785.6 (Enlargement of lymph nodes), 229.0 (Benign neoplasm of other and unspecified sites) 238.79 (Other lymphatic and hematopoietic tissues) and FDA guidance for use as well as the administration.



Upcoming provider outreach and educational events

File form faster on the ‘SPOT’ webcast

When: Tuesday, December 16

Time: 11:30 a.m.-1:00 p.m. **Type of event:** Webcast

<http://medicare.fcso.com/Events/276321.asp>

Medicare “ACT-the-Contractor” teleconference (ACT): Subsets of modifier 59 New specific modifiers for distinct procedural services

When: Thursday, December 18

Time: 11:30 a.m. -1:00 p.m. **Type of event:** Webcast

<http://medicare.fcso.com/Events/274441.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.fcsoniversity.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.



MLN Connects™ Provider eNews for October 23, 2014

MLN Connects™ Provider eNews for October 23, 2014

[View this edition as a PDF](#)

In this edition:

MLN Connects™ National Provider Calls

- CMS 2014 Certified EHR Technology Flexibility Rule – Last Chance to Register
- Transitioning to ICD-10 – Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

CMS Events

- Webinar for Comparative Billing Report on Podiatry: Debridement of Ulcers and Wounds

Announcements

- Protect Your Patients Against Influenza and Pneumonia
- Updated CDC Resource Available on Ebola
- New Affordable Care Act Initiative to Support Care Coordination Nationwide
- Extension of Shared Savings Program Fraud and Abuse Waivers Interim Final Rule
- IRF Quality Reporting Program: NHSN Quality Data Submission Deadline Extended to November 15
- LTCH Quality Reporting Program: NHSN Quality Data Submission Deadline Extended to November 15
- Open Payments Search Tool Now Available
- Open Payments: Start Preparing for the 2014

Reporting Year

- Comparative Billing Report on Podiatry: Debridement of Ulcers and Wounds
- EHR Incentive Programs: Protect Electronic Health Information Core Objective?

Claims, Pricers, and Codes

- FQHC PPS Issue with Claims Containing Both Preventive and Non-Preventive Services
- Hold on FQHC Medicare Advantage PPS Claims – Update
- Use of HCPCS X Modifiers for Distinct Procedural Services
- Mass Adjustment of Selected SNF Inpatient Claims
- October 2014 Outpatient Prospective Payment System Pricer File Update



Medicare Learning Network® Educational Products

- “Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 1]” Educational Tool – Released
- Medicare Learning Network® Web-Based Training Programs
- Updated MLN Matters® Search Indices

MLN Connects™ Provider eNews for October 30, 2014

MLN Connects™ Provider eNews for October 30, 2014

[View this edition as a PDF](#)

In this edition:

MLN Connects™ National Provider Calls

- Transitioning to ICD-10 – Register Now

Announcements

- HHS Secretary Announces \$840 Million Initiative to Improve Patient Care and Lower Costs
- Hospital Appeals Settlement: Act by October 31
- Get Ready for DMEPOS Competitive Bidding
- SNF PPS Payment Reform Research Project
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Third Quarter Hospice Item Set Question and Answer Document Available
- EHR Incentive Program: Hardship Exception Applications Due November 30
- PQRS: Submission Engine Validation Tool is Now Available for Testing

MLN Connects™ Provider eNews for November 6, 2014

MLN Connects™ Provider eNews for November 6, 2014

[View this edition as a PDF](#)

In this edition:

MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Registration Opening Soon
- National Partnership to Improve Dementia Care in Nursing Homes – Registration Now Open
- Certifying Patients for the Medicare Home Health Benefit – Registration Opening Soon

MLN Connects™ Videos

- Monthly Spotlight: Medicare Preventive Services

Announcements

- CY 2015 Policy and Payment Changes to the Medicare Physician Fee Schedule
- CY 2015 Policy and Payment Changes for ESRD Facilities and Implementation of Competitive Bidding-Based Prices for DMEPOS
- CY 2015 Payment and Policy Changes for Hospital Outpatient and Ambulatory Surgical Centers
- CY 2015 Payment Changes for Medicare Home Health

Claims, Pricers, and Codes

- Physicians, Providers, and Suppliers Must Use Revised CMS 855R Starting May 31
- Demand Letters for Polysomnography Claims

Medicare Learning Network® Educational Products

- “ICD-10-CM/PCS Billing and Payment Frequently Asked Questions” – Revised
- “ICD-10-CM/PCS The Next Generation of Coding” – Revised
- “ICD-10-CM/PCS Myths and Facts” – Revised
- “ICD-10-CM Classification Enhancements” – Revised
- “General Equivalence Mappings Frequently Asked Questions” – Revised
- Medicare Learning Network® Web-Based Training Course with Continuing Education Credits
- Medicare Learning Network® Products Available in Electronic Publication Format

Agencies

- Raising Awareness of Diabetes in November
- Final Rule Changes for Open Payments
- Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the Affordable Care Act
- CMS is Accepting Suggestions for Potential PQRS Measures
- Comparative Billing Report on Modifier 25: Family Practice

Claims, Pricers, and Codes

- Physicians, Providers, and Suppliers Must Use Revised CMS 855R Starting May 31
- Demand Letters for Polysomnography Claims

