Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers December 2013

In this issue

The SPOT does heavy lifting for physical therapy practices

Changes in Medicare coverage policy, while they protect the Medicare trust fund and promote better services for beneficiaries, can sometimes create backaches for medical office practices.

For physical therapy providers, recent policy updates such as therapy caps place providers at risk for thousands of dollars in claims when beneficiaries exceed cap limits.

To help health providers stay current on patient eligibility and other benefit information, First Coast Service Options created the **Secure Provider Online Tool (the SPOT)**.

"For many physical therapist practices in Florida, Medicare is everything. And using **the SPOT** greatly helps offices streamline their processes, particularly with eligibility and benefit verification," said Linda Zane, President, Physical Therapy Provider Network of Florida, a network of more than 150 independent rehabilitation providers in 40 Florida cities.

"My experience **with SPOT** is that it is saving me tons of time and resources. The IVR (interactive voice response system) is labor-intensive and requires a detailed script. Thanks to **the SPOT**, I no longer need a highly trained Medicare billing manager to handle eligibility look-ups, someone at the front desk can handle this with a simple set of instructions."

"SPOT is amazing because you have given us a tool which the entry level employee can use easily and has a major positive impact on our business"

– Linda Zane, President, Physical Therapy Provider Network of Florida

Linda Zane, (left) and Dr. Ira Fiebert, co-founded the Physical Therapy Institute in Palm Beach County in 1987.

Among the useful tools for physical therapy providers, **the SPOT** offers subsections which display occupational, physical, and speech therapy cap information. The

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

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

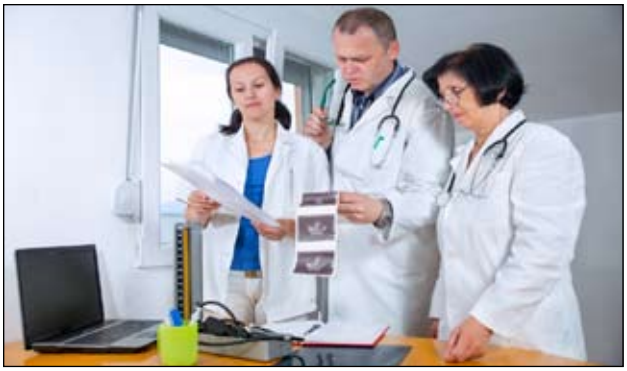
About the *Medicare B Connection*

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

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

Who receives the Connection

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



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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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

In addition to the above, other sections include:

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

The *Medicare B Connection* represents formal notice of coverage policies

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

Advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Quarterly update to the correct coding initiative edits, version 20.1

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8298 which informs Medicare contractors about the release of the latest package of CCI edits, version 20.1, which will be effective April 1, 2014. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the National CCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology* manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

Version 20.1 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: column 1/column 2 correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two-practitioner NCCI edit files and the two NCCI edit files used for needs defined (OCE). It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits. CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correctdCoding edit file on each website. The edits previously contained in the mutually exclusive edit file are **not** being deleted but are being moved to the column one/column two correct coding edit file.

Additional information

The official instruction, CR 8511 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2830CP.pdf*.

Additional information on the CCI edits is available at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

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

MLN Matters® Number: MM8511
Related Change Request (CR) #: CR 8511
Related CR Release Date: November 29, 2013
Effective Date: April 1, 2014
Related CR Transmittal #: R2830CP
Implementation Date: April 7, 2014

Quarterly update to the correct coding initiative edits, version 20.0

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8477 which informs Medicare contractors about the release of the latest package of national CCI (NCCI) edits, version 20.0, effective January 1, 2014. See the *Background* and *Additional information* sections of this article for further details regarding these changes, and make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the NCCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology* manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of CCI edits, version 20.0, effective January 1, 2014, will be available via the CMS Data Center (CDC). A test file will be available on or about November 2, 2013, and a final file will be available on or about November 17, 2013.

Version 20.0 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: column one/column two, correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits.

CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file on each website.

Note: The edits previously contained in the mutually exclusive edit file are **not** being deleted but are being moved to the column one/column two correct coding edit file.

Additional information

The official instruction, CR 8477 issued to your carriers and Part B MACs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2817CP.pdf*.

For more information, visit the CMS NCCI Web page at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

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

MLN Matters® Number: MM8477
Related Change Request (CR) #: CR 8477
Related CR Release Date: November 15, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2817CP
Implementation Date: January 6, 2014

Consolidated Billing

New therapy and speech evaluation codes added to home health consolidated billing

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8539, which provides the annual update to home health (HH) consolidated billing effective for dates of service on or after April 1, 2014. The new codes were effective January 1, 2014, but were overlooked and a 2014 annual HH consolidated billing update was not published. The following of Healthcare Common Procedure Coding System (HCPCS) codes are added to the HH consolidated billing non-routine supply code list:

- A7047 Oral interface used with respiratory suction pump, each
- A6531 Gradient compression stocking, below knee, 30-40 MMHG, each
- A6532 Gradient compression stocking, below knee, 40-50 MMHG, each

Note that A7047 is a new HCPCS code in 2014. Codes A6531 and A6532 are existing codes added due to their similarity to code A6545, which has been subject to HH consolidated billing since 2009. The following HCPCS codes are added to the HH consolidated billing therapy code list:

- *92521 Evaluation of speech fluency (eg, stuttering, cluttering)*
- *92522 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)*
- *92523 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (eg, receptive and expressive language)*
- *92524 Behavioral and qualitative analysis of voice and resonance*

These four new speech evaluation codes replace code *92506*. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to MACs will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

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Consolidated *(continued)*

Additional information

The official instruction, CR 8539, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2835CP.pdf*.

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

MLN Matters® Number: MM8539
Related Change Request (CR) #: CR 8539
Related CR Release Date: December 13, 2013
Effective Date: April 1, 2014
Related CR Transmittal #: R2835CP
Implementation Date: April 7, 2014

Drugs and Biologicals

New influenza virus vaccine code

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers, including hospitals, home health agencies, and hospices submitting claims to Medicare contractors (carriers, Medicare administrative contractors (A/B MACs), regional home health intermediaries (RHHIs), and home health & hospice Medicare administrative contractors (HH&H MACs) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8473, from which this article is taken, provides instructions for updating payment and common working file (CWF) edits to include influenza virus vaccine *Common Procedural Terminology* (*CPT*®) code *90673* (*Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutnin (HA) protein only, preservative and antibiotic free, for intramuscular use*), for claims with dates of service on or after January 1, 2014, that are processed on or after April 1, 2014. CR 8473 also corrects the effective date of code Q2033 from January 1, 2013, to July 1, 2013. You should ensure that your billing staffs are aware of these code changes.

Background

CR 8473, from which this article is taken, provides that (effective for claims with dates of service on or after January 1, 2014) Medicare will pay for vaccine *CPT*® code *90673* (*Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutnin (HA) protein only, preservative and antibiotic free, for intramuscular use*). All physicians, non-physicians practitioners and suppliers who administer the influenza virus vaccination must take assignment on the claim for the vaccine.

Your Medicare contractor will add influenza virus vaccine *CPT*® code *90673* to existing influenza virus vaccine edits and accept it for claims with dates of service on or after January 1, 2014.

Effective for dates of service on and after January 1, 2014, they will:

- Use the Medicare Part B payment limit for influenza virus vaccine *CPT*® code *90673* according to the April 2014 Part B drug pricing file; and
- Pay for vaccine code *90673* as follows:
  1. Hospitals – types of bill (TOB 12x and 13x), skilled nursing facilities (TOB 22x and 23x), home health agencies (TOB 34x), hospital-

(continued on next page)

Influenza *(continued)*

based renal dialysis facilities (TOB 72x), and critical access hospitals (TOB 85x) based on reasonable cost;

2. Indian health service (IHS) hospitals (TOB 12x and 13x) and IHS CAHs (TOB 85x) based on the lower of the actual charge or 95 percent of the average wholesale price (AWP); and

Comprehensive outpatient rehabilitation facility (TOB 75x) and independent RDFs (TOB 72x) based on the lower of actual charge or 95 percent of the AWP.

Note: In all of the above instances, annual Part B deductible and coinsurance do not apply.

In addition, (effective for dates of service between January 1, 2014, and March 31, 2014) your Medicare contractor:

- Will use local pricing guidelines to determine payment rates for influenza virus vaccine *CPT*® code *90673*; and
- Until systems changes are implemented, will hold institutional claims containing *CPT*® code *90673* (with dates of service on or after January 1, 2014) that they receive before April 1, 2014. Once the system changes described in CR 8473 are implemented, these claims will be released for processing.

Additional information

The official instruction, CR 8473, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2824CP.pdf*.

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

MLN Matters® Number: MM8473
Related Change Request (CR) #: CR 8473
Related CR Release Date: November 22, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2824CP
Implementation Date: April 7, 2014

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

Durable Medical Equipment

2014 DMEPOS fee schedule update

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8531 to advise providers of the 2014 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Make sure your staffs are aware of these updates.

Background and key points of CR 8531

The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The 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*. Payment on a fee schedule basis is required for DME, prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834 (a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN) and splints, casts, and certain intraocular lenses.

