

# C Medicare B CONNECTION



*A Newsletter for MAC Jurisdiction 9 Providers*

March 2014



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## President Obama signs the Protecting Access to Medicare Act of 2014

On April 1, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014. This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect April 1, 2014. This new law maintains the 0.5 percent update for such services that applied from January 1, 2014 through March 31, 2014 for the period April 1, 2014 through December 31, 2014. It also provides a zero percent update to the 2015 Medicare physician fee schedule (MPFS) through March 31, 2015.

The new law extends several expiring provisions of law. We have included Medicare billing and claims processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, and more information about other provisions will be forthcoming.

**Section 101 – Physician payment update –** As indicated above, the new law provides for a 0.5 percent update for claims with dates of service on or after January 1, 2014, through December 31, 2014. It also provides a zero percent update to the 2015 MPFS through March 31, 2015. CMS is currently revising the 2014 MPFS to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2014 conversion factor is \$35.8228.

**Section 102 - Extension of work GPCI floor -** The existing 1.0 floor on the physician work geographic practice cost

index is extended through March 31, 2015. As with the physician payment update, this extension will be reflected in the revised 2014 MPFS.

**Section 103 - Extension of therapy cap exceptions process -** The new law extends the exceptions process for outpatient therapy caps through March 31, 2015. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through March 31, 2015. In addition, the new law extends the application of the caps, exceptions process, and threshold to therapy services furnished in a hospital outpatient department (OPD). Additional information about the exception process for therapy services may be found in the [Medicare Claims Processing Manual, Pub.100-04, Chapter 5, Section 10.3](#).

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received beginning on January 1, 2014. For physical therapy and speech language pathology services combined, the 2014 limit on incurred expenses for a beneficiary is \$1,920. There is a separate cap for occupational therapy services which is \$1,920 for 2014. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for

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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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**904-361-0723**

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

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## About the *Medicare B Connection*

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

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

### Who receives the Connection

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

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

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

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

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

### Publication format

The *Connection* is arranged into distinct sections.

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

In addition to the above, other sections include:

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

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

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



## Advance beneficiary notices

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

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

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

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

### Patient liability notice

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

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

### ABN modifiers

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

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

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

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

## GA modifier and appeals

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

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

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



## Annual *Medicare B Connection* hardcopy registration form

To receive free editions of the Part B publication in hardcopy or email format, you must complete this registration form. To receive a hardcopy or email of future issues of the Part B publication, **your form must be faxed to 1-904-361-0723 by June 20, 2014.** Providers currently receiving hardcopy publications must renew by using this form. **Providers who do not renew by the June 20 deadline will no longer receive free hardcopy versions after the September 2014 issue.** The publication cycle begins every year on October 1 and concludes September 30.

If you miss the registration deadline, you still have the ability to receive a hard copy through subscription. The annual cost for a hardcopy subscription is \$33. Please note that you are not obligated to complete this form to access information contained in the Part B publication. Issues dating back to 1997 are available free on First Coast Service Options' provider website: [http://medicare.fcso.com/Publications\\_B/index.asp](http://medicare.fcso.com/Publications_B/index.asp).

Provider/facility name:

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National provider identifier (NPI):

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Address:

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City, state, ZIP code:

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Contact person/title:

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Telephone number:

Fax number:

E-mail address:

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Language preference: English ☐ Español ☐

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**Note:** Providers who qualify will receive one copy of each monthly publication.

Fax your completed form to:

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Please share your questions and/or concerns regarding this initiative with us.

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Additional questions or concerns may be submitted via the Medicare provider education website at <http://medicare.fcso.com/Feedback/index.asp>. You also may fax your questions or comments to 1-904-361-0723. **Our Provider Contact Center will not be able to respond to inquiries about this form.**

## Medicare only accepting revised CMS-1500 claim form (02/12)

Starting with claims received April 1, 2014, Medicare only accepts professional and supplier paper claims on the revised CMS-1500 claim form (02/12). You may purchase the revised CMS-1500 paper claim form (02/12) from the [United States Government Printing Office](#), as well as private printers. For information regarding private printers selling the revised CMS-1500 claim form (02/12), please contact the [National Uniform Claim Committee](#).

Medicare began receiving claims on the revised CMS-1500 claim form (02/12) January 6, 2014. The CMS-1500 claim form is the required format for submitting professional and supplier claims to Medicare on paper, when submitting paper claims is permissible. The dual-use period during which Medicare accepted the old CMS-1500 claim form began on January 6, 2014, and ended March 31, 2014. On and after April 1, 2014, Medicare no longer accepts claims on the old CMS-1500 claim form (08/05).

### Features of the revised form

The revised form, among other changes, notably adds the following functionality:

- Indicators for differentiating between ICD-9-CM and ICD-10-CM diagnosis codes.
- Expansion of the number of possible diagnosis codes to 12.
- Qualifiers to identify the following provider roles (on item 17):

- Ordering
- Referring
- Supervising

**Note:** Although the revised CMS-1500 claim form has functionality for accepting ICD-10 codes, do not submit ICD-10 codes on claims for dates of service prior to October 1, 2014.

### Instructions for completing the revised form

Instructions for completing the revised CMS-1500 claim form (02/12) are provided in the [“Medicare Claims Processing Manual”](#) (Publication 100-04).

**Note:** The Administrative Simplification Compliance Act (ASCA) requires that Medicare claims be sent electronically unless certain exceptions are met. Some Medicare providers qualify for these exceptions and send their claims to Medicare on paper. For more information about ASCA exceptions, please contact the [Medicare administrative contractor](#) that processes your claims. Claims sent electronically must abide by the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The current standard adopted under HIPAA for electronically submitting professional health care claims is the 5010 version of the ASC X12 837 Professional Health Care Claim standard and its implementation specification, technical report 3 (TR3). More information about the ASC X12 and TR3 is available on the [ASC X12](#) website.

**Note:** The Administrative Simplification Compliance Act (ASCA) requires that Medicare claims be sent electronically unless certain exceptions are met. Some Medicare providers qualify for these exceptions and send their claims to Medicare on paper. For more information about ASCA exceptions, please contact the [Medicare administrative contractor](#) that processes your claims. Claims sent electronically must abide by the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The current standard adopted under HIPAA for electronically submitting professional health care claims is the 5010 version of the ASC X12 837 Professional Health Care Claim standard and its implementation specification, technical report 3 (TR3). More information about the ASC X12 and TR3 is available on the [ASC X12](#) website.



*On and after April 1, 2014, Medicare no longer accepts claims on the old CMS-1500 claim form (08/05)*

### Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the [Improve Your Billing](#) section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).



## Revised paper claim form CMS-1500 (version 02/12)

The National Uniform Claim Committee (NUCC) revised the CMS-1500 claim form to align the paper claim form with changes in the 5010 837P and accommodate ICD-10 reporting needs. On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised paper claim form, CMS-1500 (version 02/12). The Centers for Medicare & Medicaid Services (CMS) has adopted form CMS-1500 (02/12), which replaced the prior CMS-1500 claim form (08/05), effective with claims received on and after April 1, 2014.

- Medicare began accepting claims on the revised form, (02/12) January 6, 2014;
- Medicare continued to accept claims on the old form, (08/05) through March 31, 2014;
- Beginning April 1, 2014, Medicare **only accepts** paper claims on the **revised CMS-1500 claim form, (02/12)**; and
- **On and after April 1, 2014, Medicare no longer accepts claims on the old claim form CMS-1500 (08/05)**

The grace period for providers and suppliers to transition to the new form expired on April 1, 2014. Providers and suppliers needed to ensure that claims submitted on the “old” 08/05 claim form mailed or sent via a courier service reached our offices in Jacksonville, FL by March 31, 2014. Claims on the “old” claim form received on/after April 1, 2014, will be returned as unprocessable claims (RUC).

- **Note:** Updating the print layout for the new claim form will require significant adjustments. The revised form, version 02/12, has a number of revisions, which require changes to the print layout for proper data alignment.

The revised form has a number of changes. The two most important changes are new indicators to differentiate between ICD-9 and ICD-10 codes and new qualifiers to identify the role of the provider entered in item 17.

- The NUCC has created a presentation that reviews the changes in detail. [Click here](#) to view the NUCC presentation on the CMS-1500 (02/12) paper claim form.

### Item 17 qualifiers

The qualifiers appropriate for identifying an ordering, referring, or supervising role are as follows:

- **DN** – referring provider
- **DK** – ordering provider
- **DQ** – supervising provider

Providers should enter the qualifier to the left of the dotted vertical line on item 17.

- **Note:** Claims submitted with a national provider identifier (NPI) and without one of the qualifiers notated above or an invalid qualifier will be returned as an unprocessable claim (RUC).

### Item 21 and 24E diagnosis changes

The revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

#### Item 21

- For version 08/05, report a valid ICD-9-CM code. Enter up to four diagnosis codes.
- For version 02/12, it may be appropriate to report either ICD-9-CM or ICD-10-CM codes depending upon the dates of service (i.e., according to the effective dates of the given code set), up to 12 diagnosis codes.
- Enter up to 12 diagnosis codes. **Note:** this information appears opposite lines with letters A-L. Relate lines A- L to lines of service in 24E by the letter of the line. Use the highest level of specificity.
- Do not provide narrative description in this field.
- Do not insert a period in the ICD-9-CM or ICD-10-CM code.
- The “ICD indicator” identifies the ICD code set being reported. Enter the applicable ICD indicator as a single digit between the vertical, dotted lines.

#### Indicator code set

- 9 – ICD-9-CM diagnosis
- 0 – ICD-10-CM diagnosis

**Reminder:** Regardless of the paper claim form version in effect, providers **cannot submit ICD-10 codes** for claims with dates of service **prior to October 1, 2014**.

#### Item 24E

- For version 08/05, this reference will be either a ‘1’, or a ‘2’, or a ‘3’, or a ‘4’.
- For version 02/12, the reference will be a letter from A-L.

### Additional changes

The following additional changes are also included in the revised form:

#### Item 8

- Form version 08/05: Check the appropriate box for the patient’s marital status and whether employed or a student.
- Form version 02/12: Leave blank.

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### Item 9b

- Form version 08/05: Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.
- Form version 02/12: Leave blank.

### Item 11b

- Form version 08/05: Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word, "RETIRED."
- Form version 02/12: provide this information to the right of the vertical dotted line.

### Item 14

- Additional information for form version 02/12: Although this version of the form includes

space for a qualifier, Medicare does not use this information; **do not enter a qualifier in item 14.**

## ASCA reminder

Only providers that meet the Administrative Simplification Compliance Act (ASCA) exception requirements are permitted to submit their claims to Medicare on paper, which must be submitted on a valid CMS-1500 claim form. Those providers meeting these exceptions are permitted to submit their claims to Medicare on paper.

More information about ASCA exceptions can be found in Chapter 24 of the *Medicare Claims Processing Manual*.

**Source:** *Medicare Claims Processing Manual, Chapter 24, Section 20.4; Chapter 26; change request (CR) 8509; NUCC website*

## Indirect payment procedure – payment to entities that provide coverage complementary to Medicare Part B

### Provider types affected

This *MLN Matters*® article is intended for physicians, providers, suppliers, and other applicable entities submitting claims using the indirect payment procedure to Part B Medicare administrative contractors (MACs) and durable medical equipment MACs (DME MACs) for services to Medicare beneficiaries.

### What you need to know

The article is based on change request (CR) 8638, which updates the manual instructions regarding the indirect payment procedure policy in the "*Medicare Claims Processing Manual*," Chapter 1, Section 30.2.8.3.

Section 1842(b)(6)(B) of the Social Security Act, as well as the Medicare regulations at 42 *Code of Federal Regulations* (CFR) Section 424.66, specify that payment may be made to an entity for Part B services furnished by a physician or other supplier under a complementary health benefit plan if the entity meets certain requirements. This process is known as the indirect payment procedure (IPP).

According to Chapter 1, Section 30.2.8.3 of the "*Medicare Claims Processing Manual*", because Section 1842(h)(1) of the Social Security Act only permits "physicians and suppliers" to enter into participation agreements and because IPP entities do not meet the definition of a "supplier" as described in 42 CFR. 400.202, IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. Therefore, IPP claims are paid at the non-participating physician/supplier rate, which is 95 percent of the physician fee schedule amount.

