Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

May 2014

In this issue

Posting the limiting charge after applying the EHR and PQRS negative adjustments

Provider types affected

This *MLN Matters*® article is intended for Medicare eligible professionals (EPs) submitting professional claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8667, whose purpose is to place the electronic health record (EHR) and physician quality reporting system (PQRS) negative adjustment limiting charge amounts on MAC websites and hard copy disclosure reports. Eligible professionals (EPs) under the Medicare EHR incentive program include: Doctor of medicine or osteopathy, doctor of oral surgery or dental medicine, doctor of podiatry, doctor of optometry, and chiropractor. Be sure your billing staffs are aware of these changes.

Background

Electronic health record

Beginning January 1, 2015, Section 1848(a)(7) of the Social Security Act as amended by Section 4101(b) of the HITECH Act, requires that EPs that are not meaningful EHR users are subject to the EHR negative adjustment.

Specifically, Section 1848(a)(7) of the Act states that: "If the eligible professional is not a meaningful EHR user (as determined under subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph)."

Physician quality reporting system

Beginning on January 1, 2015, Section 1848(a)(8) of the Social Security Act, as added by Section 3002(b) of the Affordable Care Act, requires that EPs who do not

See **POSTING,** Page 8

Contents

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.*

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.

Publication staff:
Terri Drury
Kathleen Cruz Fuentes
Sofia Lennie
Martin Smith
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
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.

CPT five-digit codes, descriptions, and other data only are copyright 2013 by American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/ DFARS apply. No fee schedules, basic units, relative values or related listings are included in CPT. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein.

ICD-9-CM codes and their descriptions used in this publication are copyright 2012 under the Uniform Copyright Convention. All rights reserved.

This document contains references to sites operated by third parties. Such references are provided for your convenience only. Blue Cross and Blue Shield of Florida, Inc. and/or First Coast Service Options Inc. do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

All stock photos used are obtained courtesy of a contract with www.shutterstock.com.

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.

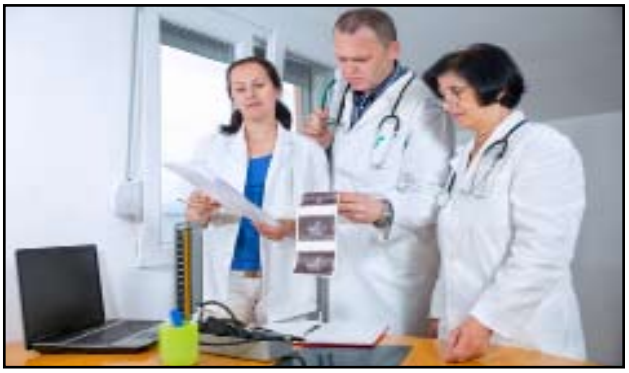
For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

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.

Mandatory reporting of an eight-digit clinical trial number on claims

Note: *This article was revised May 15, 2014, to reflect the revised change request (CR) 8401 issued May 13. The article has been revised to delete information regarding entry of the clinical trial number on institutional paper or direct data entry (DDE) claim UB-04. Also, the transmittal number, the CR release date, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the November 2013 Medicare B Connection, Pages 5-6*.

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, durable medical equipment (DME) Medicare administrative contractors (MACs) and A/B MACs) for items and services provided in clinical trials to Medicare beneficiaries.

Provider action needed

This article is based on CR 8401, which informs you that, effective January 1, 2014, it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the *Medicare National Coverage Determination (NCD)* manual, Section 310.1.

The clinical trial number to be reported is the same number that has been reported voluntarily since the implementation of CR 5790, dated January 18, 2008. That is the number assigned by the National Library of Medicine (NLM) *http://clinicaltrials.gov/* website when a new study appears in the NLM clinical trials database.

Make sure that your billing staffs are aware of this requirement.

Background

CR 5790, Transmittal 310, dated January 18, 2008, titled "Requirements for Including an 8-Digit Clinical Trial Number on Claims" is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R310OTN.pdf*. The *MLN Matters*® article for CR 5790 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5790.pdf*.

This number is listed prominently on each specific study's page and is always preceded by the letters 'NCT'.

The Centers for Medicare & Medicaid Services (CMS) uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry. Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by consulting CMS's clinical trials/registry website at *http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html*.

For institutional claims that are submitted on the electronic claim 837I, the eight-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For professional claims, the eight-digit clinical trial number preceded by the two alpha characters of CT must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) when a clinical trial claim includes:

- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an eight-digit clinical trial number will be returned as unprocessable to the provider for inclusion of the trial number using the messages listed below.

- Claim adjustment reason code (CARC) 16: "Claim/

See **MANDATORY,** next page

MANDATORY

From previous page

service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)"

- RARC MA50: "Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services."
- RARC MA130: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."
- Group code: Contractual obligation (CO).

Note: This is a reminder/clarification that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

Additional information

The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2955CP.pdf*.

See *MLN Matters*® article SE1344 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1344.pdf*) for information on an interim alternative method of satisfying the requirement in CR 8401 for providers who do not have the ability to submit the clinical trial number for trial related claims.