Fee schedule files

The DMEPOS fee schedule file will also be available for providers and suppliers, as well as state Medicaid agencies, managed care organizations, and other interested parties at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/*.

Healthcare Common Procedure Coding System (HCPCS) codes added/deleted

The following new codes are effective January 1, 2014:

- A7047 in the inexpensive/routinely purchased (IN) payment category
- E0766 in the frequently serviced (FS) payment category
- E1352

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DMEPOS *(continued)*

The following new codes are in the prosthetics and orthotics (PO) payment category: L5969, L8679, L0455, L0457, L0467, L0469, L0641-L0643, L0648-L0651, L1812, L1833, L1848, L3678, L3809, L3916, L3918, L3924, L3930, L4361, L4387, and L4397.

The following codes are deleted as of January 1, 2014: A4611, A4612, A4613, E0457, E0459, L0430, L8685, L8686, L8687, and L8688.

For gap-filling purposes, the 2013 deflation factors by payment category are listed in the following table:

Factor	Category
0.469	Oxygen
0.472	Capped rental
0.473	Prosthetics and orthotics
0.600	Surgical dressings
0.653	Parental and enteral nutrition

Specific coding and pricing issues

As part of this update, fee schedules for the following codes will be added to the DMEPOS fee schedule file effective January 1, 2014:

- A4387 Ostomy Pouch, Closed, With Barrier Attached, With Built-In Convexity, (I Piece), Each
- L3031 Foot, Insert/Plate, Removable, Addition to Lower Extremity Orthotic, High Strength, Lightweight Material, All Hybrid Lamination/ Prepreg Composite, Each

CMS is adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes,A5512 or A5513. To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of 2004. For 2014, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the 2012. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2014.

Off-the-shelf orthotics

Section 1847(a)(2)(C) of the Act mandates implementation of competitive bidding programs throughout the United States for awarding contracts for furnishing off-the-shelf (OTS) orthotics which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual. Regulations at 42 CFR 414.402 define the term “minimal self-adjustment” to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist,an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc, or by the Board for Orthotist/Prosthetist Certificationor an individual who has specialized training.

As shown in the following table, 22 new codes are added to the HCPCS for OTS orthotics. In addition, as part of the review to determine which HCPCS codes for prefabricated orthotics describe OTS orthotics, it was determined that HCPCS codes for prefabricated orthotics describe items that are furnished OTS and items that require expertise in customizing the orthotic to fit the individual patient. Therefore, it was necessary to explode these codes into two sets of codes. One set is the existing codes revised, effective January 1, 2014, to only describe devices customized to fit a specific patient by an individual with expertise and a second set of new codes describing the OTS items.

Also, as shown in the table that follows for 2014, the fee schedule amounts for existing codes will be applied to the corresponding new codes added for the items furnished OTS. 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, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

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DMEPOS *(continued)*

Prefabricated orthotic codes split into two codes, effective January 1, 2014

Fee from existing code	Crosswalk to new OTF and revised custom-fitted orthotic codes
L0454	L0455 and L0454
L0456	L0457 and L0456
L0466	L0467 and L0466
L0468	L0469 and L0468
L0626	L0641 and L0626
L0627	L0642 and L0627
L0630	L0643 and L0630
L0631	L0648 and L0631
L0633	L0649 and L0633
L0637	L0650 and L0637
L0639	L0651 and L0639
L1810	L1812 and L1810
L1832	L1833 and L1832
L1847	L1848 and L1847
L3807	L3809 and L3807
L3915	L3916 and L3915
L3917	L3918 and L3917
L3923	L3924 and L3923
L3929	L3930 and L3929
L4360	L4361 and L4360
L4386	L4387 and L4386
L4396	L4397 and L4396

Further information on the development of new OTS orthotic codes can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html*.

Neurostimulator devices

HCPCS codes, L8685, L8686, L8687, and L8688 are not included on the 2014 DMEPOS fee schedule file. They were removed from the file to reflect the change in the coverage indicators for these codes to invalid for Medicare ("I") effective January 1, 2014. However, code L8679 (Implantable neurostimulator, pulse generator, any type) is added to the HCPCS and DMEPOS fee schedule file, effective January 1, 2014, for billing Medicare claims previously submitted under L8685, L8686, L8687, and L8688. The fee schedule amounts for code L8679 are based on the established Medicare fee schedule amounts for all types of pulse generators under the previous HCPCS code E0756 (Implantable neurostimulator pulse generator), which was discontinued effective December 31, 2005. The payment amount is based on the explosion of code E0756 into four codes for different types of neurostimulator pulse generator systems which were not materially utilized in the Medicare program. As such, payment for code L8679 will revert back to the fee schedule amounts previously established for code E0756.

Diabetic testing supplies

The fee schedule amounts for non-mail order diabetic testing supplies, without KL modifier, for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they are equal to the single payment amounts for mail order diabetic testing supplies (DTS) established in implementing the national mail order Competitive Bidding Program (CBP) under Section 1847 of the Act. The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are recompeted. The national CBP for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016. The program instructions reviewing these changes are transmittal 2709, change request (CR) 8325, dated May 17, 2013, and transmittal 2661, CR 8204, dated February 22, 2013. You may review the following *MLN Matters*® articles for these CRs:

MM8204

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf

MM8325

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for multi-factor productivity (MFP), which results in update of 1.0 percent for 2014. The single payment amount public use file for the national mail order competitive bidding program is available *http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts*.

2014 fee schedule update factor

For 2014, the update factor of 1.0 percent is applied to the applicable 2013 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2014 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2013, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm

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DMEPOS *(continued)*

business multi-factor productivity (MFP).

The MFP adjustment is 0.8 percent and the CPI-U percentage increase is 1.8 percent. Thus, the 1.8 percentage increase in the CPI-U is reduced by the 0.8 percentage increase in the MFP resulting in a net increase of 1.0 percent for the update factor.

2014 update to the labor payment rates

The 2014 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.8 percent effective for claims with dates of service from January 1, 2014, through December 31, 2014 and those rates are as follows:

State	K0739	L4205	L7520	State	K0739	L4205	L7520
AK	$27.40	$31.22	$36.73	**NC**	$14.55	$21.68	$29.43
AL	$14.55	$21.68	$29.43	**ND**	$18.13	$31.16	$36.73
AR	$14.55	$21.68	$29.43	**NE**	$14.55	$21.66	$41.04
AZ	$17.99	$21.66	$36.21	**NH**	$15.62	$21.66	$29.43
CA	$22.32	$35.59	$41.48	**NJ**	$19.63	$21.66	$29.43
CO	$14.55	$21.68	$29.43	**NM**	$14.55	$21.68	$29.43
CT	$24.30	$22.16	$29.43	**NV**	$23.18	$21.66	$40.12
DC	$14.55	$21.66	$29.43	**NY**	$26.79	$21.68	$29.43
DE	$26.79	$21.66	$29.43	**OH**	$14.55	$21.66	$29.43
FL	$14.55	$21.68	$29.43	**OK**	$14.55	$21.68	$29.43
GA	$14.55	$21.68	$29.43	**OR**	$14.55	$21.66	$42.32
HI	$17.99	$31.22	$36.73	**PA**	$15.62	$22.30	$29.43
IA	$14.55	$21.66	$35.23	**PR**	$14.55	$21.68	$29.43
ID	$14.55	$21.66	$29.43	**RI**	$17.34	$22.32	$29.43
IL	$14.55	$21.66	$29.43	**SC**	$14.55	$21.68	$29.43
IN	$14.55	$21.66	$29.43	**SD**	$16.26	$21.66	$39.35
KS	$14.55	$21.66	$36.73	**TN**	$14.55	$21.68	$29.43
KY	$14.55	$27.76	$37.64	**TX**	$14.55	$21.68	$29.43
LA	$14.55	$21.68	$29.43	**UT**	$14.59	$21.66	$45.83
MA	$24.30	$21.66	$29.43	**VA**	$14.55	$21.66	$29.43
MD	$14.55	$21.66	$29.43	**VI**	$14.55	$21.68	$29.43
ME	$24.30	$21.66	$29.43	**VT**	$15.62	$21.66	$29.43
MI	$14.55	$21.66	$29.43	**WA**	$23.18	$31.77	$37.74
MN	$14.55	$21.66	$29.43	**WI**	$14.55	$21.66	$29.43
MO	$14.55	$21.66	$29.43	**WV**	$14.55	$21.66	$29.43
MS	$14.55	$21.68	$29.43	**WY**	$20.28	$28.89	$41.04
MT	$14.55	$21.66	$36.73				

2014 national monthly payment amounts for stationary oxygen equipment

CR 8531 implements the 2014 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2014. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE). The updated 2014 monthly payment amount of $178.24 includes the 1.0 percent update factor for the 2014 DMEPOS fee schedule.