Payment under the IPP can only be made for covered Part B services. If an IPP entity submits a claim for a beneficiary's service that has already been billed to Medicare (for example, the claim was submitted by a physician before the IPP entity submitted its claim), then Medicare cannot make payment to the IPP entity for that same service. Conversely, if a physician or supplier submits a claim for a beneficiary's service that has already been billed to Medicare (for example, the claim was submitted by an IPP entity before the physician submitted his/her claim), then Medicare cannot make payment to the physician for that same service. Medicare payment can only be made once for a beneficiary's specific service. Therefore, claims for services that have already been billed to Medicare shall be denied (with appeal rights) by Medicare's contractors.

In addition, Medicare payment cannot be made under the IPP for services that are payable for a particular beneficiary under any other part of Medicare. For example, if a beneficiary's service is payable under Part C and a Medicare Advantage organization is also an IPP entity under 42 CFR 424.66, then a Medicare Part B payment under the IPP cannot be made to that Medicare Advantage organization for that beneficiary's service. In these types of dual or multiple enrollment situations, services that are payable under those other Parts of Medicare (e.g., Part C or D) cannot also be billed and paid for under Part B. Therefore, IPP entities that submit Part B claims for services that are payable under another Part of Medicare (e.g., Part C or D) shall be denied (with appeal rights) by Medicare's contractors.

Payment for IPP claims by Medicare is conditioned upon the claim and the underlying transaction

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complying with the Medicare laws, regulations, and program instructions applicable to IPP entities, and on the IPP entity's continued compliance with the regulatory requirements described in 42 CFR 424.66.

Medicare's IPP policy states that Medicare may pay an entity for Part B services furnished by a physician or other supplier if the entity meets all of the following requirements:

- 1) Provides coverage of the service under a complementary health benefit plan (that is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).
- 2) Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.
- 3) Has the written authorization of the beneficiary or of a person authorized to sign claims on the beneficiary's behalf under 42 CFR 424.36 to receive the Part B payment for the services for which the entity pays.
- 4) Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, or from the beneficiary's survivors or estate.
- 5) Submits any information the Centers for Medicare & Medicaid Services (CMS) or the MAC may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.
- 6) Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

Entities that satisfy all of the requirements above may include employers, unions, insurance companies, and retirement homes. They also may include health care

prepayment plans, health maintenance organizations (HMOs), competitive medical plans, and Medicare Advantage organizations.

The IPP permits a physician or supplier to file a single claim with the complementary insurer and receive full payment in a single payment, relieves the beneficiary of the need to file a claim, and protects the beneficiary against any financial liability for the service.

In addition, any entity wishing to bill using the IPP must register through Provider Enrollment and meet such requirements specified in the *Medicare Program Integrity Manual*, Chapter 15, Sections 15.7.9 through 15.7.9.7. This part of the manual is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf>.



<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf>.

### Additional information

The official instruction, CR 8638, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2896CP.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: MM8638  
 Related Change Request (CR) #: CR 8638  
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 Effective Date: June 6, 2014  
 Related CR Transmittal #: R2896CP  
 Implementation Date: June 6, 2014

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## July update to the correct coding initiative edits – version 20.2

### 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

#### Stop – impact to you

This article is based on change request (CR) 8558 which informs Medicare contractors about the release of the latest package of correct coding initiative (CCI) edits, version 20.2, which will be effective July 1, 2014.

#### Go – what you need to do

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.

**Note:** The latest package of CCI edits, effective July 1, 2014, will soon be available to the MACs.

Version 20.2 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 practitioners, 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. 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. Refer to the CMS NCCI Web page for additional information at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>.



### Additional information

The official instruction, CR 8558 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2892CP.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 Change Request (CR) #: CR 8558  
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Effective Date: July 1, 2014  
Related CR Transmittal #: R2892CP  
Implementation Date: July 7, 2014

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## Ambulatory Surgical Center

### April 2014 update of the ambulatory surgical center payment system

#### Provider types affected

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



#### Provider action needed

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

#### Background

This CR includes updates to the healthcare common procedure coding system (HCPCS). The update applies to Chapter 14 of the *Medicare Claims Processing Manual* (Ambulatory Surgical Centers). Make sure that your billing staffs are aware of these changes.

#### Key points of CR 8675

##### New services

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

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

##### Billing for drugs, biologicals, and radiopharmaceuticals

- Drugs and biologicals with payments based on average sales price (ASP), effective April 1, 2014:** Payments for separately payable drugs and biologicals based on the ASPs are updated on a quarterly basis, as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the April 2014 release of the ASC DRUG file. The updated payment rates, effective April 1, 2014, are included in the April 2014 update of the ASC, Addendum BB, which will be posted on the CMS website.
- HCPCS codes for drugs and biologicals separately payable under the ASC payment system, effective April 1, 2014:** Two drugs and biologicals have been granted ASC payment status effective April 1, 2014. These items, along with their descriptors and ASC payment indicator, are shown below and are listed in CR 8675, Attachment A, Table 2.

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

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

- Revised ASC payment indicator for HCPCS codes A9545, J1446, J7178, and Q0181:** Effective April 1, 2014, the payment indicator for HCPCS code A9545 (Iodine I-131 tositumomab, therapeutic, per treatment dose) will change from K2 to Y5 because the product associated with HCPCS code A9545 (brand name Bexxar) is no longer marketed.

Effective January 1, 2014, the payment indicator for HCPCS code J1446 (Injection, TBO-Filgrastim, 5 micrograms) will change from Y5 for K2 to indicate that the drug will be paid separately effective January 1, 2014. Suppliers who think they may have received an incorrect payment for dates of service January 01, 2014, through March 31, 2014, may request contractor adjustment of the previously processed claims. Effective January 1, 2014, the payment indicator for HCPCS code J7178 (Injection, human fibrinogen concentrate, 1 mg) will change from N1 to K2 to indicate that the drug will be paid

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separately effective January 1, 2014. Suppliers who think they may have received an incorrect payment for dates of service January 01, 2014 through March 31, 2014, may request contractor adjustment of the previously processed claims. Effective January 1, 2014, the payment indicator for HCPCS code Q0181 (Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as) will change from Y5 to N1.

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

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

- d) **Updated payment rate for certain HCPCS codes, effective April 1, 2013, through June 30, 2013:** The payment rate for one HCPCS code was incorrect in the April 2013 ASC drug file. The corrected payment rate is listed below and in CR 8675, Attachment A, Table 4, and has been installed in the April 2014 ASC drug file, effective for services furnished on April 1, 2013 through June 30, 2013. Suppliers who think they may have received an incorrect payment for dates of service April 1, 2014, through June 30, 2014, may request contractor adjustment of the previously processed claims.

HCPCS	Short descriptor	Corrected payment	ASC PI
Q4127	Talymed	\$13.78	K2

- e) **Updated payment rate for certain HCPCS codes, effective July 1, 2013, through**

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

HCPCS	Short descriptor	Corrected payment	ASC PI
Q4127	Talymed	\$13.78	K2

- f) **Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013, through December 1, 2013:** The payment rates for two HCPCS codes were incorrect in the October 2013 ASC Drug File. The corrected payment rates are listed below and in CR8675, Attachment A, Table 6, and have been installed in the April 2014 ASC Drug File, effective for services furnished on October 01, 2013, through December 31, 2013. Suppliers who think they may have received an incorrect payment for dates of service October 1, 2013 through December 31, 2013, may request contractor adjustment of the previously processed claims.

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

- g) **Reassignment of skin substitute products that are new for 2014 from the low cost group to the high cost group:** In the 2014 OPPTS/ASC final rule, CMS finalized a policy to package payment for skin substitute products into the associated skin substitute application procedure. For packaging purposes, CMS created two groups of application procedures: application procedures that use high cost skin substitute products (billed using CPT® codes 15271-15278) and application procedures that use low cost skin substitute products (billed using HCPCS codes C5271-C5278). Assignment of skin substitute products to the high cost or low cost groups depended upon a comparison of the July 2013 payment rate for the skin substitute product to \$32, which is the weighted average payment per unit for all skin substitute products using the skin substitute utilization from the 2012 claims data and the July 2013 payment rate for each product. Skin substitute products with a July 2013 payment rate that was above \$32 per square centimeter are paid through the high cost group and those with a July 2013 payment rate that was at or below \$32 per square centimeter

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are paid through the low cost group for 2014. As a reminder, 2015, CMS will follow their usual policy with regard to the specific quarterly ASP data sets used for proposed and final rule-making in that CMS will use April 2014 ASP data to establish the proposed rule low/high cost threshold and they will use July 2014 ASP data to establish the final low/high cost threshold for 2015.

CMS also finalized a policy that will use the \$32 per square centimeter threshold to determine mapping to the high or low cost skin substitute group for any new skin substitute products approved for payment during 2014. Any new skin substitute products without pricing information were assigned to the low cost category until pricing information becomes available. There were nine new skin substitute products that were effective January 1, 2014, and that were assigned to the low cost payment group because pricing information was not available for these products at the time of the January 2014 update. There is now pricing information available for three of these nine products. That information is listed below and in CR 8675, Attachment A, Table 7, and it shows the 3 new products and their low/high cost status based on the comparison of the price per square centimeter for each product to the \$32 square centimeter threshold for 2014.

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

- h) **Billing guidance for the topical application of mitomycin during ophthalmic surgery:** This is a reminder that ASCs are not permitted to bill HCPCS code J9280 (Injection, mitomycin, 5 mg) for the topical application of mitomycin.

### Coverage determinations

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

### Additional information

The official instruction, CR 8675, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2901CP.pdf>.

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

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## Durable Medical Equipment

### April 2014 durable medical equipment, prosthetics, orthotics, and supplies fee schedule update

#### Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Part A/B Medicare administrative contractors (MACs), hospice and home health (HHMACs), and durable medical equipment MACs (DME MACs) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

#### Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8645 that alerts providers and suppliers that CMS issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing personnel are aware of these changes.

#### Background

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

#### Key points of CR 8645

##### Splints, casts, and certain intraocular lenses (IOLs)

The following are the HCPCS codes for splints, casts, and certain IOLs added to the fee schedule file:

A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010,

Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021,

Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032,

Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041, Q4042, Q4043,

Q4044, Q4045, Q4046, Q4047, Q4048, Q4049, V2630, V2631, V2632.

As written in the *MLN Matters*® article MM8523 (Change to the Reasonable Charge Update for 2014 for Splints, Casts, and Certain Intraocular Lenses) at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8523.pdf>, for dates of service on or after April 1, 2014, payment for splints, casts and IOLs inserted in a physician's office will be made using

national fee schedule amounts.

For splints and casts, codes A4565 and Q4001-Q4049 are used when supplies are indicated for cast and splint purposes and:

- Payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast. Per the regulations at 42 *CFR* Section 414.106, national fee schedule amounts for 2014 for these items were developed using 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, which is 1.8 percent; and



- For each year subsequent to 2014, 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 Social Security Act.

For intraocular lenses (codes V2630, V2631 and V2632), payment under the DMEPOS fee schedule is only made for lenses implanted in a physician's office:

- For payment of IOLs inserted in a physician's office furnished from April 1, 2014, through December 31, 2014, regulations at 42 *CFR* Section 414.108

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require national fee schedules be established based on the 2012 national average allowed charges 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, which is 3.5 percent;

- For each year subsequent to 2014, 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, adjusted by the productivity adjustment as described in Section 1886(b)(3)(B)(xi)(II) of the Act; and
- For IOL codes V2630 and V2631, national fee schedule amounts have been established using the fee schedule amounts for comparable code V2632 since there is insufficient allowed charge data for use in calculating the fee schedule amounts.

Subject to coinsurance and deductible 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.

### Payment category reclassification of certain DME

Effective for dates of service on or after April 1, 2014, certain HCPCS codes for DME are reclassified from the payment category for inexpensive or other routinely purchased DME to the payment category for capped rental items, to align with the regulatory definition of routinely purchased equipment found at *42 CFR Section 414.220(a)(2)*.

These changes were determined through rulemaking (CMS-1526-F) and as written in the *MLN Matters*® article MM8566, titled *Rescind/Replace Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category*, available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network/MLN/MLNMattersArticles/Downloads/MM8566.pdf>.

As part of the April 2014 update to the DMEPOS fee schedule, the methodology used to calculate fee schedule amounts for capped rental items has been used to establish new fee schedule amounts for the following HCPCS codes:

A4639, A7025, E0117, E0144, E0198, E0300, E0620, E0656, E0657, E0740, E0762, E0764, E0849, E0855, E0856, E0984, E0986, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1010, E1014, E1029, E1030, E1161, E1232, E1233, E1234, E1235, E1236, E1237, E1238, E1700, E2227, E2310, E2311, E2312, E2313,

E2321, E2322, E2325, E2326, E2327, E2328, E2329, E2330, E2351, E2373, E2374, E2376, E2377, E2378, E2500, E2502, E2504, E2506, E2508, E2510, K0607, K0730.