Medicare Learning Network® Educational Products

- “Medicare Appeals Process” Podcast – New
- “Skilled Nursing Facility Prospective Payment System” Fact Sheet – Revised
- “Inpatient Rehabilitation Facility Prospective Payment System” Fact Sheet – Revised
- Medicare Learning Network® Products Available in Electronic Publication Format

MLN Connects™ Provider eNews for November 13, 2014

MLN Connects™ Provider eNews for November 13, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Registration Now Open
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Certifying Patients for the Medicare Home Health Benefit – Registration Now Open
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

CMS Events

- Participate in ICD-10 Acknowledgement Testing Week: November 17 through 21, 2014

Announcements

- Recognizing Lung Cancer Awareness Month and the Great American Smokeout
- Dialysis Facility Compare Star Ratings and Data Release for January 2015
- Coverage of Speech Generating Devices
- Clinical Laboratory Improvement Amendments Proposed Rule
- PQRS Negative Payment Adjustment
- FY 2016 IRF Quality Reporting Program Submission Deadline: November 15
- FY 2016 LTCH Quality Reporting Program Submission Deadline: November 15
- OASIS Updates for Home Health Agencies
- Get Ready for DMEPOS Competitive Bidding
- EHR Incentive Program: Deadlines for 2014 Hospital Reporting on November 30
- Changes to Medicare EHR Incentive Program Hardship Exceptions



- ICD-10 Resources for Small Physician Practices on Medscape

Claims, Pricers, and Codes

- ICD-10 MS-DRG v32 Definitions Manual and Medicare Code Editor Files Available
- 2015 HCPCS Annual Update
- Acute Inpatient PPS FY 2015.2 Software Release Available
- FDG PET for Solid Tumors: Claims Hold Extension

Medicare Learning Network® Educational Products

- “Safeguarding Your Medical Identity” Web-Based Training Course – Revised
- “Medicare Enrollment and Claim Submission Guidelines” Booklet – Revised
- “Medicaid Program Integrity: Understanding and Preventing Provider Medical Identity Theft” Booklet – Revised
- “Medicaid Program Integrity: Preventing Provider Medical Identity Theft” Fact Sheet – Revised
- “Medicaid Program Integrity: Safeguarding Your Medical Identity Using Continuing Medical Education (CME)” Educational Tool – Revised
- Medicare Learning Network® Products Available in Electronic Publication Format

Phone numbers

Customer service

866-454-9007
877-660-1759 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

866-454-9007
877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

866-454-9007
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 2537
Jacksonville, FL 32231-2537

Redeterminations

Medicare Part B Redetermination
P.O. Box 2360
Jacksonville, FL 32231-0018

Redetermination of overpayments

Overpayment Redetermination, Review Request
P.O. Box 45248
Jacksonville, FL 32232-5248

Reconsiderations

Q2 Administrators, LLC
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

General inquiry request
P.O. Box 2360
Jacksonville, FL 32231-2537

Email: FloridaB@fcsso.com
Online form: <http://medicare.fcsso.com/Feedback/161670.asp>

Provider enrollment

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

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 44141
Jacksonville, FL 32231-4141

Medicare Education and Outreach

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

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Florida
P.O. Box 2078
Jacksonville, FL 32231-2078

Overnight mail and/or special courier service

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

Websites

Provider

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

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services
<http://www.cms.gov>

First Coast University
<http://www.fcsouniversity.com/>

Beneficiaries

Centers for Medicare & Medicaid Services
<http://www.medicare.gov>

Phone numbers

Customer service

866-454-9007
877-660-1759 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

866-454-9007
877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 2525
Jacksonville, FL 32231-0019

Redeterminations

Medicare Part B Redetermination
P.O. Box 45013
Jacksonville, FL 32232-5024

Redetermination of overpayments

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

Reconsiderations

Q2 Administrators, LLC
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

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

Email: askFloridaB@fcsso.com

Online form: <http://medicare.fcsso.com/Feedback/161670.asp>

Provider enrollment

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

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 44141
Jacksonville, FL 32231-4141

Medicare Education and Outreach

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

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

Special courier service

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

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor

<http://medicare.fcsso.com>

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services

<http://www.cms.gov>

First Coast University

<http://www.fcsouniversity.com/>

Beneficiaries

Centers for Medicare & Medicaid Services

<http://www.medicare.gov>

Phone numbers

Customer service

1-877-715-1921
1-888-216-8261 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)
904-361-0407 (FAX)

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

877-715-1921
877-660-1759 (TTY)

General inquiries

877-715-1921
888-216-8261 (TTY)

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

877-715-1921
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 2525
Jacksonville, FL 32231-0019

Redeterminations

Medicare Part B Redetermination
P.O. Box 45056
Jacksonville, FL 32232-5056

Redetermination of overpayments

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

Reconsiderations

Q2 Administrators, LLC
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

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

Email: askFloridaB@fcsso.com
Online form: <http://medicare.fcsso.com/Feedback/161670.asp>

Provider enrollment

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

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 45040
Jacksonville, FL 32231-5040

Medicare Education and Outreach

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

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Puerto Rico
P.O. Box 45092
Jacksonville, FL 32231-5092

Special courier service

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

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor
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Centers for Medicare & Medicaid Services
<http://www.cms.gov>

First Coast University
<http://www.fcsouniversity.com/>

Beneficiaries

Centers for Medicare & Medicaid Services
<http://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.

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<i>Please write legibly</i>			Subtotal	\$
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