Please note that when updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2014 maintenance and servicing payment amount for certain oxygen equipment

CR 8531 also updates the 2014 payment amount for maintenance and servicing for certain oxygen equipment. You can read more about payment for claims for maintenance and servicing for oxygen equipment in *MLN Matters*® articles,MM6792 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/*

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DMEPOS *(continued)*

MLNMattersArticles/downloads/MM6792.pdf and MM6990 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf*.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the MS modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2013 maintenance and servicing fee is adjusted by the 1 percent MFP-adjusted covered item update factor to yield a 2014 maintenance and servicing fee of $68.73 for oxygen concentrators and transfilling equipment.

Additional information

The official instruction, CR 8531, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2836CP.pdf*.

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

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Related CR Release Date: December 13, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2836CP
Implementation January 6, 2014

Payment calculations for splints, casts, and certain intraocular lenses

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8523 which informs Medicare contractors about the changes in payment basis for splints, casts, and certain intraocular lenses furnished in 2014. Make sure that your billing staffs are aware of these changes.

Background

Payment has been made on a reasonable charge basis for splints and casts, and intraocular lenses (IOLs) inserted in a physician's office with the criteria for determining reasonable charges set forth at 42 CFR part 405, subpart E of CMS regulations. However, Section 1842(s) of the Social Security Act provides the authority for replacing the reasonable charge payment methodology with statewide or other area wide fee schedules to be used for payment for these items. The final rule implementing fee schedules for splints and casts, and IOLs inserted in a physician's office was published December 2, 2013. Effective for dates of service on or after April 1, 2104, payment for splints and casts, and IOLs inserted in a physician's office will be made using national fee schedule amounts, and reasonable charges will no longer be calculated for these items.

For payment of splints and casts furnished from April 1, 2014, through December 31, 2014, regulations at 42 CFR 414.106 require national fee schedules be established based on 2013 reasonable charges updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June 2013. For subsequent years, the fee schedule amounts will be updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period

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IOLs *(continued)*

ending with June of the preceding year, reduced by the productivity adjustment as described in Section 1886(b)(3)(B)(xi)(II) of the Act. The splints and cast Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.

For payment of IOLs inserted in a physician's office furnished from April 1, 2014, through December 31, 2014, regulations at 42 CFR 414.108 require national fee schedules be established based on the national average allowed charge for the item from January 1, 2012, through December 31, 2012, updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 24-month period ending with June 2013. For subsequent years, the fee schedule amounts will be updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment as described in section 1886(b)(3)(B)(xi)(II) of the Act.

The reasonable charge amounts for splints and casts that are effective for dates of service January 1, 2014, through March 31, 2014, are shown in Attachment A of CR 8523, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2837CP.pdf*. MACs will make payment for splints and casts based on the lower of the actual charge or the reasonable charge payment limits established for these codes. Payment will also be made on a reasonable charge basis for IOL codes V2630, V2631, and V2632 that are inserted in a physician's office for dates of service January 1, 2014, through March 31, 2014.

MACs shall use the national fee schedule amounts listed in Attachment B of CR 8523 to pay claims for splints and casts, and IOLs inserted in a physician's office for dates of service from April 1, 2014, through December 31, 2014. Subject to coinsurance and deductibles rules, Medicare payment for these items is to be equal to the lower of the actual charge for the item or the amount determined under the applicable fee schedule payment methodology. Please note that beginning April 1, 2014, the applicable HCPCS codes and the national fee schedule amounts for splints and casts, and IOLs inserted in a physician's office will be included in the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule file. For subsequent calendar years, MACs are to pay claims for splints and casts, and IOLs inserted in a physician's office using the national fee schedule amounts available in the DMEPOS fee schedule file.

Additional information

The official instruction, CR 8523, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2837CP.pdf*.

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

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Implementation Date: January 6, 2014 for payment on a reasonable charge basis and April 7, 2014 for payment on a national fee schedule basis

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Laboratory/Pathology

2014 update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

Provider types affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories who submit claims to Medicare claims administration contractors (carriers, fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8517 which provides instructions for the 2014 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Be sure that your billing staff is aware of these updates.

Background

Updates to fees

In accordance with the Social Security Act (Section 1833(h)(2)(A)(i)), as amended by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Section 628), and further amended by the Affordable Care Act (Section 3401), the annual update to the local clinical laboratory fees for 2014 is (-0.75) percent. The annual update to local clinical laboratory fees for 2014 reflects an additional multi-factor productivity adjustment and a (-1.75) percentage point reduction as described by the Affordable Care Act. The annual update to payments made on a reasonable charge basis for all other laboratory services for 2014 is 1.80 percent (See 42 CFR 405.509(b)(1) at *http://www.ecfr.gov/cgi-bin/text-idx?SID=40538fb2e20d60fb4d4de0ab33d0ca22&node=42:2.0.1.2.5&rgn=div5%2342:2.0.1.2.5.5.25.10*). The Social Security Act Section 1833(a)(1)(D); (see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA).

For a cervical or vaginal smear test (pap smear), the Social Security Act (Section 1833(h)(7)) requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National minimum payment amounts

For a cervical or vaginal smear test (pap smear), the Social Security Act (Section 1833(h)(7)) requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The 2014 national minimum payment amount is $14.42 ($14.53 plus (-0.75) percent update for 2014). The affected codes for the national minimum payment amount are: *88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175*, G0123, G0143, G0144, G0145, G0147, G0148, and P3000.

National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with the Social Security Act (Section 1833(h)(4)(B)(viii)).

Access to data file

The 2014 clinical laboratory fee schedule data file will be retrieved electronically through Centers for Medicare & Medicaid Services (CMS) mainframe telecommunications system. Carriers will retrieve the data file on or after November 19, 2013. Intermediaries will retrieve the data file on or after November 19, 2013. Internet access to the 2014 clinical laboratory fee schedule data file will be available after November 19, 2013, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*.

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Laboratory *(continued)*

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

Data file format

For each test code, if your system retains only the pricing amount, load the data from the field named "60% Pricing Amt." For each test code, if your system has been developed to retain the local fee and the NLA, you may load the data from the fields named "60% Local Fee Amt" and "60% Natl Limit Amt" to determine payment. For test codes for cervical or vaginal smears (pap smears), you should load the data from the field named "60% Pricing Amt" which reflects the lower of the local fee or the NLA, but not less than the national minimum payment amount. Fiscal intermediaries should use the field "62% Pricing Amt" for payment to qualified laboratories of sole community hospitals.

Public comments

On July 10, 2013, CMS hosted a public meeting to solicit input on the payment relationship between 2013 codes and new 2014 *CPT*® codes. Notice of the meeting was published in the *Federal Register* on May 24, 2013 (see *http://www.federalregister.gov/articles/2013/05/24/2013-12225/medicare-program-public-meeting-in-calendar-year-2013-for-new-clinical-laboratory-test-payment*), and on the CMS website approximately June 1, 2013. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Additional written comments from the public were accepted until October 30, 2013. CMS has posted a summary of the public comments and the rationale for the final payment determinations on the CMS website.

Pricing information

The 2014 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes *36415*, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Social Security Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for 2014, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2014 clinical laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

Similar to prior years, the 2014 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping information

82777 is priced at the same rate as *84244*.

80155 is priced at the same rate as *80198*.

80159 is priced at the same rate as *80154*.

80169 is priced at the same rate as *80195*.

80171 is priced at the same rate as *80157*.

80175 is priced at the same rate as *80157*.

80177 is priced at the same rate as *80157*.

80180 is priced at the same rate as *80158*.

80183 is priced at the same rate as *80157*.

80199 is priced at the same rate as *82542*.

80203 is priced at the same rate as *80157*.

81161 is to be gap filled.

81287 is to be gap filled.

87661 is priced at the same rate as *87511*.

Laboratory costs subject to reasonable charge payment in 2014

For outpatients, the following codes are paid under a reasonable charge basis (See the Social Security Act (Section 1842(b)(3)) at *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm*). In accordance with 42 CFR 405.502 through 42 CFR 405.508 (see *http://www.ecfr.gov/cgi-bin/text-idx?SID=ab7bf0a61515aca26cefc0f2e7dae3b9&c=ecfr&tpl=/ecfrbrowse/Title42/42cfrv2_02.tpl*), the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1) (see *http://www.ecfr.gov/cgi-bin/text-idx?SID=40538fb2e20d60fb4d4de0ab33d0ca22&node=42:2.0.1.2.5&rgn=div5#42:2.0.1.2.5.5.25.10*). **The inflation-indexed update for 2014 is 1.8 percent**.

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Laboratory *(continued)*

Manual instructions for determining the reasonable charge payment can be found in Publication 100-4, *Medicare Claims Processing Manual, Chapter 23*, Section 80 through 80.8 (see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf*). If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 8, Section 60.3 (see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf*) instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood products

Blood products codes are: P9010, P9011, P9012, P9016, P9017, P9019, P9020, P9021, P9022, P9023, P9031, P9032, P9033, P9034, P9035, P9036, P9037, P9038, P9039, P9040, P9044, P9050, P9051, P9052, P9053, P9054, P9055, P9056, P9057, P9058, P9059, and P9060.

Also, payment for the following codes (including transfusion medicine, and reproductive medicine procedures, listed below) should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility, and Entitlement Manual*," Chapter 3, Section 20.5 through 20.5.4: P9010, P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9056, P9057, and P9058.