Consistent with the capped rental payment methodology, only rental amounts (RR) will appear on the fee schedule file for the above codes, effective April 1, 2014, and:

- The HCPCS codes transitioning to the capped rental payment category with corresponding KC, KF or KE modifiers will continue to have rental amounts associated with these modifiers on the fee schedule file;
- The capped rental fee schedule amount is calculated based on ten percent of the base year purchase price increased by the covered item update;
- This is the fee schedule amount for rental months one through three. Beginning with the fourth month, the fee schedule amount is equal to 75 percent of the fee schedule amount paid in each of the first three rental months; and
- All of the payment rules for capped rental items, including guidelines regarding continuous use and transfer of title to the beneficiary following 13 months of continuous use, apply to these codes, effective for claims with dates of service on or after April 1, 2014.

Also effective April 1, 2014, MACs will process and pay claims for capped rental wheelchair accessories on a lump sum purchase basis when used with complex rehabilitative power wheelchairs (wheelchair base codes K0835 – K0864). In this case, the supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished. The purchase fee schedule amount for capped rental accessories furnished in this manner is equal to the rental fee (for months one through three) multiplied by ten. If the beneficiary declines the purchase option, the supplier must furnish the accessory on a rental basis and payment will be made in accordance with the capped rental payment rules.

### Specific coding and pricing issues

As part of this update, effective April 1, 2014, HCPCS code L8680 is not included on the 2014 DMEPOS fee schedule file and the coverage indicator is revised to “I” to show it is not payable by Medicare. Note that:

- For neurostimulator devices, HCPCS L8680 is no longer separately billable for Medicare because payment for electrodes has been incorporated in *CPT*® code 63650 *Percutaneous implantation of neurostimulator electrode array, epidural*.

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## 2014 annual update for DMEPOS fee schedule

**Note:** This article was revised March 6 to provide updates regarding healthcare common procedure coding system (HCPCS) code changes that were effective January 1, 2014. The changes are in **bold print** under *HCPCS codes added/deleted*. This information was previously published in the December 2013 *Medicare B Connection*, Pages 9-13.

### 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 durable medical equipment (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/>.

### 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; and E1352

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 code is deleted from the HCPCS effective January 1, 2014, and therefore, is removed from the DMEPOS fee schedule files: L0430

The following codes are deleted from the DMEPOS fee schedule files as of January 1, 2014: A4611, A4612, A4613, E0457, E0459, L8685, L8686, L8687, and L8688.

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- CMS established non-facility practice expense inputs for CPT® code 63650 in the Medicare physician fee schedule final rule (published November 27, 2013). As a result, practitioners should not report electrode(s) using code L8680 in conjunction with a lead implantation procedure furnished in any setting for Medicare.
- Also, this change for code L8680 will be available on the HCPCS Quarterly Update website at [http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS\\_Quarterly\\_Update.html](http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html).

### Additional information

The official instruction, CR 8645 issued to your MAC regarding this change may be viewed at [http://www.](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2902CP.pdf)

[cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2902CP.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2902CP.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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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, (1 piece), each; and
- 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 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 certification or 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>.

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

Fee from existing code	Crosswalk to new off-the-shelf 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

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Fee from existing code	Crosswalk to new off-the-shelf and revised custom fitted orthotic codes
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](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 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 recompleted. 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, CR 8325, dated May 17, 2013, and transmittal 2661, CR 8204, dated February 22, 2013. Additional information related to these CRs is available in the following *MLN Matters*® articles:

- **MM8325** <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf>
- **MM8204** <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.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 at <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 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 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 in Table A (Page 19).

**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

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**Table A**

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

equipment (OGPE). The updated 2014 monthly payment amount of \$178.24 includes the 1 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 the following *MLN Matters*® articles:

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

**MLN Matters**® Number: MM8531 *Revised*  
 Related Change Request (CR) #: CR 8531  
 Related CR Release Date: December 13, 2013  
 Effective Date: January 1, 2014  
 Related CR Transmittal #: R2836CP  
 Implementation January 6, 2014

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

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State	K0739	L4205	L7520	State	K0739	L4205	L7520
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				

## Evaluation and Management

### E/M services billed with allergen immunotherapy services CPT® codes 95115-95199 require modifier 25

First Coast Service Options Inc. (First Coast) recently conducted a data analysis to evaluate allergen immunotherapy services *Current Procedural Terminology* (CPT® codes 95115-95199) and found that evaluation and management (E/M) services were billed without appending modifier 25 to indicate the E/M service was a significant and separately identifiable service performed on the same patient same date as the allergen immunotherapy services by the same provider.



According to the American Medical Association (AMA) CPT® code book, "Codes for Allergen Immunotherapy CPT® codes 95115-95199 includes the professional services necessary for allergen immunotherapy. Office visit codes may be used in addition to allergen immunotherapy if other identifiable services are provided at that time".

### Modifier 25

According to the guidelines for the correct use of modifier 25 for global procedures found in the Center Medicare & Medicaid services (CMS) [Publication 100-40 Medicare Claims Processing Manual Chapter 12](#), Section 30.6.6 B, and 40.2.8 which indicates that the 25 modifier is used only with claims for E/M services and only when the services are provided by the same physician or by a qualified healthcare practitioner to the same patient on the same day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable and the E/M service was above and beyond the usual pre- and post- operative work of the procedure.

The 25 modifier is used to denote a significant, separately identifiable E/M services performed by the same physician on the same day that he or she performed another procedure or service. The following guidelines apply:

- The 25 modifier should only be used with E/M services (CPT® code range 99201-99499) and not with surgery/global codes
- Different diagnoses are not required for reporting E/M service
- Adequate documentation is required to indicate the medical necessity E/M service and the procedure must be appropriately and sufficiently documented in the medical records
- Medicare administrative contractor (MAC) will pay for E/M services with modifier 25 in addition to

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the global fee without any other requirements for documentation, however, carriers may conduct a specific medical review on a case-by-case basis when high statistics regarding the use of the modifier 25 by an individual or group is significant

- The 25 modifier is only used to notify the payer that the E/M service needs to be paid separately from the reimbursement for the procedure indicating the E/M service was significant and separately identifiable.

### Billing requirements for global surgeries

The billing requirements for global surgeries can be found in the CMS Publication 100-40 *Medicare Claims Processing Manual* Chapter 12, Section 40.20 to ensure that the proper identification of services for both included and excluded services from the global package the following procedures apply:

The use of modifiers apply to major procedures with a global period of 90-day postoperative period and minor procedures with a 10-day postoperative period and or zero day postoperative period in the case of modifiers 22 and 25.

The documentation must clearly reflect that the E/M

services was above and beyond the usual care provided on the same day of the procedure and the services provided were not a normal part of the procedure. The documentation must reflect the following:

An independent evaluation and management service due to a complaint, symptom, condition, problem, or circumstance that may or may not be related to the procedure or service being provided and should include important, notable and distinct correlation with the signs and symptoms for a distinct problem.

### Educational resources

The LCD numbers for the First Coast local coverage determination (LCD) for allergen immunotherapy (10/01/2011 revision) are L29056 for Florida and L29074 for Puerto Rico and the U.S. Virgin Islands.

The following Web-based training courses are available on the [First Coast University](#) website to help providers learn more about the proper billing of the 25 modifier as well as the documentation requirements to support the necessity or validity of its use:

- [Introduction to Global Surgery](#)
- [Modifier 25](#)
- [Medical Documentation Request](#)

## Documenting psychiatry and psychotherapy services

**Note:** This article was revised March 18, 2014. This information was previously published in the February 2014 *Medicare B Connection*, Page 34.



### Provider types affected

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

### Provider action needed

#### Stop – impact to you

The comprehensive error rate testing (CERT)

program's reviews of claims for Part B psychiatry and psychotherapy services have identified many improper payments.

This SE article provides an overview of billing for psychiatry and psychotherapy services with Healthcare Common Procedure Coding System (HCPCS)/ *Current Procedural Terminology*® (CPT®) codes. Major changes to the American Medical Association's (AMA) CPT® took effect on January 1, 2013.

Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

### Background

The main error that CERT has identified with the revised psychiatry and psychotherapy codes is not clearly documenting the amount of time spent only on psychotherapy services. The correct evaluation and management (E&M) code selection must be based on the elements of the history and exam and medical decision making required by the complexity/intensity of the patient's condition. The psychotherapy code is chosen on the basis of the time spent providing psychotherapy.

When a beneficiary receives an evaluation and management service (E&M) service with a psychotherapeutic service on the same day, by the

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same provider, both services are payable if they are significant and separately identifiable and billed using the correct codes. New add-on codes (in the bulleted list below) designate psychotherapeutic services performed with E&M codes. An add-on code (often designated with a "+" in codebooks) describes a service performed with another primary service.

An add-on code is eligible for payment only if reported with an appropriate primary service performed on the same date of service. Time spent for the E&M service is separate from the time spent providing psychotherapy and time spent providing psychotherapy cannot be used to meet criteria for the E&M service.

**Because time is indicated in the code descriptor for the psychotherapy CPT® codes, it is important for providers to clearly document in the patient's medical record the time spent providing the psychotherapy service rather than entering one time period including the E&M service.**

**For psychotherapy services provided with an E&M service:**

- + 90833: Psychotherapy, 30 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure)
- + 90836: Psychotherapy, 45 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure)
- + 90838: Psychotherapy, 60 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure)

**For psychotherapy services provided without an E&M service, the correct code depends on the time spent with the beneficiary.**

- 90832: *Psychotherapy, 30 minutes with patient and/or family member*
- 90834: *Psychotherapy, 45 minutes with patient and/or family member*
- 90837: *Psychotherapy, 60 minutes with patient and/or family member*

In general, providers should select the code that most closely matches the actual time spent performing psychotherapy. CPT® provides flexibility by identifying time ranges that may be associated with each of the three codes:

- 90832 (or + 90833): 16 to 37 minutes,
- 90834 (or + 90836): 38 to 52 minutes, or

- 90837 (or + 90838): 53 minutes or longer

Do not bill psychotherapy codes for sessions lasting less than 16 minutes.

Psychotherapy codes are no longer dependent on the service location (i.e., office, hospital, residential setting, or other location is not a factor). However, effective January 1, 2014, when E&M services are paid under Medicare's partial hospitalization program (PHP) and not in the physician office setting, the CPT® outpatient visit codes 99201-99215 have been replaced with one Level II HCPCS code G0463. Further information about this code can be found in the 2014 OPPS/ASC final rule that was published in the *Federal Register* on December 10, 2013.

**Example:** A geriatric psychiatrist (physician) billed for a level three E&M service (99213) and 45 minutes of psychotherapy (90836). The medical record contained one entry for the date of service and, at the top, a notation: "45 minutes". It did not indicate whether the 45 minutes was spent providing the psychotherapy services or both services. An overpayment for the psychotherapy service and a billing error occur when there is no separate entry for the amount of time spent performing psychotherapy services.

### Additional information

You can find more information on how to avoid errors on claims for psychiatric and psychotherapy services by reviewing the following resources:

- Local coverage determinations, which are available at <http://www.cms.gov/medicare-coverage-database/>;
- CPT® 2014 available from the AMA; Refer to page xxiv (E/M and Psychotherapy Coding Algorithm) of the 2014 CPT® Professional Edition in choosing the appropriate psychotherapy codes.
- *Federal Register*, December 10, 2013, Table 42, 2013 Clinic and Emergency Department Visit HCPCS Codes and APC Assignments Compared to 2014 Clinic and Emergency Department Visit HCPCS Codes and APC Assignments. p. 75042 - 75043. This table is available in the file at <http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf>.
- *Federal Register*, November 15, 2012, Table 42. Crosswalk of Deleted and New PHP CPT® and HCPCS Billable Codes for 2013 p. 68416. This table is available within the document at <http://www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf>.
- Psychotherapy notes are discussed in *MLN Matters*® article MM3457, Revised February 4, 2013. This article is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm3457.pdf>.