Note: Biologic products not paid on a cost or prospective payment basis are paid based on the Social Security Act (Section 1842(o)). The payment limits based on the Social Security Act (Section 1842(o)), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine

Transfusion medicine codes are: *86850, 86860, 86870, 86880, 86885, 86886, 86890, 86891, 86900, 86901, 86903, 86904, 86905, 86906, 86920, 86921, 86922, 86923, 86927, 86930, 86931, 86932, 86945, 86950, 86960, 86965, 86970, 86971, 86972, 86975, 86976, 86977, 86978,* and *86985*.

Reproductive medicine procedures

Reproductive medicine procedures codes are: *89250, 89251, 89253, 89254, 89255, 89257, 89258, 89259, 89260, 89261, 89264, 89268, 89272, 89280, 89281, 89290, 89291, 89335, 89342, 89343, 89344, 89346, 89352, 89353, 89354*, and *89356*.

MACs will not search their files to either retract payment or retroactively pay claims processed prior to implementation of CR 8517; however, they will adjust such claims that you bring to their attention.

Additional information

You can find the official instruction, CR 8517, issued to your MAC regarding this change at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2823CP.pdf*.

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

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Surgery

Transcatheter aortic valve replacement – implementation of permanent code

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8537 which informs MACs that the Centers for Medicare & Medicaid Services (CMS) is retiring the remaining temporary *Current Procedural Terminology*® (*CPT*®) code *0318T* and replacing it with permanent *CPT*® code *33366*, effective January 1, 2014. Make sure that your billing staffs are aware of these changes.

Background

Transcatheter aortic valve replacement (TAVR, which is also known as TAVI or transcatheter aortic valve implantation) is a new technology for use in treating aortic stenosis. A bio-prosthetic valve is inserted percutaneously using a catheter and implanted in the orifice of the native aortic valve. The procedure is performed in a cardiac catheterization lab or a hybrid operating room/cardiac catheterization lab with advanced quality imaging and with the ability to safely accommodate complicated cases that may require conversion to an open surgical procedure. The interventional cardiologist and cardiac surgeon jointly participate in the intra-operative technical aspects of TAVR. On May 1, 2012, CMS issued a national coverage determination (NCD) covering TAVR under coverage with evidence development (CED). The policy is available at *http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=355*.

CR 8537 is an update to CR 8168, dated January 7, 2013. CR 8168 implemented replacement codes for TAVR claims with dates of service on and after January 1, 2013, and contains more detailed billing instructions for TAVR services.

Specifically, for dates of service on or after January 1, 2014, CMS is retiring the remaining temporary *CPT*® code *0318T* (*Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (e.g., left thoracotomy)*) with permanent *CPT*® code *33366* (*Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (e.g., left thoracotomy)*). This coding change appears in the January 2014 Medicare physician fee schedule database and integrated outpatient code editor updates.

Providers should also note that if a TAVR claim is denied because a place of service (POS) code other than POS code 21 was used, the following messages will also be used:

- **Claim adjustment reason code (CARC) 58**: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

Additional information

The official instruction, CR 8537 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2827CP.pdf*.

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

MLN Matters® Number: MM8537
Related Change Request (CR) #: CR 8537
Related CR Release Date: November 29, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2827CP
Implementation Date: January 6, 2014

Bariatric surgery to treat co-morbid conditions related to morbid obesity

Provider types affected

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

What you need to know

This article is based on change request (CR) 8484, which informs Medicare contractors that:

- Effective for dates of service on and after September 24, 2013, facility certification will no longer be required for coverage of covered bariatric surgery procedures;
- The Centers for Medicare & Medicaid Services (CMS) has determined that no changes be made to the bariatric surgery procedures that are deemed covered in Section 100.1 of the *National Coverage Determination (NCD) Manual*; and
- CMS is clarifying in the *NCD Manual* that, under the existing policy, the local MACs have the authority to make coverage decisions for any bariatric surgery procedures not specifically identified as covered or non-covered by an NCD.

Be sure that your billing staffs are aware of these updates.

Background

CR 8484 is due to a reconsideration of Section 100.1 of the *NCD Manual* currently titled "Bariatric Surgery for Treatment of Morbid Obesity." On January 24, 2013, CMS initiated a national coverage analysis (NCA) for the reconsideration of the requirement that covered bariatric surgery procedures are only covered when performed in facilities that are certified. CMS also made changes to the NCD which are defined below.

In 2006, CMS established an NCD on bariatric surgery for the treatment of morbid obesity (*NCD Manual*, Section 100.1). For Medicare beneficiaries who have a body mass index (BMI) ≥ 35, have at least one co-morbidity related to obesity, and who have been previously unsuccessful with medical treatment for obesity, the following procedures were determined to be reasonable and necessary:

- Open and laparoscopic Roux-en-Y gastric bypass (RYGBP)
- Laparoscopic adjustable gastric banding (LAGB)
- Open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS)

In addition, the NCD stipulates that these bariatric procedures are covered only when performed at facilities that are: (1) Certified by the American College of Surgeons (ACS) as a Level 1 Bariatric Surgery Center, or (2) Certified by the American Society for Bariatric Surgery (ASBS) as a Bariatric Surgery Center of Excellence (BSCOE) (Program Standards and requirements in effect on February 15, 2006). The 2006 NCD specifically non-covered open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding because there was a paucity of evidence to support claims of improved health outcomes from those procedures.

This NCD specifically addressed the need for the continuation of the requirement for facility certification by ACS or by the ASBS (currently the American Society for Metabolic and Bariatric Surgeons (ASMBS)).

CMS policy and manual changes

CMS has determined that the evidence is sufficient to conclude that continuing the requirement for certification for bariatric surgery facilities would not improve health outcomes for Medicare beneficiaries. Therefore, CMS removes this certification requirement, effective with dates of service on or after September 24, 2013.

CMS has determined that no changes need to be made to the bariatric surgery procedures that are deemed covered in Section 100.1 of the *NCD Manual*.

CMS plans to change the title to "Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity," to better reflect the scope of the NCD and to make it clear in the manual that under the existing policy the local MACs have the authority to make coverage decisions for any bariatric surgery procedures not specifically identified as covered or non-covered by an NCD.

In addition, to the proposed decision above, CMS is renumbering and consolidating its manual for Section 100.1. This is an administrative change only to make it easier for the public to read and understand the *NCD Manual*. There is no change in coverage because of the renumbering and consolidation.

The additional NCDs related to bariatric surgery will be consolidated and subsumed into Section 100.1 of the *NCD Manual*. These include Sections 40.5, 100.8, 100.11 and 100.14.

(continued on next page)

Obesity *(continued)*

Additional information

The official instruction, CR 8484, was issued to your MAC regarding this change via two transmittals. The first is the claim processing transmittal and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2841CP.pdf*. The second transmittal updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R158NCD.pdf*.

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

MLN Matters® Number: MM8484
Related Change Request (CR) #: CR 8484
Related CR Release Date: November 15, 2013
Effective Date: September 24, 2013
Related CR Transmittal #: R2841CP and R158NCD
Implementation Date: December 17, 2013

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.

Use of claim adjustment reason code 23

Provider types affected

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

What you need to know

Change request (CR) 8279, from which this article is taken, modifies Medicare claims processing systems to use Medicare claim adjustment reason codes (CARC) 23 to report impact of prior payers' adjudication on Medicare payment in the case of a secondary claim.

Background

Effective April 1, 2013, CR 8154 – "Remittance Advice Remark and Claims Adjustment Reason Code, Medicare Remit Easy Print, and PC Print Update" modified CARC 23 (The impact of prior payer(s) adjudication including payments and/or adjustments (Use only with group code OA)); to include the instruction that it must be used with group code OA (other adjustment). The Centers for Medicare & Medicaid Services (CMS) has become aware that the modification to this CARC has resulted in some issues for Medicare. (You can find the *MLN Matters*® article associated with CR 8154 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8154.pdf*.

CR 8297, from which this article is taken, instructs the Medicare's shared system maintainers (SSMs) on how to use CARC 23 to report prior payers' adjudication in the case of a secondary claim.

Medicare beneficiaries may have multiple coverages that occur either before or after Medicare. If (per coordination of benefits) Medicare is the secondary payer, the adjudication process has to take into consideration how previous payers have adjudicated the claim, and report accordingly on the remittance advice (RA). The implementation guide for the current electronic remittance advice (ERA) - ASC x12 transaction 835 version 5010 - has explicit instruction in the Front Matter, Section 1.10.2.13 (Secondary Payment Reporting Consideration) to:

> "Report the "impact" in the appropriate claim or service level CAS segment with reason code 23 (Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments); and claim adjustment group code OA (other adjustment). Code OA is used to identify this as an administrative adjustment……It is essential that any secondary payer report in the remittance advice only the primary amount that has actually impacted their secondary payment. In many cases, this "impact" is less than the actual primary payment." In these instances, reporting the actual payment would prevent the transaction from balancing.