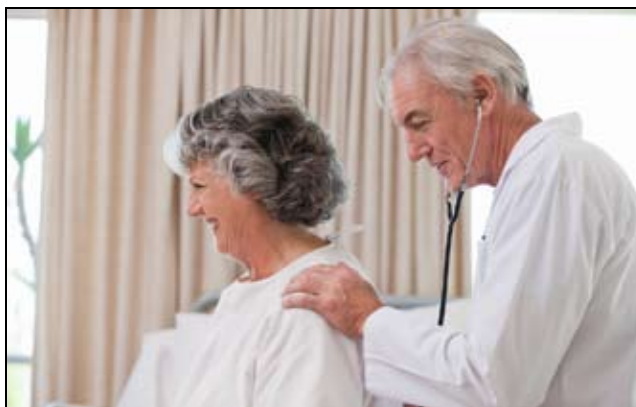
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## New audit review for evaluation and management home visits CPT® codes 99348-99350 in Puerto Rico

First Coast Service Options Inc. (First Coast) recently conducted data analysis pertaining to the potential overutilization of home visits evaluation and management (E/M) codes *Common Procedural Terminology* (CPT® codes 99348-99350) in Puerto Rico. The findings indicated that First Coast was at risk for payment errors for these services. The national comparison data has remained high for Puerto Rico despite previous medical review actions.

In the local coverage determination (LCD) L29421 titled E&M Home and Domiciliary Visits revised effective date of March 2, 2009, First Coast outlines the indication and limitations of coverage and/or medical necessity for reimbursement by Medicare in lieu of an office visit. The following information is an excerpt from the LCD:

- The service/visit must be medically reasonable and necessary and not for the convenience of the physician or qualified nurse practitioner (NPP) with the appropriate documentation for the home visit in lieu of an office visit.
- Service/visit must be equal to or similar services provided in an office. The frequency of visits required to address any given clinical problem should be dictated by medical necessity rather than site of service and the expected frequency of visits addressed in the home setting will not exceed that of an office setting, except on rare occasions.
- Each visit must meet applicable medical standards of practice.
- The service is of such nature that it could not be provided by a visiting nurse/home health service



agency under the home health benefit.

- A qualified physician or qualified non-physician practitioner must perform the service
- If the total number of home and domiciliary E/M services exceeds what could reasonably be provided, based upon the standard of care and the

component requirements for those E/M codes, those E/M codes may be subject to medical review. The physician/qualified non-physician practitioner must be the provider of record and be responsible for managing the entire disease process addressed in the visit. If the home/domiciliary care is being provided by other than the provider of record for a limited condition that would not typically prevent return to an office environment after

recovery, the service will be presumed to be not medically necessary, unless the provider of record requests a consultation and the care is medically necessary and clearly documented in the medical record.

As outlined in the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.14.1

- Home services codes 99341-99350 are paid when they are billed to report evaluation and management services provided in a private resident. A home visit cannot be billed by physician unless the physician was actually present in the beneficiary's home.
- For home services provided by a physician using these codes, the beneficiary does not need to be confined to the home. The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.

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- Add-on HCPCS/CPT® codes without primary codes are discussed in *MLN Matters*® article SE1320, Revised August 16, 2013, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMatters/Articles/Downloads/SE1320.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: SE1407

Related Change Request (CR) #: n/a

Related CR Release Date: n/a

Effective Date: n/a

Related CR Transmittal #: n/a

Implementation Date: n/a

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- Payment maybe made in some medically underserved areas where there is a lack of personnel and home health services for injections, EKGs, and venipuncture's that are performed for homebound patients under general physician supervision by nurses and paramedical employees of physicians or physician-directed clinics,

### Documentation requirements

Medicare's medically reasonable and necessary criteria must be met, Standing visits or standing orders are not

considered medically necessary unless the patient's medical condition is clearly documented and they are considered to be medically necessary when they relate to acceptable standards of medical practice.

### First Coast action

In response to the risk for payment error First Coast will be implementing a prepayment edit for these services effective date of January 15, 2014. The random edit will apply a 50 percent prepayment threshold medical review based on processed dates for home visits codes 99348-99350.

## Laboratory/Pathology

### 2014 Medicare travel allowances for collecting lab specimens

#### Provider types affected

This *MLN Matters*® article for clinical diagnostic laboratories submitting claims to A/B Medicare administration contractors (A/B MACs) for services provided to Medicare beneficiaries.

#### Provider action needed

##### Stop – impact to you

This article is based on change request (CR) 8641 which informs MACs and providers about changes to the clinical laboratory fee schedule (CLFS) related to travel allowances and specimen collection fees.

##### Caution – What you need to know

CR 8641 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat rate basis using HCPCS code P9604 for 2014.

##### Go – What you need to do

Make sure your billing staffs are aware of these changes.

#### Background

HCPCS travel codes allow for payment on either a per mileage basis (HCPCS code P9603) or a flat rate per trip basis (HCPCS code P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. MAC discretion allows the MAC to choose

either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs have established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory, or when the flat rate is set by the MAC.



#### Per mile travel allowance (P9603)

The per mile travel allowance is to be:

- Used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and
- Prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The Internal Revenue Service determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile. The allowance per mile was computed using the federal mileage rate of **\$0.56 per mile plus an additional \$0.45 per mile** to cover the technician's time and travel costs.

**Note:** MACs have the option of establishing a higher per mile rate in excess of the minimum total of \$1.01 per mile (\$0.56 per mile plus \$0.45 per mile) if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well

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## April 2014 Medicare physician fee schedule database update

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

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2. **Adjust facility and non-facility PE RVUs for HCPCS 77293 via CMS update files. See Table A (Page 27).**
3. **HCPCS code G9361 will be added to your Medicare contractor's systems as indicated in the chart below.**

Field	Indicator
Procedure status	M
Short descriptor	Doc comm risk calc
Effective date	01/01/2014
Work RVU	0
Full non-facility PE RVU	0
Full non-facility NA indicator	(blank)
Full facility PE RVU	0
Full facility NA indicator	(blank)
Malpractice RVU	0
Multiple procedure indicator	9
Bilateral surgery indicator	9
Assistant surgery indicator	9
Co-surgery indicator	9
Team surgery indicator	9
PC/TC	9
Site of service	9
Global surgery	XXX
Pre	0.00
Intra	0.00
Post	0.00
Physician supervision diagnostic indicator	09
Diagnostic family imaging indicator	99
Non-facility PE used for OPPS payment amount	0.00
Facility PE used for OPPS payment amount	0.00
MP used for OPPS payment amount	0.00
Type of service	9

Field	Indicator
Long descriptor	Medical indication for induction [Documentation of reason(s) for elective delivery or early induction (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-premature, prolonged maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, malposition and malpresentation of fetus, late pregnancy, prior uterine surgery, or participation in clinical trial)]

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

HCPCS	Description	Indicator
70450TC	CT head/brain w/o dye - Phys diag supv correction (TC)	01
70460TC	CT head/brain w/ dye - Phys diag supv correction (TC)	02
70551TC	MRI brain stem w/o dye - Phys diag supv correction (TC)	01
70552TC	MRI brain stem w/ dye - Phys diag supv correction (TC)	02
70553TC	MRI brain stem w/o & w/dye - Phys diag supv Correction (TC)	02
72141TC	MRI neck spine w/o dye - Phys diag supv correction (TC)	01
72142TC	MRI neck spine w/ dye - Phys diag supv correction (TC)	02
72146TC	MRI chest spine w/o dye - Phys diag supv correction (TC)	01
72147TC	MRI chest spine w/ dye - Phys diag supv correction (TC)	02

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# MPFSDB

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Table A

HCPCS	Status	Description	Non-facility PE RVUs	Facility PE RVUs	Global	
77293	A	Respirator motion mgmt simul	9.96	NA	ZZZ	Jan 1 to March 31, 2014
77293TC	A	Respirator motion mgmt simul	9.16	NA	ZZZ	Jan 1 to March 31, 2014
77293	A	Respirator motion mgmt simul	10.72	NA	ZZZ	<b>Correction</b> April 1, 2014
77293TC	A	Respirator motion mgmt simul	9.92	NA	ZZZ	<b>Correction</b> April 1, 2014

HCPCS	Description	Indicator
72148TC	MRI lumbar spine w/o dye - Phys diag supv correction (TC)	01
72149TC	MRI lumbar spine w/ dye - Phys diag supv correction (TC)	02
72156TC	MRI neck spine w/o & w/dye - Phys diag supv correction (TC)	02
72157TC	MRI chest spine w/o & w/dye - Phys diag supv correction (TC)	02
72158TC	MRI lumbar spine w/o & w/dye - Phys diag supv correction (TC)	02
72191TC	CT angiograph pelv w/o&w/dye - Phys diag supv correction (TC)	02
74174TC	CT angio abd&pelv w/o&w/dye - Phys diag supv correction (TC)	02
74175TC	CT angio abdom w/o & w/dye - Phys diag supv correction (TC)	02
93880TC	Extracranial bilat study - Phys diag supv correction (TC)	01
93882TC	Extracranial uni/ltd study - Phys diag supv correction (TC)	01

HCPCS	Description	Indicator
77001TC	Fluoroguide for vein device - Phys diag supv correction (TC)	03
77002TC	Needle localization by xray - Phys diag supv correction (TC)	03
77003TC	Fluoroguide for spine inject - Phys diag supv correction (TC)	03

## Additional information

The official instruction, CR 8664 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2912CP.pdf>.

Direct questions to your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.

MLN Matters® Number: MM8664  
Related Change Request (CR) #: CR 8664  
Related CR Release Date: March 14, 2014  
Effective Date: January 1, 2014, and April 1, 2014  
Related CR Transmittal #: R2912CP  
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.*

## Radiology

### Changes affecting Medicare coverage of fluorodeoxyglucose (FDG) positron emission tomography (PET) scans

**Effective for dates of service June 11, 2013**

- The Centers for Medicare & Medicaid Services (CMS) covers three FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy after completion of the initial anti-cancer therapy for the same cancer diagnosis.
- Each (different) cancer DX is allowed one initial treatment strategy PET scans (billed with PI modifier) and three subsequent treatment strategy PET scans (billed with PS modifier).
- Coverage with evidence development (CED) requirements have ended; therefore modifier Q0/Q1, condition code 30 (institutional claims), and diagnosis code V70.7 (institutional and practitioner claims), are no longer required.

To ensure proper processing of claims please coordinate with your billing entities to discontinue the

use of modifiers Q0/Q1.

**Effective for dates of service July 7, 2014**

- First Coast will deny subsequent treatment strategy claims for oncologic FDG PET scans when no initial treatment strategy claim is present in history when appropriate.
- Coverage of additional FDG PET scans used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be allowed when billed with the KX modifier.
- Use of the KX modifier indicates that requirements specified in the medical policy have been met

To prevent unnecessary claim denials it is strongly suggested that claims contain both the PET scan *Current Procedural Terminology (CPT®)* code and the tracer HCPCS code A9552 on the same claim form.

## Therapy Services

### Task force scenario: Documenting therapy and rehabilitation services

The CERT A/B MAC Outreach & Education Task Force, a partnership of all A/B Medicare administrative contractors, created this guide to educate providers on common documentation errors for outpatient rehabilitation therapy services. These widespread errors contribute to Medicare's national payment error rate, as measured by the Comprehensive Error Rate Testing (CERT) program.

The leading cause of payment errors for therapy services is "insufficient" documentation in the medical records. Documentation is often missing the required elements as outlined in applicable local coverage determinations and the *Medicare Benefit Policy Manual* (BPM), Chapter 15, [Section 220](#) and [Section 230](#). Providers in jurisdiction 9 (J9) can locate the applicable LCD for their locality and line of business on First Coast Service Options' [LCD Lookup tool](#). The J9 LCD identification numbers are:

- Florida: Part A L28992, Part B L29289
- Puerto Rico and U.S. Virgin Islands: Part A L29024, Part B L29339

For example, a provider indicates in the plan of care: "We would like to see the patient three times per week to initiate exercises and modalities to decrease pain and increase range of motion, stretching, strengthening and function." This plan is missing key elements to support the medical necessity of the

service, such as measurable long term goals, the patient's diagnosis, the proposed type, duration and frequency of services required to achieve each goal, or anticipated plan of discharge.

Additional widespread issues that result in "insufficient" documentation errors include:

- Missing or illegible signature on the plan of care;
- Missing or illegible signature for physician's certification; and
- Missing legible signature and required treatment minutes in narrative or on flow sheet.

The CERT A/B MAC Outreach & Education Task Force recommends providers carefully review the following documentation requirements and tips for ensuring complete and accurate medical records.