Medicare does not have to report everything a previous payer has done, because that information is reported by that payer to the provider through the previous payer's remittance advice (RA). In order to generate and send a balanced Medicare RA and coordination of benefits (COB) claim, Medicare should report only the part of previous payers' adjudication that impacts Medicare calculation of payment and adjustments.

"Report the "impact" in the appropriate claim or service level CAS segment with reason code 23 (Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments); and claim adjustment group code OA (other adjustment). Code OA is used to identify this as an administrative adjustment……It is essential that any secondary payer report in the remittance advice only the primary amount that has actually impacted their secondary payment. In many cases, this "impact" is less than the actual primary payment." In these instances, reporting the actual payment would prevent the transaction from balancing.

Medicare does not have to report everything a previous payer has done, because that information is reported by that payer to the provider through the previous payer's remittance advice (RA). In order to generate and send a balanced Medicare RA and COB claim, Medicare should report only the part of previous payers' adjudication that impacts Medicare calculation of payment and adjustments.

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Code *(continued)*

Specifically, CR 8279 requires the Medicare SSMs to report:

1. The Medicare allowed amount in the appropriate claim or service level "AMT" segment using qualifier AU (claim level) or B6 (service level) in AMT01 (actual amount qualifier code);
2. Any patient responsibility, remaining after coordination of benefits with the previous payer(s), with group code "PR" (patient responsibility) and the appropriate claim adjustment reason code (for example: 1 - deductible amount, 2 - coinsurance amount); and
3. Any further adjustment, taken by Medicare as a result of previous payer(s) payment and/or adjustment(s), with group code OA and claim adjustment reason code 23.

Additional information

The official instruction, CR 8279, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1318OTN.pdf*.

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

MLN Matters® Number: MM8297
Related Change Request (CR) #: CR 8297
Related CR Release Date: November 15, 2013
Effective Date: April 1, 2014
Related CR Transmittal #: R1318OTN
Implementation Date: April 7, 2014, except July 7, 2014, for suppliers billing DME MACs

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

Provider types affected

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

Provider action needed

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

Background

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

More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to electronic data interchange (EDI) from paper has been slow and disappointing. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost

(continued on next page)

CORE 360 *(continued)*

reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

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

Additional information

The official instruction, CR 8518 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1316OTN.pdf*.

In CR 8365, released August 16, 2013, CMS instructed Medicare contractors to implement this updated rule set by January 6, 2014. You can find the associated *MLN Matters*® article, MM8365 "Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8365.pdf*.

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

MLN Matters® Number: MM8518
Related Change Request (CR) #: CR 8518
Related CR Release Date: November 15, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R1316OTN
Implementation April 7, 2014

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SPOT *(continued)*

deductibles/caps section displays the amount of therapy services used by the Medicare beneficiary, allowing providers to determine whether the patient exceeded the respective annual therapy cap.

Zane also likes the ability to review patient eligibility within a few days of a patient's appointment. Before **the SPOT**, Zane said eligibility would take place several days prior to a patient visit. As the owner of an independent physical therapy practice, not having timely access to benefit verification and accurate eligibility information sometimes hit her back pocket.

"A patient with a bed sore may need home care to change their wound dressing. When a patient like this comes for physical therapy, they tell us they were not receiving home health care. Only later, we find out our claim was denied because the patient did not understand their wound care was a home health care episode.

"With **the SPOT**, I can determine if a patient is under a home health plan of care before they arrive at the office," Zane said. "If there is an issue with the timing of claims not appearing on the system, then I can address the issue, if possible, and I'm only at risk for only one physical therapy visit at the most.

Zane said she sees many other benefits to **the SPOT**. "**The SPOT** allows me an easy way to keep track of the therapy cap. With the IVR, providers are limited to three inquiries per call. **The SPOT** gives me time to determine if the patient is about to bump up against the cap. There's no limit to how many inquires you do. If you have a dozen patients who are close to the cap, you can track them almost every day to make sure they haven't bumped over it."

Zane says she promotes usage of **the SPOT** to her peers as often as possible. "**The SPOT** is amazing because you have given us a tool which the entry level employee can use easily and has a major positive impact on our business," Zane said.

To gain access to **the SPOT**, click *here*.

Additional updates to Chapter 15 of the *Program Integrity Manual*

Provider types affected

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

What you need to know

This article is based on change request (CR) 8393, which instructs MACs to implement several recent provider enrollment policy determinations that were incorporated into Chapter 15 of the *Medicare Program Integrity Manual* (*PIM*). Make sure that your billing staffs are aware of these updates.

Background

As stated in CR 8393, the provider enrollment application fee for January 1-December 31, 2014, is $542.00.

Additional information

The official instruction, CR 8393, issued to your MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R492PI.pdf*. See CR 8393 to read other provider enrollment policy determinations that have been incorporated into Chapter 15 of the *PIM*. The revised Chapter of the *PIM* is attached to CR 8393.

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

MLN Matters® Number: MM8393
Related Change Request (CR) #: CR 8393
Related CR Release Date: December 6, 2013
Effective Date: January 7, 2014
Related CR Transmittal #: R492PI
Implementation Date: January 7, 2014

Revised liability and denial messages for services furnished to incarcerated beneficiaries

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administration contractors (MACs), including durable medical equipment (DME) MACs for services provided to Medicare beneficiaries while they are in federal, state, or local custody.

Provider action needed

This article is based on change request (CR) 8488 which instructs Medicare claims administration contractors to use an updated claim adjustment reason code (CARC), remittance advice remark code (RARC), and group code when denying claims for services furnished to incarcerated Medicare beneficiaries. See the *Background* and A*dditional information* sections for further details regarding these changes. Make sure that your billing staffs are aware of these changes.

Background

According to federal regulations at 42 CFR 411.4, Medicare does not pay for services furnished to a beneficiary who has no legal obligation to pay for the service, and no other person or organization has a legal obligation to provide or pay for the service. Refer to the *Electronic Code of Federal Regulations* (e-CFR) at *http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=1270613eb7cae1ed8c62899034b0eca2&rgn=div8&view=text&node=42:2.0.1.2.11.1.35.3&idno=42*. This exclusion presumptively applies to individuals who are incarcerated.

Under 42 CFR 411.6, Medicare does not pay for services furnished by a federal provider of services or by a federal agency. Also, under 42 CFR 411.8, Medicare does not pay for services that are paid for directly or indirectly by a governmental entity.

As such, when claims for services furnished to beneficiaries who are incarcerated are submitted to Medicare, the claims are rejected by the common working file (CWF) and denied by the claims processing contractors. Per previously issued instructions (most recently, CR 7678, Transmittal 1054, issued March 7, 2012; see related *MLN Matters*® article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7678.pdf*), MACs use the following remittance advice messages and group code when denying such claims:

- Claim adjustment reason code (CARC): 96 - "Non-covered charges."
- Remittance advice remark code (RARC): N103 - "Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt."
- **Group code: PR** – Patient responsibility.

CR 8488 revises the remittance advice messages and group code used for denials of claims for services furnished to incarcerated beneficiaries.

MACs will begin using the following new CARC code when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody:

- **CARC: 258** – Claim/service is not covered when patient is in custody or incarcerated. Appropriate Federal, State or Local authority may cover this claim/service.

In addition, MACs will begin using the following revised RARC N103 language when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody:

- **RARC: N103** – "Medicare records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local

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Incarcerated *(continued)*

government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts."

MACs will begin using the following group code to assign proper liability when denying claims for services furnished to beneficiaries while they are in Federal, state, or local custody so that the provider or supplier should seek repayment for the cost of its services provided from the authority that was in custody of the beneficiary on the date of service:

- **Group code**: OA – Other adjustment

Other than the above, MACs will continue to use existing remittance advice codes and messages and MSN language already in place when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody.

Additional information

The official instruction, CR 8488 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1320OTN.pdf*.

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

MLN Matters® Number: MM8488
Related Change Request (CR) #: CR 8488
Related CR Release Date: November 22, 2013
Effective Date: February 24, 2014
Related CR Transmittal #: R1320OTN
Implementation Date: February 24, 2014

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Recalcitrant provider procedures

Provider types affected

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

What you need to know

Change request (CR) 8394 refers to how MACs will address recalcitrant providers and suppliers. The Centers for Medicare & Medicaid Services (CMS) has learned from contractors that some providers are abusing the Medicare program and not changing inappropriate behavior even after contractors provide them extensive education to address these behaviors. These noncompliant providers who refuse to comply with CMS rules, result in contractors' placing these providers on prepay medical review and causing an administrative burden.

Background

Over the years, CMS has heard from contractors that some providers are abusing the Medicare program; and, even after extensive educational efforts, do not change their inappropriate behavior.

Notes: In this context:

1. Providers are defined as both providers and suppliers, under their current definitions found in the *Code of Federal Regulations* (CFR) at 42 CFR, Section 400.202); and
2. Recalcitrant providers are defined as those who abuse the Medicare program and do not change their inappropriate behavior even after their Medicare contractors have given them extensive provider education addressing these behaviors.

The behavior of these recalcitrant providers who refuse to comply with CMS requirements has resulted in their being placed on prepay medical review for long periods of time, requiring the extensive use of contractor resources; that (while, indeed, protecting trust fund dollars) would be better utilized for other types of more productive oversight activity.

Accordingly, CMS is encouraging contractors to take advantage of current sanctions to address this problem of recalcitrant providers. The two authorities that may be appropriate to impose such a sanction are 1128A (a)(1)(E) of the Social Security Act (the Act), or 1128(b)(6)of the Act; which you can find at *http://www.ssa.gov/OP_Home/ssact/title11/1128.htm*. Both of these sanctions are delegated to the Office of the Inspector General (OIG), who will work with CMS to pursue these cases.

CR 8394, from which this article is taken, updates Chapter 4, Section 4.27 of the *Medicare Program Integrity Manual* by adding a section formalizing the process for addressing recalcitrant providers and suppliers.

Note: Any provider referred as a potential recalcitrant provider case should be an "outlier," meaning a provider who has been the least receptive to changing and has a significant history of non-compliance. For any case submitted, it is important to remember that

(continued on next page)

Recalcitrant *(continued)*

different mitigating or aggravating circumstances may need to be applied.

Additional information

The official instruction, CR 8394, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R495PI.pdf*. You will find the updated *Medicare Program Integrity Manual*, Chapter 4 (Benefit Integrity), Section 27 (Recalcitrant Providers) as an attachment to that CR.

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

MLN Matters® Number: MM8394
Related Change Request (CR) #: CR 8394
Related CR Release Date: December 13, 2013
Effective Date: January 15, 2014 – This process is currently in effect and this is a clarification through a manual update.
Related CR Transmittal #: R495PI
Implementation Date: January 15, 2014

New timeline proposed for achieving Stage 3 EHR meaningful use

The Centers for Medicare & Medicaid Services (CMS) recently proposed a new timeline for the implementation of Stage 3 meaningful use for the Medicare electronic health record (EHR) incentive programs.

"Meaningful use" is the extent to which a provider uses electronic records in the conduct of their clinical practice such as issuing prescriptions or ordering medical tests, tracking patient health status, or submitting clinical quality measures through electronic systems. The revised timeframe will involve:

- Providers in their first year of Stage 1 for the Medicare EHR incentive program in 2014, must begin 90 days of Stage 1 of meaningful use no later than July 1, 2014, and submit attestation by October 1, 2014, in order to avoid the 2015 payment adjustment.
- Providers who have completed one year of Stage 1 of meaningful use must demonstrate a second year of Stage 1 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare. These providers will need to demonstrate Stage 2 of meaningful use for two years (2015 and 2016), and will begin Stage 3 of meaningful use in 2017.
- Providers who have completed two or more years of Stage 1 of meaningful use still need to demonstrate Stage 2 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare. These providers will demonstrate Stage 2 of meaningful use for three years (2014, 2015, and 2016), and begin Stage 3 of meaningful use in 2017.

These changes will allow CMS to focus efforts on the successful implementation of the enhanced patient engagement, interoperability and health information exchange requirements in Stage 2; and to use information gathered from Stage 2 participation to inform policy decisions for Stage 3. According to CMS, the new timeline would allow ample time for developers to create and distribute certified EHR technology before Stage 3 begins. For more information on EHR incentives, visit the *Medicare EHR Web page* on the CMS website.

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

CMS updates EFT authorization agreement: CMS 588

The Office of Management and Budget recently approved changes to the *CMS 588*, Electronic Funds Transfer (EFT) Authorization Agreement. The revised CMS 588 is available on the *CMS Forms List*.

Medicare administrative contractors (MACs) will continue to accept the 05/10 version of the CMS 588 through December 31, 2013. After December 31, 2013, the MACs will return any newly submitted 05/10 versions of the CMS 588 applications with a letter explaining the CMS 588 application has been updated and the provider/supplier must submit a current version (09/13) of the CMS 588 application.

Source: CMS PERL 201312-03

Implementation of provider enrollment provisions in CMS-6028-FC

Note: This article was revised December 9, 2013, to provide the application fee amount of $542.00 for 2014. All other information remains the same. This information was previously published in the December 2012 *Medicare B Connection*, Pages 56-59.

Provider types affected

All providers and suppliers submitting enrollment applications to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse (NSC) are affected by this article.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, titled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the *Federal Register*.

Caution – what you need to know

This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories;
- Submission of application fees as part of the provider enrollment process;
- Suspensions of payment based on credible allegations of fraud; and
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

Go – what you need to do

This article is based on change request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria (payment suspensions will be addressed via separate CMS guidance). Please ensure that your staffs are aware of these new provisions.

Background

CR 7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new Sections 19 through 19.4 of Chapter 15 in the *Medicare Program Integrity Manual*. Those manual sections are attached to CR 7350 and are summarized as follows:

Screening processes

Beginning on March 25, 2011, Medicare will place newly enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the *Program Integrity Manual* (*PIM*) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new section of the PIM is attached to CR 7350.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the "high" category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

Application fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011. Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee.

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for January 1, 2013, through December 31, 2013, is $532.00. The fee for January 1, 2014, through December 31, 2014, is $542.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved;

(continued on next page)

CMS-6028-FC *(continued)*

- An application that was rejected prior to the Medicare contractor's initiation of the screening process; or
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR 424.570.

The provider or supplier must pay the application fee electronically by going to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do* and paying their fee via credit card, debit card, or check. Providers and suppliers are strongly encouraged to submit with their application a copy of their receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

Hardship exception

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter must accompany the application. If the application is submitted via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the hardship exception letter must accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. During this review period, the contractor will not begin processing the provider's application. CMS will communicate its decision to the institutional provider and the contractor via letter.

Important: In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the application will be processed in the order in which it was received.

Review of hardship exception request

As already stated, the application fee for 2014 is $542. This generally should not represent a significant burden for an adequately capitalized provider or supplier. It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

a) Considerable bad debt expenses,

b) Significant amount of charity care/financial assistance furnished to patients, (c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;

c) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

d) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note: If the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

Appeal of the denial of hardship exception decision

If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the procedures outlined in Chapter 15, Section 19 of the *Program Integrity Manual* (*PIM*), which is attached to CR 7350.

Temporary moratoria

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the *Federal Register*. For initial and new location applications involving the affected provider and supplier type, the moratorium:

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium,

(continued on next page)

CMS-6028-FC *(continued)*

even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.

- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the "high" level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within six months after the applicable moratorium was lifted, the contractor will process the application using the "high" level of categorical screening.

Additional Information

The official instruction, CR 7350, issued to your FI, RHHI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R371PI.pdf*.

Complete details regarding this issue, as defined in the PIM revisions, are attached to CR 7350.

MLN Matters® article SE1126, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf*, has further details on the Affordable Care Act-required revalidation of provider enrollment information for all providers and suppliers who enrolled in the Medicare program prior to March 25, 2011.

For more information about the application fee payment process, refer to *MLN Matters*® article SE1130, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf*.

A sample letter requesting providers to review, update, and certify their enrollment information is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf*.

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

MLN Matters® Number: MM7350 *Revised*
Related Change Request (CR) #: 7350
Related CR Release Date: March 23, 2011
Effective Date: March 25, 2011
Related CR Transmittal #: R371PI
Implementation Date: March 25, 2011

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.