#### Contents of plan of care

The plan of care shall contain, at minimum, the following information as required by regulation ([42CFR§424.24](#) and [410.61](#) and BPM, Chapter 15, Section 220.1.2(B)):

- Diagnoses
- Long term treatment goals – should be developed for the entire episode of care and not only for the services provided under a plan for one interval of



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care

- Type – may be physical therapy, occupational therapy, or speech language pathology, or when appropriate, the type may be a description of a specific treatment of intervention. When a physician or non-physician practitioner (NPP) establishes a plan, the plan must specify the type of therapy planned.
- Amount – refers to the number of times in a day the type of treatment will be provided. When amount is not specified, one treatment session a day is assumed.
- Duration – number of weeks or the number of treatment sessions for the plan of care
- Frequency of therapy services – refers to the number of times in a week the type of treatment is provided. When frequency is not specified, one treatment is assumed.

The plan of care shall be consistent with the related evaluation. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.

### Signature and certification of the plan of care

The legible signature and professional identity (e.g., MD, OTR/L) of the individual, who established the plan, as well as the date it was established, must be recorded with the plan. A physician or NPP must certify (and date) the plan of care (\*note: for CORF services, NPPs may not order or certify therapy services). Certification may be established in the patient's medical record through:

- Physician's or NPP's progress note
- Physician or NPP's order\*
- Plan of care that is signed and dated by a physician/NPP\*
- Documentation must indicate that the physician/ NPP\* is aware that the therapy service is or was in progress; and
- Agrees with the plan, when there is evidence the plan was sent to the physician/NPP, or is available in the patient's medical record for the physician/ NPP to review.

### Treatment note

The purpose of treatment notes is to create a record of all treatments and skilled interventions that are provided and to record the time of the services to justify the use of billing codes and units on the claim. Documentation is required for every treatment day and every therapy service. Documentation of each

treatment note must include the following required elements:

- Date of treatment
- Identification of each specific intervention/modality provided and billed (both timed and untimed codes)
- Total timed code treatment minutes and total treatment time in minutes
- Signature and professional identification of the qualified professional who furnished the services; or, for incident to services, supervised the services, including a list of each person who contributed to the treatment

### Functional reporting



Claims for therapy services that are required to contain the nonpayable G-codes and corresponding modifiers should include documentation of Functional Reporting in the medical record. Specifically, documentation of the nonpayable G-codes and severity modifiers regarding functional limitations reported on claims must be included in the patient's medical record of therapy services for each required reporting interval as outlined in the BPM, Chapter 15, [Section 220.4](#).

Documentation of functional reporting must be completed by the clinician furnishing the therapy services. Therapists must also document his/her clinical judgment in the assignment of the severity modifier.

### Avoid CERT errors: Tips to improve therapy documentation

- Ensure the medical records submitted provide proof the service(s) was certified and rendered.
- Ensure the medical records provide justification supporting medical necessity and that skilled services were needed.
- Create a complete plan of care, making certain to include your legible signature, professional identification (e.g., PT, OTR/L) and date the plan was established.

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- Document when the plan of care is modified, including how it has been modified and why the previous goals were not met or could not be met.
- Confirm the plan of care is certified (recertified when appropriate) with physician/NPP legible signature and date.
- Clearly document, in minutes, the total time spent on timed-code treatment only and the total treatment time (including timed and untimed codes) in the patient's record.

## Additional resources

To find additional information regarding therapy and

rehabilitation services, refer to the following resources on the CMS website:

- **CORFs:** Chapter 5 of the [Medicare Claims Processing Manual \(Publication 100-04\)](#) and Chapter 12 of the [Medicare Benefit Policy \(Publication 100-02\)](#)
- **Skilled therapy services** provided in [Skilled Nursing Facilities: Chapter 8 of the Medicare Benefit Policy Manual \(Publication 100-02\)](#)
- **Other guidance:** [CMS Therapy Services Web page](#)

*Disclaimer: The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare Fee-for-Service improper payment rate.*

## Therapy services billed by the specialty 25 – Puerto Rico only

On July 24, 2012, First Coast activated a prepayment edit for therapy services rendered by specialty 25 (Physical Medicine and Rehabilitation) in Puerto Rico. This was due to medical review findings that revealed this specialty presents an 88 percent error rate.



The purpose of the edit is to prevent the payment of non-covered, incorrectly coded, and inappropriately billed services. Also, with medical review assistance,

customer service now advises providers in correcting the billing and documentation errors.

Data for October 1 through December 31, 2013, show an error rate of 81 percent. A significant amount of this error rate is due to either non-response to requests for documentation or to the submission of incomplete documentation. These same claims on many occasions are paid at the appeals level. Although, while an increase in claims being paid on appeal is noticeable, the error rate remains high.

**Providers can be removed from the prepayment edit.** Providers who decrease their error rate to less than 10 percent can be released from the prepayment edit. However, claims must be evaluated for payment at the prepayment level to lower the error rate.

Providers must:

- Submit documentation in a timely manner, and
- Submit all documentation necessary to properly evaluate the claims for payment.

Once you have received the request for documentation (ADR), submit a copy of the ADR letter with the medical records within 30 days.

First Coast recommends you visit our specialty page for rehabilitation services at <http://medicare.fcso.com/Landing/138325.asp>. This page offers resources that outlines documentation requirements and offers a [rehabilitation services documentation checklist](#) that will assist you in responding to documentation requests.

### Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at [http://medicare.fcso.com/Fee\\_lookup/fee\\_schedule.asp](http://medicare.fcso.com/Fee_lookup/fee_schedule.asp). This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.



## Wound Care

### Skin substitutes – clarification of coverage

Effective January 1, 2014, the Centers for Medicare & Medicaid Services (CMS) implemented an outpatient prospective payment system (OPPS) change request edit (CR 8572) that requires hospitals to report all high cost skin substitute products in combination with one of the skin application procedures described by *Current Procedural Terminology*® (CPT®) codes 15271-15278 and to report all low cost skin substitute products in combination with one of the skin application procedures described by HCPCS codes C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT® codes 15271-15278.

Based on this change in payment methodology in OPPS, the varied application of these products in the hospital setting, and the additional controls in the hospital setting, the Medicare administrative contractor (MAC) J9 retired the Part A skin substitutes local coverage determination (LCD). Currently, the

MAC J9 is silent on coverage for skin substitute services in the hospital setting, given there is no LCD or national coverage determination (NCD) in play. If a claim is audited, any service/procedure utilizing these products in an episode of care would have to meet the Medicare reasonable and necessary (R&N) threshold of coverage as documented in the patient's medical record, assuming all other requirements of the Medicare program are met.

The Part B LCD remains in effect and has limited coverage to the following four products- Apligraf®, Dermagraft®, Integra Dermal Regeneration Template®, and Oasis® Wound Matrix and Oasis® Ultra Tri-Layer Matrix, with the R&N criteria as outlined in the indications and limitations section of the LCD. To review the products that remain non covered, as medical necessity for these products has not been established, please refer to the Part B LCD-skin substitutes, L29279 (Florida) and L29393 (Puerto Rico/U.S.Virgin Islands).

## General Coverage

### Bilateral procedures and MUEs

First Coast Service Options Inc. (First Coast) Provider Contact Center has received numerous inquiries regarding medically unlikely edits (MUEs), anatomical modifiers (e.g., RT, LT, E1, E3, etc.) and the usage of modifier 50. The purpose of this article is to provide clarification on how modifier 50 should be billed.

Bilateral surgery is defined as a procedure performed on both sides of the body at the same operative session or on the same day. This definition does not include procedures that are bilateral in nature or include the terms "bilateral" or "unilateral/bilateral" in their descriptors.

Use modifier 50 with the procedure code when submitting claims for bilateral surgery. Claims for bilateral surgical procedures should be billed on a single claim detail line with the appropriate procedure code and modifier 50 and one (1) unit of service (UOS). Modifiers RT and LT should not be used when modifier

50 applies. When billing claims for procedure codes that are bilateral in nature, regardless of whether these services are performed unilaterally or bilaterally, providers should bill the surgical procedure code as a single claim detail line item without modifier 50.

To determine if a procedure should be billed with the modifier 50 as a bilateral procedure, providers may access the [Medicare Physician Fee Schedule \(MPFS\) look-up tool](#). Select MPFS and enter the date of service, locality and procedure code. Once you select "Submit," the details of the procedure code will be revealed. Under the heading "Modifier," select "more." The "Bilateral Surgery" indicator will advise if a modifier 50 should be billed with the code. [Click here](#) for guidance on the modifier 50 payment policy indicator.



**Source:** *Medicare Claims Processing Manual*, Chapter 4, Section 20.6.2; Chapter 23



## ICD-10 testing with providers through the CEM and CEDI

**Note:** This article was revised March 10, 2014, to reflect a revised change request (CR). The due date for the contractor report to the Centers for Medicare & Medicaid Services (CMS) was changed to March 12, 2014, under *Background*. This date was also added to the implementation date for this reporting requirement only. On February 27, 2014, the article was revised to provide additional information to providers, suppliers, and clearinghouses about how claims will be submitted for testing (under *What providers need to know*). The transmittal number, CR release date and link to the CR were also changed. This information was previously published in the November 2013 *Medicare B Connection*, Page 21.

### Provider types affected

This *MLN Matters*® article is intended for Medicare providers and suppliers submitting claims to Medicare contractors (A/B Medicare administrative contractors (A/B MACs), home health and hospice MACs (HHH MACs) and the durable medical equipment MACs (DME MACs) for services to Medicare beneficiaries.

### What providers need to know

This article is based on CR 8465, which announces plans for front-end ICD-10 testing between MACs and their trading partners.

**For dates of service of October 1, 2014, (and after) providers are required to submit ICD-10 codes on their claims. MACs must provide the opportunity for providers and suppliers to submit test claims through the CEM or the CEDI on the designated testing days.**

- **Test claims with ICD-10 codes must be submitted with current dates of service (i.e. October 1, 2013, through March 3, 2014), since testing does not support future dated claims.**
- **Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system.**
- **Testing will not confirm claim payment or produce remittance advice.**
- **MACs and CEDI will be staffed to handle increased call volume during this week.**

Make sure that your billing staff is aware of these upcoming ICD-10 testing periods.

### Background

CMS is in the process of implementing ICD-10. All covered entities have to be fully compliant on October 1

CR 8465 instructed all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the

trading partners' ability to meet technical compliance and performance processing standards during the HIPAA 5010 implementation. The ICD-10 testing week was created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

This testing week gave trading partners access to the MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on each MAC and the CEDI website as well as the CMS website.

The testing week was March 3 through March 7, 2014.

### Testing week information

- Your MAC announced and actively promoted the testing week via listserv messages and posted the testing week announcement on their website.
- Your MAC hosted a registration site for the testing week, or provide an email address for the trading partners to provide registration information. The registration site or email address information was available and publicized to trading partners at least four weeks prior to the testing week.
- During the testing week, EDI help desk support was available, at a minimum, from 9:00 a.m. to 4:00 p.m. local contractor time, with enough support to handle any increased call volume.
- Providers and suppliers participating during the testing week will receive electronic acknowledgement confirming that the submitted test claims were accepted or rejected.
- **On or before March 12, 2014, your contractor reported the following to CMS:**
  - Number of trading partners conducting testing during the testing week.
  - Percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract.
  - Percent of test claims accepted versus rejected.
  - Report of significant issues found during testing.

### Additional information

The official instruction, CR 8465, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1357OTN.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->

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## ICD-10 limited end-to-end testing with submitters

**Note:** This article was revised March 10, 2014, to add a link to a related *MLN Matters*® special edition (SE) article. SE1409 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1409.pdf>) conveys the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

### Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare claims administration contractors (durable medical equipment Medicare administrative contractors (DME MACs), A/B MACs, and/or home health and hospices (HH & H MACs) for services provided to Medicare beneficiaries.

### What you need to know

This article is based on change request (CR) 8602 which instructs providers and clearinghouses on how to volunteer to be chosen for International Classification of Diseases, Tenth Revision (ICD-10) end-to-end testing with Medicare in July 2014. Potential testers had to complete the volunteer form by March 24, 2014.

### Background

The ICD-10 must be implemented by October 1, 2014. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS.

CR 8602 will allow for a small subset of Medicare claims submitters to test with MACs and the common electronic data interchange (CEDI) contractor to demonstrate that CMS systems are ready for the ICD-10 implementation. This additional testing effort will further ensure a successful transition to ICD-10.