2014 update to the AIC requirements for ALJ and Federal District Court appeals

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

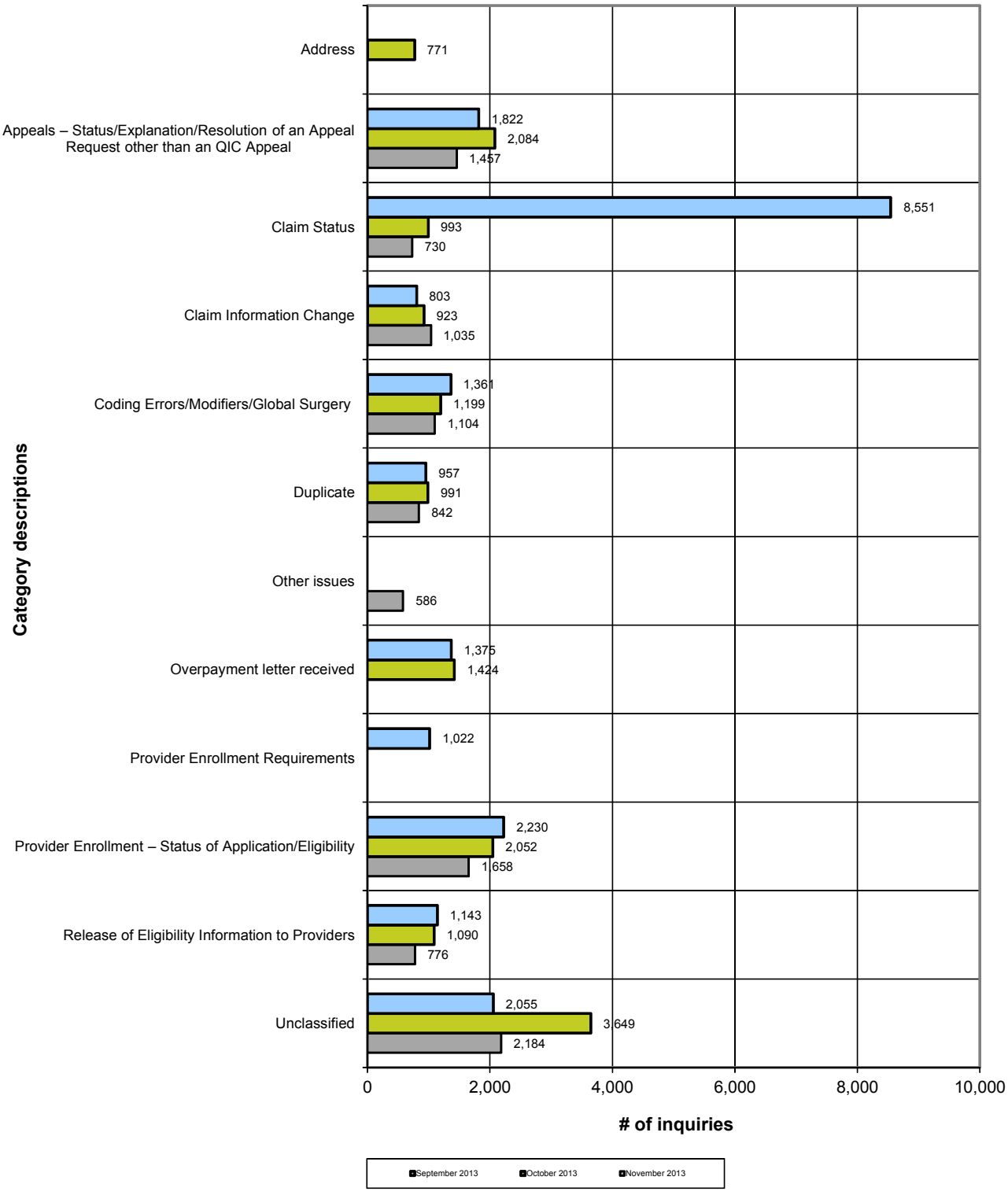
- **ALJ hearing request**: The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2013, is $140. This amount remains at $140 for ALJ hearing requests filed on or after January 1, 2014.
- **Federal District Court review**: The amount that must remain in controversy for Federal District Court review requests filed on or before December 31, 2013, is $1,400. This amount increased to $1,430 for appeals to Federal District Court filed on or after January 1, 2014.

Top inquiries, denials, and return unprocessable claims

The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during September-November 2013.

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

Part B top inquiries for September-November 2013



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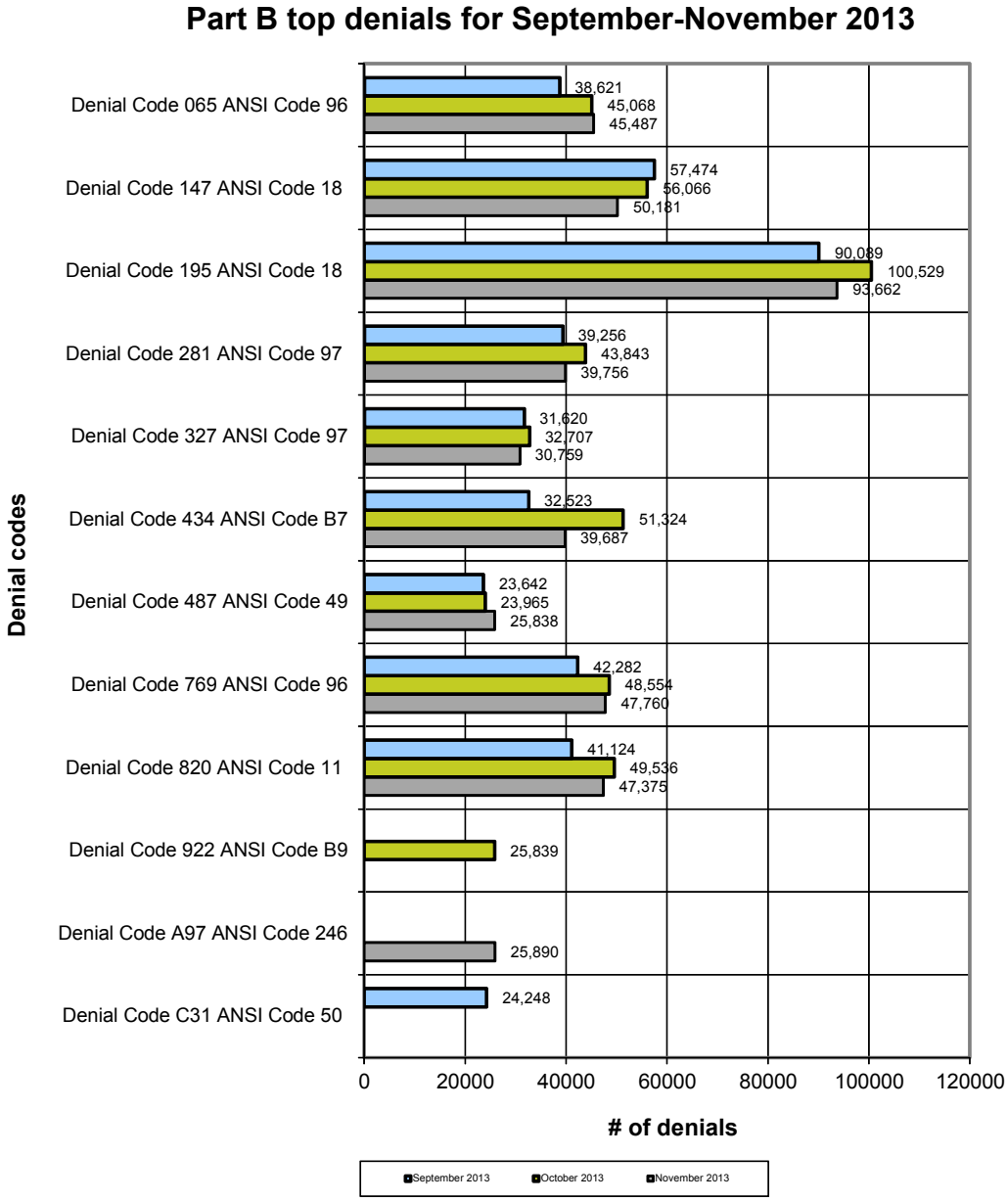


What to do when your claim is denied

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

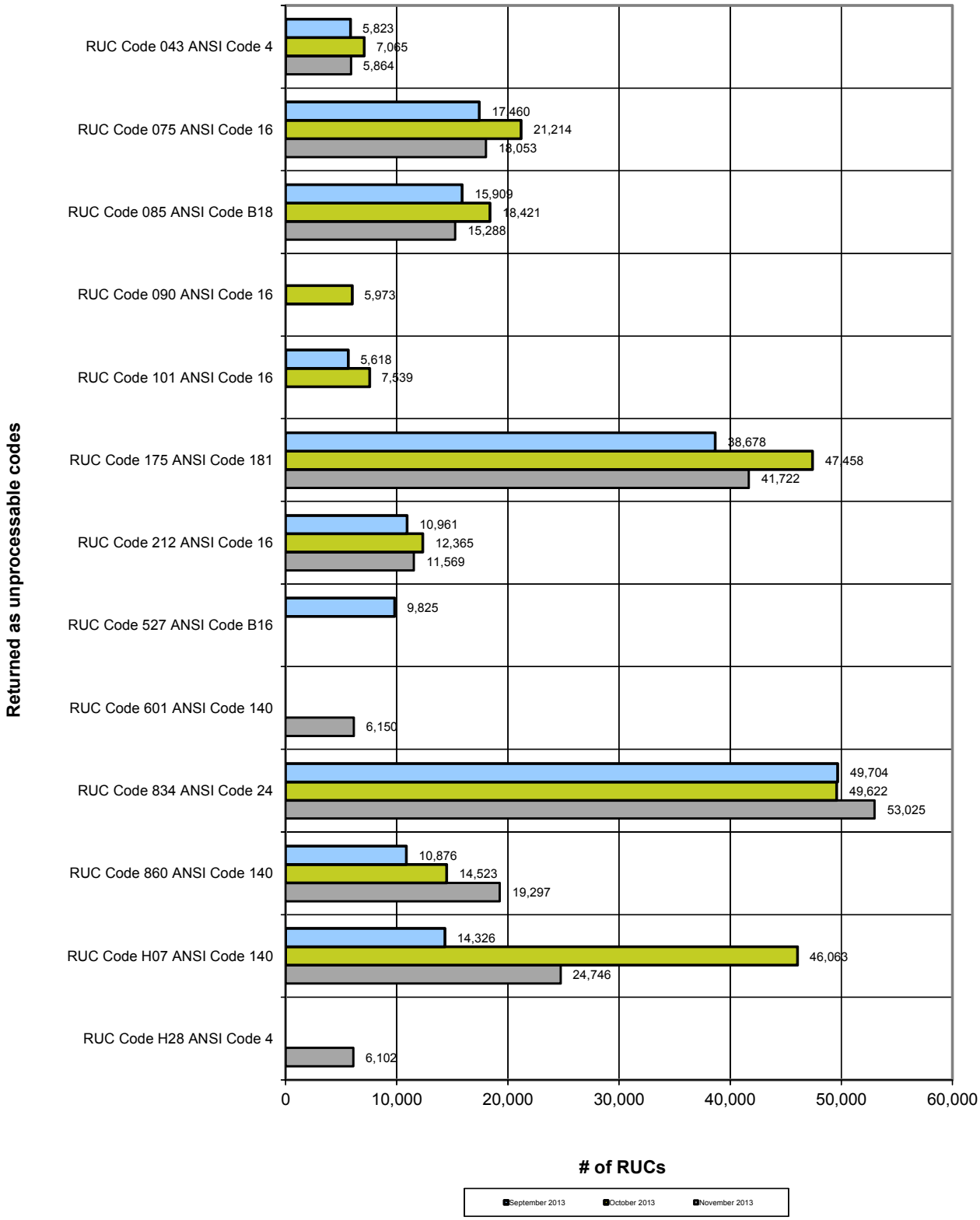
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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

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

Top *(continued)*

Part B top return as unprocessable claims for September-November 2013



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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Contents

Advance beneficiary notice

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

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

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

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

Looking for LCDs?