To facilitate this testing, CR 8602 requires MACs to do the following:

- Conduct a limited end-to-end testing with submitters in July 2014. Test claims will be submitted July 21-25, 2014.
- Each MAC (and CEDI with assistance from DME MACs) will select 32 submitters to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will select 16 submitters.)

Testers will be selected randomly from a list of volunteers. At least five, but not more than ten of the testers will be a clearinghouse, and submitters should be a mix of provider types.

- By March 7, 2014, the MACs and CEDI posted a volunteer form to their website to collect volunteer information with which to select volunteers. The form will provide information to verify that volunteers are ready to test, meet the requirements to test, and collect needed data about the tester (how they submit claims, what type of claims will be tested, etc.). Volunteers had to submit the completed forms to the MACs and CEDI by March 24, 2014.
- By April 14, 2014, the MACs and CEDI (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
  - How to submit test claims (for example, what test indicators should be set)
  - What dates of service may be used for testing
  - How many claims may be submitted for testing (test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files)
  - Request for national provider identifiers (NPIs) and health insurance claim numbers (HICNs) that will be used in testing (no more than five NPIs and 10 HICNs per submitter)
  - Notice that if more than 50 claims are submitted, they may not be processed
  - Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed, and
  - Notice of potential Protected Health Information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).
- MACs and CEDI (for the DME MACs) will collect information from the selected test volunteers to request the HICNs, NPIs, and provider transaction access numbers (PTANs) the testers will use during the testing. The forms for this information must be completed and returned to the MAC/CEDI

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### ICD-10

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[map/index.html](#).

*MLN Matters*® Number: MM8465 *Revised*  
Related Change Request (CR) #: CR 8465  
Related CR Release Date: March 7, 2014  
Effective Date: December 3, 2013  
Related CR Transmittal #: R1357OTN

Implementation Date: March 3, 2014; March 12, 2014 for contractor report to CMS

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by May 2, 2014. If these forms are not returned by May 2, the tester may lose the opportunity to test.

- CEDI will instruct suppliers to submit claims with ICD-10 codes with dates of service (DOS) October 1-October 15, 2014. They may also submit claims with ICD-9 codes with DOS before October 1.
- MACs will instruct testers to submit test claims with ICD-10 codes with DOS on or after October 1. They may also submit test claims with ICD-9 codes with DOS before October 1, 2014.
- MACs and CEDI will be prepared to support increased call volume from testers during the testing window, and up to two weeks following the receipt of the electronic remittance advices (ERAs) from testing. MACs and CEDI will provide information to the testers on who to contact for testing questions. There may be separate contacts for front end questions and remittance questions.
- Announcement about the testing and other information related to ICD-10 will be posted on your MACs website as it become available.

### Additional information

The official instruction, CR 8602, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1352OTN.pdf>.

Direct questions to your MAC; their toll-free number, may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.

MLN Matters® Number: MM8602

Related Change Request (CR) #: CR 8602

Related CR Release Date: February 21, 2014

Effective Date: July 7, 2014

Related CR Transmittal #: R1352OTN

Implementation Date: July 7, 2014

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## Medicare fee-for-service ICD-10 testing approach

**Note:** This article was revised March 10, 2014, to add a link to a related *MLN Matters*® article MM8602 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8602.pdf>) that instructs providers and clearinghouses on volunteering for International Classification of Diseases, 10th Edition (ICD-10) end-to-end testing with Medicare in July 2014.

Potential testers had to completed the volunteer form on the MAC website by March 24, 2014. This article was previously revised February 27, 2014, to add information about the second week of acknowledgement testing and to provide more details about end-to-end testing. All other information is the same. This article was previously published in the February 2014 *Medicare B Connection*, Pages 38-39.

### Provider types affected

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

### Provider action needed

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes

must be used for dates of service on and after October 1, 2014. Be sure you are ready. This *MLN Matters*® special edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

### Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2014, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing to ensure that CMS as well as the Medicare fee-for-service (FFS) provider community is ready.

When “you” is used in this publication, we are referring to the FFS provider community. The four-pronged approach includes:

- CMS internal testing of its claim processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail in this article.

### CMS internal testing of its claims processing systems

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## APPROACH

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CMS has a very mature and rigorous testing program for its Medicare FFS claim processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for four weeks;
- Beta testing is performed by a separate integration contractor for eight weeks; and
- Acceptance testing is performed by each MAC for four weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claim processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.



### Provider-initiated beta testing tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as national coverage determination (NCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at <http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html>;
- The ICD-10 Medicare severity-diagnosis related groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the general equivalence mappings to convert ICD-9 codes to ICD-10, clinical modification codes, located at <http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html>. On this Web page, you can also find current versions of the ICD-10-CM MS-DRG grouper, Medicare code editor (available from National Technical Information Service), and MS-DRG definitions manual that will allow you to analyze any payment impact from

the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and

- A pilot version of the October 2013 integrated outpatient code editor (IOCE) that utilizes ICD-10-CM located at <http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf>. The final version of IOCE that utilizes ICD-10-CM is scheduled for release in August 2014.

Crosswalks for local coverage determinations (LCDs) will be available in April 2014.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2014, you should investigate downloading the free billing software that CMS offers from their MACs. The software has been updated to support ICD-10 codes and requires an Internet connection. This billing software only works for submitting fee-for-service claims to Medicare.

Alternatively, many MACs

offer provider internet portals, and some MACs offer a subset of these portals that you can register for to ensure that you have the flexibility to submit professional claims this way as a contingency.

### Acknowledgement testing

CMS offered ICD-10 acknowledgement testing March 3-7, 2014. This testing allowed all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims were not adjudicated, the MACs returned an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected. For more information about acknowledgement testing, refer to the information on your MAC's website.

CMS plans to offer a second week of acknowledgement testing in early May 2014.

### End-to-end testing

In late July 2014, CMS will offer end-to-end testing to a small sample group of providers.

End-to-end testing includes the submission of test claims to CMS with ICD-10 codes and the provider's receipt of a remittance advice (RA) that explains the

See **APPROACH**, Next Page



## Implementation of operating rules for electronic funds transfers

### Provider types affected

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



### What you need to know

This article is based on change request (CR) 8629 which informs MACs that they must comply with NACHA operating rules that are applicable to initiators of health care payments. CR 8629 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) network with electronic health care payments. The overarching goal of the requirements of CR 8629 is to assure that providers receiving health care payments via EFT will receive a “trace number”

that facilitates automatic re-association of the EFT health care payment with its associated remittance advice.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider’s financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the company entry description and the TRN segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

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

### Background

In support of Health Insurance Portability & Accountability Act of 1996 (HIPAA) Operating Rules for health care EFT and remittance advice transactions adopted by HHS, NACHA – The Electronic Payments Association has adopted its own operating rules that apply to ACH transactions that are health care payments from health plans to providers. NACHA manages the development, administration and governance of the ACH Network used by all types of financial networks and represents more than 10,000 financial institutions.

See **RULES**, Next Page

## APPROACH

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adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available in March 2014. Over 500 volunteer submitters will be selected nationwide to participate in the end-to-end testing. The small sample group of participants will be selected to represent a broad cross-section of provider types, claims types, and submitter types.

Additional details about the end-to-end testing process

will be disseminated at a later date in a separate *MLN Matters*® article.

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: SE1409  
 Related Change Request (CR) #: SE 1409  
 Related CR Release Date: n/a  
 Effective Date: October 1, 2014  
 Related CR Transmittal #: N/A  
 Implementation Date: N/A

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## RULES

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

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

- Company Entry Description of "HCCLAIMPMT" to identify the payment as healthcare;
- Company Name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a record type code of "7" and an addenda type code equal to "05"; and
- Payment related information in the addenda record must contain the ASC x12 835 TRN (Re-association trace number) data segment that is included on the electronic remittance advice.
- Healthcare providers will utilize the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. See "Healthcare EFT Standard Format" in the Medicare IOM for more information.

Example:

TRN\*1\*12345\*1512345678\*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

\* data element separator

The following table explains this example:

Element	Element name	Mandatory or optional	Data content
TRN	Re-association trace number	M	ASC X12 835 segment identifier. This is always "TRN".

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

### Additional information

For information on the NACHA operating rules that apply to health care payments, particularly with regard to requirements for originators, see <https://healthcare.nacha.org/healthcarerules>. The official instruction, CR 8629 issued to your MAC may be viewed at <http://>

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## EFTs

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data segment in the addenda record. The healthcare EFT standard requires the following:

- Company entry description of "HCCLAIMPMT" to identify the payment as healthcare;
- Company name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a record type code of "7" and an addenda type code equal to "05"; and
- Payment related information in the addenda record must contain the ASC x12 835 TRN (Re-association trace number) data segment that is included on the electronic remittance advice.

Healthcare providers will use the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. The TRN data segment must contain the following data elements, separated by an asterisk "\*\*".

Example: TRN\*1\*12345\*1512345678\*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

\* data element separator

Element	Element name	Mandatory or optional	Data content
TRN	Re-association trace number	M	ASC X12 835 segment identifier. This is always "TRN".
TRN01	Trace type code	M	Trace type code is always a "1".
TRN02	Re-association Information	M	Data element must contain the EFT trace number.

Element	Element name	Mandatory or optional	Data content
TRN03	Origination company ID	M	Unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's tax identification number .
TRN04	Reference	O	Data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.
	Segment terminator	M	TRN data segment in the addenda record must end with a tilde "~" or backslash "\".

### Additional information

The official instruction, CR 8619 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1351OTN.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/>

## April 2014 update to the healthcare provider taxonomy codes

### Provider types affected

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

### Provider action needed

Change request (CR) 8611, from which this article is taken, instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

### Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used.

Both the current Accredited Standards Committee (ASC) X-12 837 institutional and professional technical report type 3 (TR3s) require that the National Uniform Claim Committee (NUCC) HPTC set be used to identify provider specialty information on a health care claim. However, the standards do not mandate the reporting of provider specialty information via a HPTC be on every claim, nor for every provider to be identified by specialty. The standard implementation guides state that this information is:

- “Required when the payer’s adjudication is known to be impacted by the provider taxonomy code,” and
- “If not required by this implementation guide, do not send.”

**Note:** Medicare does not use HPTCs to adjudicate its claims and would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC set.

The transactions and code sets final rule, published on August 17, 2000, establishes that the maintainer of the code set determines its effective date. See <http://aspe.hhs.gov/admsimp/final/txfin00.htm>. This rule also mandates that covered entities must use the

nonmedical data code set specified in the standard implementation guide that is valid at the time the transaction is initiated. For implementation purposes, Medicare generally uses the date the transaction is received for validating a particular nonmedical data code set required in a standard transaction.

The HTPC set is maintained by the NUCC for standardized classification of health care providers, and the NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at <http://www.wpc-edl.com/codes>.

CR 8611 implements the NUCC HPTC code set that is effective April 1, 2014, and instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

- New items are green
- Modified items are orange, and
- Inactive items are red.

### Additional information

The official instruction, CR 8611 issued to your carriers, FIs, A/B MACs, RHHIs, HHHs, and DME MACs, regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2888CP.pdf>.

If you have any questions, please contact your carriers, FIs, A/B MACs, RHHIs, HHHs, or DME 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: MM8611

Related Change Request (CR) #: CR 8611

Related CR Release Date: February 28, 2014

Effective Date: April 1, 2014

Related CR Transmittal #: R2888CP

Implementation Date: July 7, 2014 (Contractors with the capability to do so will implement April 1, 2014)

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## Claim status category and claim status codes update

**Note:** This article was revised on February 27, 2014, to reflect an updated change request (CR). The CR corrects the date when the claim status category codes and claim status codes will be posted, which is March 1, 2014. All other information remains the same. This information was previously published in the February 2014 *Medicare B Connection*, Page 40.

### 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) and home health & hospice MACs, for services to Medicare beneficiaries.



### Provider action needed

This article is based on CR 8582 which informs Medicare contractors about the changes to claim status category codes and claim status codes. Make sure that your billing personnel are aware of these changes.

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (e.g. previous HIPAA named

versions included 004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at <http://www.wpc-edi.com/reference/codelist/healthcare/claim-status-category-codes/> and <http://www.wpc-edi.com/reference/codelist/healthcare/claim-status-codes/>.

All code changes approved during the January 2014 committee meeting shall be posted on these sites on or about March 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes are to be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR 8582.

### Additional information

The official instruction, CR 8582 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2884CP.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: MM8582 *Revised*  
 Related Change Request (CR) #: CR 8582  
 Related CR Release Date: February 24, 2014  
 Effective Date: April 1, 2014  
 Related CR Transmittal #: R2884CP  
 Implementation Date: April 7, 2014

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### EFTs

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[Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html).