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

Find out first: Subscribe to First Coast eNews

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

Revisions to LCDs

Surgical management of morbid obesity – revision to the Part B LCD

LCD ID number: L29317 (Florida)
LCD ID number: L29477 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for surgical management of morbid obesity was most recently revised January 29, 2013. Since that time, based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8484, the LCD has been revised under the "CMS National Coverage Policy" and "Indications and Limitations of Coverage and /or Medical Necessity" sections of the LCD. The LCD was revised to remove the facility certification requirement for coverage of covered bariatric surgery procedures.

Effective date

This LCD revision is effective for claims processed **on or after December 17, 2013**, for services rendered **on or after September 24, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

Take advantage of First Coast's exclusive PDS report

Did you know that First Coast's exclusive provider data summary (PDS) report can help you improve the accuracy and efficiency of the Medicare billing? Accessible through First Coast's PDS's portal at *https://medicare.fcso.com/reporting/index.asp*, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specific time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your business botton line.

Educational Events

Upcoming provider outreach and educational events
January – February 2014

Medicare "Ask-the-Contractor" teleconference (ACT): 935 recoupment process

When: Tuesday, January 28
Time: 10:00 a.m.-11:30 a.m.

EDI presents an overview of PC-ACE Pro32™, Medicare's free billing software

When: Monday, February 17 **Type of event:** Face-to-face
Time: 9:00 a.m.-11:00 a.m.

Medicare Speaks 2014 Orlando

When: Tuesday-Wednesday, February 18-19 **Type of event:** Face-to-face
Time: 7:30 a.m.-4:15 p.m.

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects™ Provider eNews

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

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

- "MLN Connects™ Provider eNews': November 27, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-27-eNews-PDF.pdf*
- "MLN Connects™ Provider eNews': December 5, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-05-Enews.pdf*
- "MLN Connects™ Provider eNews': December 12, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-12-Enews.pdf*
- "MLN Connects™ Provider eNews': December 19, 2013 – *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-19-Enews.pdf*

Source: CMS PERL 201311-08, 201312-01, 201312-03, 201312-04

Medicare Learning Network®

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

Preventive Resources

Improve your patients' health with the IPPE and AWV

Note: This article was re-issued November 27, 2013.

Provider types affected

Health care professionals eligible to furnish the initial preventive physical examination (IPPE) or the annual wellness visit (AWV).

What you need to know

Medicare covers the following services for Medicare patients that meet certain eligibility requirements:

- The IPPE (also known as the "Welcome to Medicare" preventive visit)
- The AWV

These preventive benefits allow you to assess your patients' health on an annual basis to help you determine if they have any risk factors and if they are eligible for other preventive services and screenings that Medicare covers.

These preventive benefits are a great way for you to detect illnesses in their earliest stages when treatment works best. The average reimbursement level for the AWV is about $107 and about $150 for the IPPE with no patient deductible or co-pay.

Note: Please check the physician fee schedule for the exact amount of reimbursement for your locality and setting. You can view the physician fee schedule by visiting *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html*.

The initial preventative physical exam ("Welcome to Medicare" preventive visit)

Medicare covers an IPPE for all patients who have newly enrolled in Medicare Part B.

- The patient must receive this service within the first 12 months after the effective date of their Medicare Part B coverage.
- The IPPE is a one-time benefit.
- The IPPE consists of the following:
  - Review the patient's medical and social history
  - Review potential risk factors for depression and other mood disorders
  - Review functional ability and level of safety
  - Measurement of height, weight, body mass index (BMI), and visual acuity screening
  - End-of-life planning (upon agreement of the individual)
  - Education, counseling and referral based on the review of previous 5 components
  - Education, counseling and referral for other preventive services, including a brief written plan such as a checklist

For more information about the IPPE, please see "Quick Reference Information: The ABCs of the IPPE" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf*.

The annual wellness visit

Medicare covers an annual AWV for patients:

- Who are no longer within 12 months of the effective date of their first Part B coverage period; and
- Who have not gotten either an IPPE or AWV within the previous 12 months.

Medicare pays for only one first AWV. Medicare will pay for a subsequent AWV for each patient annually.

Note: The elements in first and subsequent AWVs, and the codes to bill them, are different.

- The first AWV includes the following elements:
  - A health risk assessment
  - Establishment of a current list of provider and suppliers

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Improve *(continued)*

- Review of medical and family history
- Measurement of height, weight, BMI, and blood pressure
- Review of potential risk factors for depression and other mood disorders
- Review of functional ability and level of safety
- Detection of any cognitive impairment the patient may have
- Establishment of a written screening schedule (such as a checklist)
- Establishment of a list of risk factors
- Provision of personalized health advice and referral to appropriate health education or other preventive services

- Subsequent AWVs include the following elements:
  - Review of updated health risk assessment
  - Update medical and family history
  - Update of list of current providers and suppliers
  - Measurement of weight and blood pressure
  - Detection of cognitive impairment the patient may have
  - Update of the written screening schedule (such as a checklist)
  - Update of the list of risk factors
  - Provision of personalized health advice and referral to appropriate health education or other preventive services

For more information about the AWV, please see the following resources:

- **"Quick Reference Information: The ABCs of the AWV"** at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf*
- **"Providing the Annual Wellness Visit"** at: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AnnualWellnessVisit-ICN907786.pdf*

Additional information

The *Medicare Learning Network*® has published a variety of additional educational material on Medicare-covered Preventive Services, which includes the following:

- **Preventive Services Educational Products**: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/education_products_prevserv.pdf*
- **The Preventive Services *MLN*® page**: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html*
- ***MLN Matters*® articles related to Medicare-covered preventive benefits:** *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf*

For general information about Medicare-covered preventive services, visit the CMS Prevention page at *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*. For information to share with your Medicare patients, please visit *http://www.medicare.gov*.

MLN Matters® Number: SE1338 *Re-issued*
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation Date: NA

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.

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

Mail directory

Claims submissions

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating providers
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare secondary payer
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD claims
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

Communication

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

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of Information Act
Freedom of Information Act requests
P.O. Box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

Durable medical equipment (DME)

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

Electronic media claims (EMC)

Claims, agreements and inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

Pending request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Denied request for lack of response: Submit as a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education

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

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

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

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

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

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

Phone numbers

Providers

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

Interactive Voice Response (IVR):
1-877-847-4992

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

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

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

U.S. Virgin Islands Contact Information

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange (EDI)

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

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

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

Provider enrollment

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

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

and

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

Durable medical equipment (DME)

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

Redeterminations

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

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

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

Congressional inquiries

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

Provider education

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

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

Email address:
AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

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

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Addresses

Claims
Additional documentation
General mailing
Congressional mailing
First Coast Service Options Inc.
P.O. Box 45036
Jacksonville, FL 32232-5036

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

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

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

Freedom of Information Act (FOIA) related requests
First Coast Service Options Inc.
P.O. Box 45092
Jacksonville, FL 32232-5092

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

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

Electronic Data Interchange (EDI)
First Coast Service Options Inc.
Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

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

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

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

Overnight mail and other special handling postal services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare contractors and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)
CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

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

Phone numbers

Providers
Customer service – free of charge
Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-715-1921

For the hearing and speech impaired (TDD)
1-888-216-8261

Interactive voice response (IVR)
1-877-847-4992

Beneficiary
Customer service – free of charge
1-800-MEDICARE
1-800-633-4227

Hearing and speech impaired (TDD)
1-800-754-7820

Electronic Data Interchange
1-888-875-9779

Educational Events Enrollment
1-904-791-8103

Fax number
1-904-361-0407

Website for Medicare

Providers
First Coast – MAC J9
medicare.fcso.com
medicareespanol.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary
Centers for Medicare & Medicaid Services
www.medicare.gov

Order form for Medicare Part B materials

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2013 through September 2014.	40300260	$33		
2014 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2014, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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