**MLN Matters**® Number: MM8619  
 Related Change Request (CR) #: CR 8619  
 Related CR Release Date: February 21, 2014  
 Effective Date: July 1, 2014

Related CR Transmittal #: R1351OTN  
 Implementation Date: July 7, 2014

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## Now is the time to get prepared for the ICD-10 transition

The compliance date for implementation of the ICD-10-CM/PCS, **October 1, 2014, is approaching quickly.**

Are you taking the necessary steps to prepare for this transition? To do so effectively, it is important you think of **all entities** that involve claims processing.

Each step in the **process must be ICD-10 compliant** in order for the claim to be considered for payment. The following resources are available to assist you towards ICD-10 readiness:

- Access a wealth of information and resources designed to guide you through the ICD-10 transition on the Centers for Medicare & Medicaid Services' (CMS) [designated ICD-10](#) section.
- Tip: Use the links on the left hand side of CMS' ICD-10 section to easily navigate to appropriate resources.
- Also, be sure to view [CMS' ICD-10 Implementation Guide](#) specifically developed for providers, small hospitals, and payers.
- ICD-10 coding training is not provided by Medicare administrative contractors (MACs) – [find where to receive training to learn how to use the ICD-10 code set.](#)
- Speak with all of your vendors about ICD-10
- View these [helpful tips from CMS](#)
- Stay informed with free email subscriptions from First Coast Service Options and CMS
- [Join eNews](#) (either Part A or B general, or the designated ICD-10 subscription)
- Sign up for [CMS' ICD-10 industry email updates](#)



### MEDICARE

From Front Page

services above the cap where the KX modifier is used.

The new law also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2014 through March 31, 2015, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of \$3,700 for therapy services, including OPD therapy services, for a year. There are two separate \$3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services combined, and (2) occupational therapy services.

**Section 104 – Extension of ambulance add-on payments** – The new law extends the following two expiring ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas is extended through March 31, 2015 and (2) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as

the “super rural” bonus) is extended through March 31, 2015. The provision relating to air ambulance services that continued to treat as rural any area that was designated as rural December 31, 2006, for purposes of payment under the ambulance fee schedule, expired on June 30, 2013.

**Section 105 – Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals** – The new law extends, through March 31, 2015, a provision that allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges from the hospital. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital.

**Section 106 – Extension of the Medicare-dependent hospital (MDH) program** – The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program through March 31, 2015.

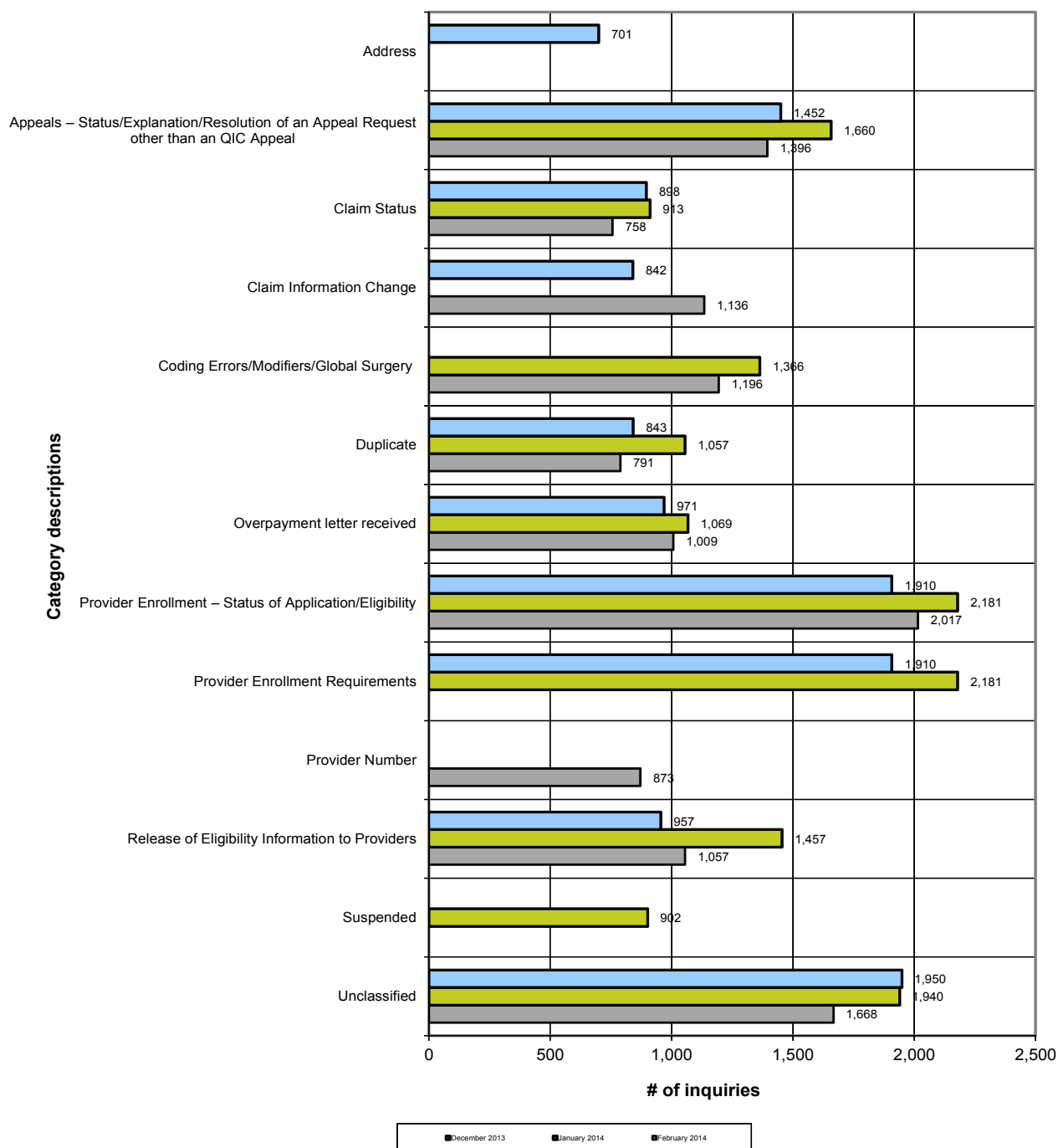
*Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not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

## 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 December 2013–February 2014.

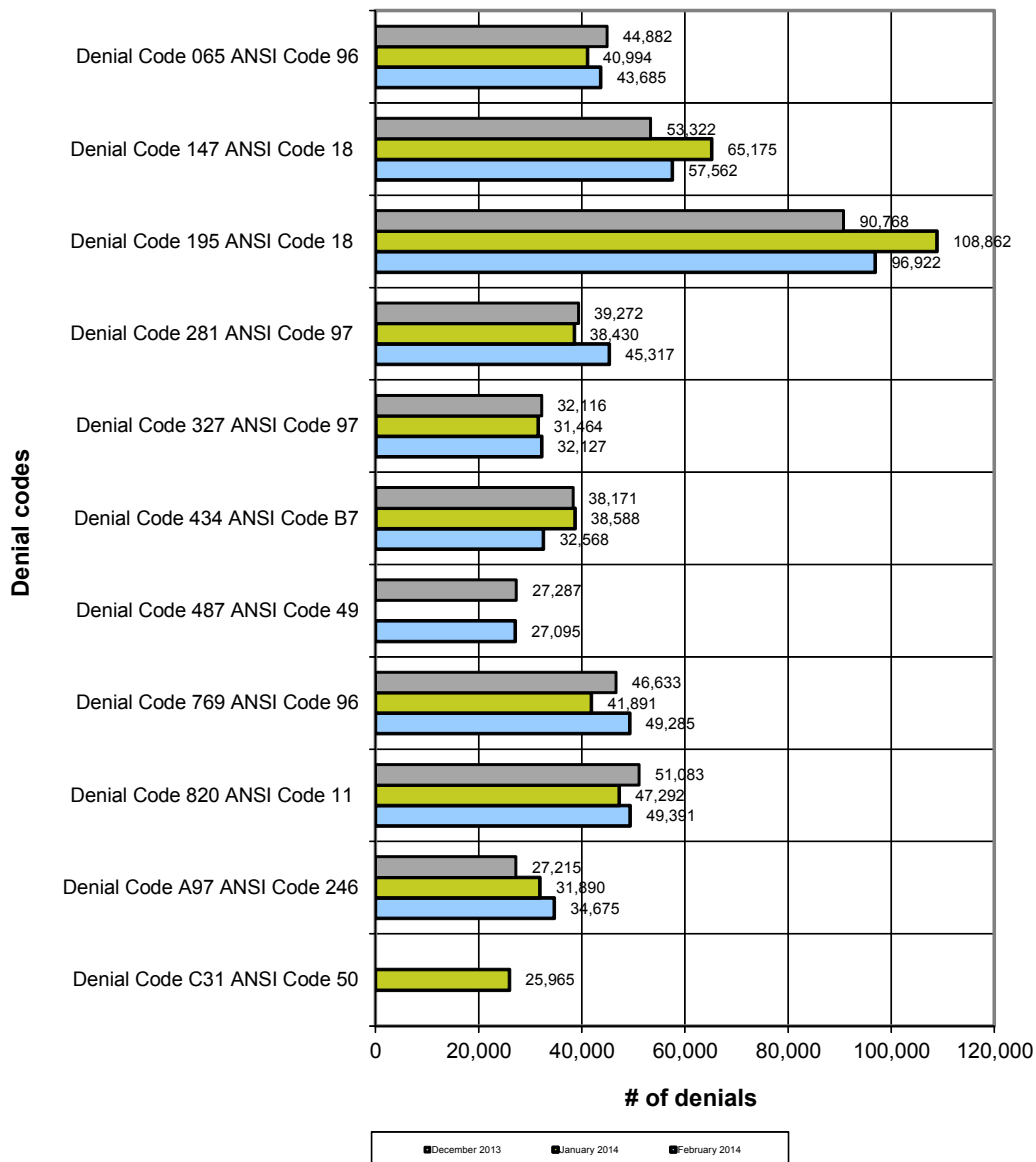
For tips and resources to help providers avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at [http://medicare.fcso.com/inquiries\\_and\\_denials/index.asp](http://medicare.fcso.com/inquiries_and_denials/index.asp).

### Part B top inquiries for December 2013–February 2014





## Part B top denials for December 2013-February 2014



## What to do when your claim is denied

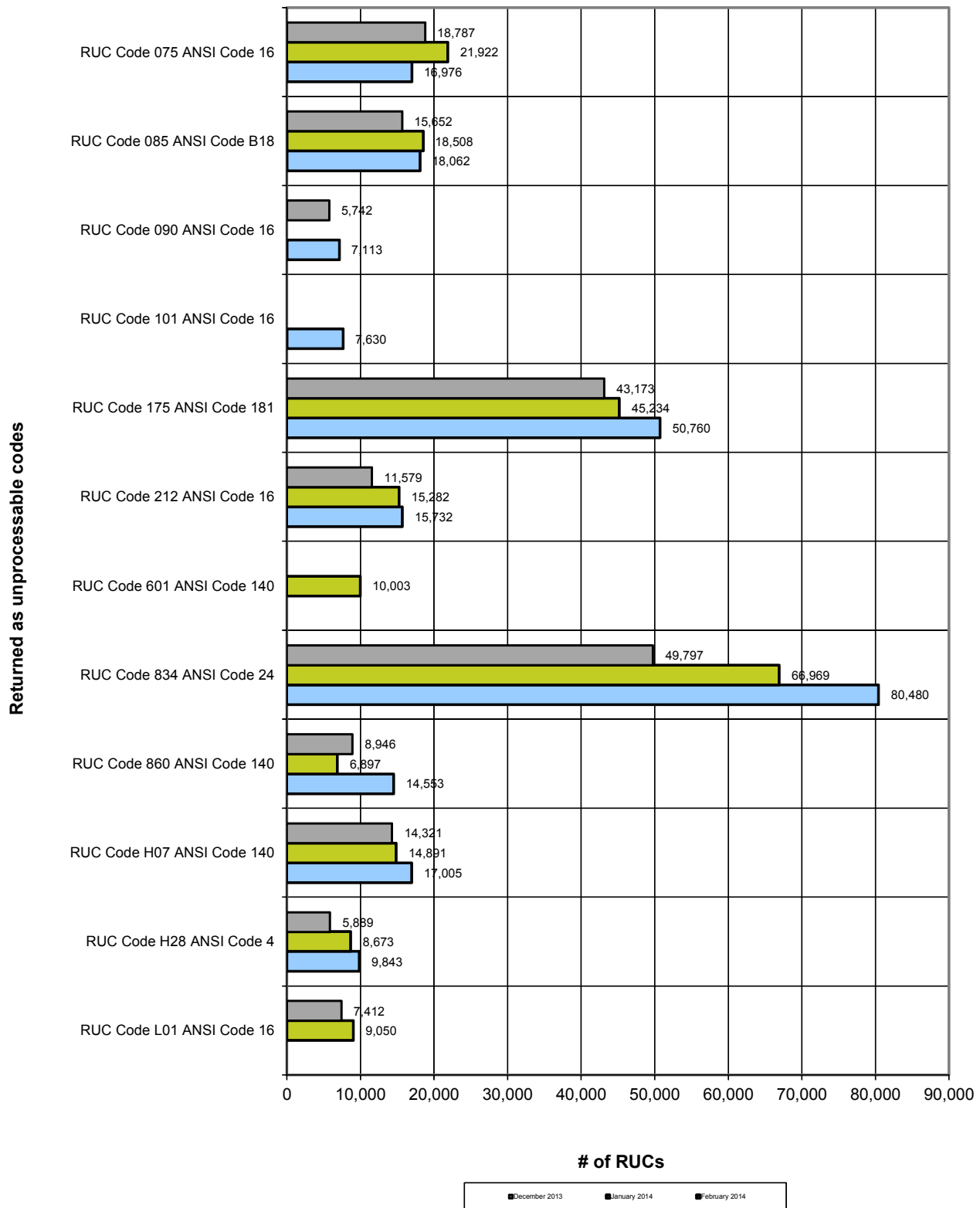
Before contacting customer service, check claim status through the IVR. The IVR will release necessary details around claim denials.

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

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

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

## Part B top return as unprocessable claims for December 2013-February 2014



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

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

### Effective and notice dates

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

### Electronic notification

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

### More information

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

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

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## Advance beneficiary notice

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

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

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

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

## Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? First Coast's LCD lookup, available at [http://medicare.fcso.com/coverage\\_find\\_lcds\\_and\\_ncds/lcd\\_search.asp](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

### Molecular pathology procedures for human leukocyte antigen (HLA) typing – revision to the LCD

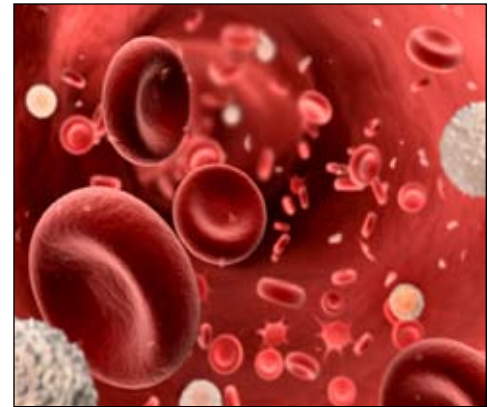
#### LCD ID number: L33732 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for molecular pathology procedures for human leukocyte antigen (HLA) typing was effective October 7, 2013. Since that time, the LCD has been revised to add ICD-9-CM diagnosis codes 287.30 (Primary thrombocytopenia unspecified) and 287.49 (Other secondary thrombocytopenia) under the “ICD-9 Codes that Support Medical Necessity” section of the LCD. In addition, the “CMS National Coverage Policy” section of the LCD was revised.

#### Effective date

This LCD revision is effective for claims processed **on or after March 20, 2014**, for services rendered **on or after October 7, 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](#).



### Pegfilgrastim (Neulasta®) – revision to the Part B LCD

#### LCD ID number: L29254 (Florida)

#### LCD ID number: L29463 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pegfilgrastim (Neulasta®) was most recently revised February 7, 2013. Since that time, the LCD has been revised to add ICD-9-CM diagnosis code 209.30 (Malignant poorly differentiated neuroendocrine carcinoma, any site) under the “ICD-9 Codes that Support Medical Necessity” section of the LCD. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated.

#### Effective date

This LCD revision is effective for services rendered **on or after March 17, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page.

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



## Skin substitutes – revision to the Part B LCD

**LCD ID number: L29279 (Florida)**

**LCD ID number: L29393 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for skin substitutes was most recently revised January 1, 2014. Since that time, based on information from the Centers for Medicare & Medicaid Services (CMS) related to change request (CR) 7909 (2013 Healthcare Common Procedure Code System [HCPCS] Annual Update), HCPCS code C9367 (Skin substitute, endoform dermal template, per square centimeter) is a deleted code. Therefore, the “CPT®/HCPCS Codes” section of the LCD under subsection “The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products” has been revised to delete HCPCS code C9367, as it is no longer a valid HCPCS code.

### Effective date

This LCD revision is effective for claims processed **on or after February 13, 2014**, for services rendered **on or after January 1, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page.

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



### 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>.



## Educational Events

### Upcoming provider outreach and educational events May-June 2014

#### *Medicare's 'incident to' and physician signature requirements ACT*

**When:** Wednesday, May 14      **Type of event:** Webcast

**Time:** 1:30-3:00 p.m.

<http://medicare.fcso.com/Events/267732.asp>

#### *Internet-based PECOS class*

**When:** Thursday, June 19      **Type of event:** Face-to-face

**Time:** 1:00-5:00 p.m.

<http://medicare.fcso.com/Events/266996.asp>

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

### Two easy ways to register

**Online** – Visit our provider training website at [www.fcsouniversity.com](http://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](http://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 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”: February 27, 2014 – <http://go.usa.gov/BJwz>

“MLN Connects™ Provider eNews”: March 6, 2014 – <http://go.usa.gov/KgZY>

“MLN Connects™ Provider eNews”: March 13, 2014 – <http://go.usa.gov/K83W>

“MLN Connects™ Provider eNews”: March 20, 2014 – <http://go.usa.gov/KEym>

“MLN Connects™ Provider eNews”: March 27, 2014 – <http://qrs.ly/i93y6u5>

## Other resources

### Training for ICD-10 coding provided by external resources

Training for ICD-10 coding is **not** being provided by Medicare administrative contractors (MACs) or legacy contractors in jurisdictions that are not yet administered by a MAC. Training will instead be provided by several external sources.

The resources below are external to the First Coast and Centers for Medicare & Medicaid Services (CMS) websites but are being offered for your convenience. First Coast and CMS are not responsible for the content or maintenance of these external sites.

- **AAPC Web resources:** Find ICD-10 news and information from the American Academy of Professional Coders (AAPC).
- **AHA Web resources:** Here you will find ICD-10 information from the American Hospital Association.
- **AHIMA Web resources:** The American Health Information Management Association (AHIMA) website shares information and training sessions for ICD-10.
- **HIMSS Web resources:** The Health Information

and Management Systems Society (HIMSS) website offers ICD-10 information and guidance.

- **CDC Web resources:** The Centers for Disease Control and Prevention website offers ICD-10 information.



In addition, [view a list of helpful links to educational resources](#) designed to assist providers during and after the ICD-10 implementation process.

## Mail directory

### Claims submissions

#### Routine paper claims

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

#### Participating providers

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

#### Chiropractic claims

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

#### Ambulance claims

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

#### Medicare secondary payer

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

#### ESRD claims

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

### Communication

#### Redetermination requests

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

#### Fair hearing requests

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

#### Freedom of Information Act

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

#### Administrative law judge hearing

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

#### Status/general inquiries

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

#### Overpayments

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

### Durable medical equipment (DME)

#### DME, orthotic or prosthetic claims

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

### Electronic media claims (EMC)

#### Claims, agreements and inquiries

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

### Additional development

#### Pending request:

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

#### Denied request for lack of response:

**Submit as a new claim, to:**  
Medicare Part B Claims  
P. O. Box 2525  
Jacksonville, FL 32231-0019

### Miscellaneous

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

#### Provider change of address:

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

### Provider education

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

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

#### Education event registration:

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

#### Limiting charge issues:

#### Processing errors:

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

#### Refund verification:

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

#### Medicare claims for Railroad retirees:

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

### Fraud and abuse

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

## Phone numbers

### Providers

#### Toll-Free

#### Customer Service:

1-866-454-9007

#### Interactive Voice Response (IVR):

1-877-847-4992

Email address: [AskFloridaB@fcso.com](mailto: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](http://www.cms.gov)

### Beneficiaries

Centers for Medicare & Medicaid Services

[www.medicare.gov](http://www.medicare.gov)

## Mail directory

### Claims, additional development, general correspondence

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

### Flu rosters

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

### Electronic data interchange (EDI)

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

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

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

### Provider enrollment

#### Where to mail provider/supplier applications

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

#### Provider change of address

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

and

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

### Durable medical equipment (DME)

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

### Redeterminations

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

### Redetermination overpayment

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

### Freedom of Information Act requests (FOIA)

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

### Congressional inquiries

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

### Provider education

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

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

#### Education event registration:

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

### Medicare claims for railroad retirees

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

### Fraud and abuse

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

### Local coverage determinations

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

### Post pay medical review

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

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

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

## Medicare websites

### Provider

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

### Centers for Medicare & Medicaid Services

[www.cms.gov](http://www.cms.gov)

### Beneficiaries

Centers for Medicare & Medicaid Services  
[www.medicare.gov](http://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](mailto:AskFloridaB@fcso.com)

FAX: 1-904-361-0696

### Beneficiary customer service

1-800-MEDICARE

Hearing Impaired:

1-800-754-7820

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

### Education event registration

1-904-791-8103

### Electronic data interchange (EDI)

1-888-670-0940

**Option 1** -Transaction support

**Option 2** - PC-ACE support

**Option 4** - Enrollment support

**Option 5** - 5010 testing

**Option 6** - Automated response line

### DME, orthotic or prosthetic claims

CGS Administrators, LLC  
1-866-270-4909

### Medicare Part A

Toll-Free:

1-888-664-4112

**Addresses****Claims****Additional documentation****General mailing****Congressional mailing**

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

**Redeterminations**

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

**Redeterminations on  
overpayment**

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

**Post-payment medical exams**

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

**Freedom of Information Act  
(FOIA) related requests**

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

**Medicare fraud and abuse**

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

**Provider enrollment****Mailing address changes**

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

**Electronic Data Interchange (EDI)**

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

**Flu vaccinated list**

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

**Local coverage determinations**

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

**Debt collection**

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

**Overnight mail and other special  
handling postal services**

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

**Other Medicare contractors  
and intermediaries****Durable Medical Equipment Regional  
Carrier (DMERC)**

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

**Regional Home Health &  
Hospice Intermediary**

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

**Railroad Medicare**

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

**Phone numbers****Providers****Customer service – free of charge**

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

**For the hearing and speech  
impaired (TDD)**

1-888-216-8261

**Interactive voice response (IVR)**

1-877-847-4992

**Beneficiary****Customer service – free of charge**

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

**Hearing and speech impaired  
(TDD)**

1-800-754-7820

**Electronic Data Interchange**

1-888-875-9779

**Educational Events Enrollment**

1-904-791-8103

**Fax number**

1-904-361-0407

**Website for Medicare****Providers****First Coast – MAC J9**

[medicare.fcso.com](http://medicare.fcso.com)

[medicareespanol.fcso.com](http://medicareespanol.fcso.com)

**Centers for Medicare & Medicaid  
Services**

[www.cms.gov](http://www.cms.gov)

**Beneficiary****Centers for Medicare & Medicaid  
Services**

[www.medicare.gov](http://www.medicare.gov)



## Order form for Medicare Part B materials

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

**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
<b>Part B subscription</b> – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at <a href="http://medicare.fcso.com/Publications_B/index.asp">http://medicare.fcso.com/Publications_B/index.asp</a> (English) or <a href="http://medicareespanol.fcso.com/Publicaciones/">http://medicareespanol.fcso.com/Publicaciones/</a> (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		
<b>2014 Fee Schedule</b> – 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 <a href="http://medicare.fcso.com/Data_files/">http://medicare.fcso.com/Data_files/</a> (English) or <a href="http://medicareespanol.fcso.com/Fichero_de_datos/">http://medicareespanol.fcso.com/Fichero_de_datos/</a> (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.  <b>Note:</b> 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: <b>English</b> [ ] <b>Español</b> [ ]				
<i>Please write legibly</i>			Subtotal	\$
			Tax ( <i>add % for your area</i> )	\$
			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)