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

MLN Matters® Number: MM8401 *Revised*
Related Change Request (CR) #: CR 8401
Related CR Release Date: May 13, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R2955CP
Implementation Date: 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.

Quarterly provider update

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

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

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

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).

Drugs & Biologicals

July 2014 quarterly ASP Medicare Part B drug pricing files and revisions to prior files

Provider types affected

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

Provider action needed

MACs will use the July 2014 average sales price (ASP) and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 1, 2014, with dates of service July 1, 2014, through September 30, 2014.

CR 8748, from which this article is taken, instructs MACs to implement the July 2014 ASP Medicare Part B drug pricing file for Medicate Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised April 2014, January 2014, October 2013, and July 2013 ASP drug pricing files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies the MACs with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4, Section 50 (Outpatient PRICER)) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

The following table shows how the quarterly payment files will be applied:

Files	Effective for dates of service
July 2014 ASP and ASP NOC	July 1 through September 30, 2014
April 2014 ASP and ASP NOC	April 1 through June 30, 2014
January 2014 ASP and ASP NOC	January 1 through March 31, 2014
October 2013 ASP and ASP NOC	October 1 through December 31, 2013
July 2013 ASP and ASP NOC	July 1 through September 30, 2013

Additional information

The official instruction, CR 8748 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2936CP.pdf*.

MLN Matters® Number: MM8748
Related Change Request (CR) #: CR 8748
Related CR Release Date: April 25, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R2936CP
Implementation Date: July 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.

Find out first: Subscribe to First Coast *eNews*

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

Common working file editing for vaccines furnished at hospice – correction

Note: *This article was revised May 1, 2014, to reflect the revised change request (CR) 8620 issued April 28. In the article, we added a reference to home health and hospice (HHH) MACs. Also, the CR transmittal number, the CR release date, and the Web address for accessing the CR are revised. This information was previously published in* the *February 2014 Medicare B Connection, Page 16*.

Provider types affected

This *MLN Matters*® article is intended as an update for non-hospice providers furnishing vaccines to hospice beneficiaries and submitting claims to Medicare administrative contractors (MACs), including HHH MACs.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 8620 to alert providers that any provider may furnish vaccines to hospice beneficiaries. Be sure your billing staffs are aware of this change.

Background

When CR 8098, Transmittal 1298, was published, effective October 1, 2013, it denied claims for vaccines furnished to hospice patients that were provided by anyone other than the patient's hospice provider. This was to enforce the statement in the *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.4 that vaccines "may be covered when furnished by the hospice." CMS has determined that this enforcement is too restrictive, since the manual does not say "only when furnished by the hospice." CR 8620 removes the changes made to Medicare systems in CR 8098, in order to allow any provider to furnish vaccines to hospice beneficiaries.

Key points

- Your MAC will allow professional claims for vaccines (influenza, PPV, and hepatitis B) and vaccine administration containing modifier GW when the date of service falls within a hospice election.
- Your MAC will adjust vaccine claims with dates of service on or after October 1, 2013, which were previously rejected due to a hospice election, if you bring such claims to your MAC's attention.

Additional information

The official instruction, CR 8620, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1373OTN.pdf*.

MLN Matters® Number: MM8620 *Revised*
Related Change Request (CR) #: CR 8620
Related CR Release Date: April 28, 2014
Effective Date: October 1, 2013
Related CR Transmittal #: R1373OTN
Implementation: 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.

Medicare Physician Fee Schedule Database

POSTING

From front page

satisfactorily report data on quality measures for covered professional services for the quality reporting period of the year are subject to the PQRS negative adjustment.

Specifically, Section 1848(a)(8) of the Act states that: "If the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph)."

The negative payment adjustment applies to all EPs, regardless of whether the EP elects to be "participating" or "non-participating" for purposes of Medicare payments.

Non-participating (non-par) EPs in the Medicare program may choose either to accept or not accept assignment on Medicare claims on a claim-by-claim basis. If EPs choose not to accept assignment, they may not charge the beneficiary more than the Medicare limiting charge for unassigned claims for Medicare services. The limiting charge is 115 percent of the Medicare physician fee schedule (MPFS) amount. The beneficiary is not responsible for billed amounts in excess of the limiting charge for a covered service.

Non-participating EPs that do not accept assignment on a claim may choose to collect the entire limiting charge amount up front from the beneficiary at the time of service.

Submission of a non-par, non-assigned MPFS service with a charge in excess of the Medicare limiting charge amount constitutes a violation of the limiting charge. A physician or supplier who violates the limiting charge is subject to a civil monetary penalty of not more than $10,000, an assessment of not more than three times the amount claimed for each item or service, and possible exclusion

See **POSTING,** next page

POSTING

From front page

from the Medicare program. Therefore, it is crucial that EPs are provided with the correct limiting charge they may bill for a MPFS service.

Your MAC will list and display the limiting charge amount after applying the EHR and PQRS negative adjustment on their website. Specifically, they will add the following to their website:

- EHR limiting charge
- PQRS limiting charge
- EHR/2014 eRx limiting charge
- EHR + PQRS limiting charge
- EHR/2014 eRx + PQRS limiting charge

Examples

Non-par non-assigned claim no EHR/PQRS adjustment:

Original fee schedule amount: $100
5 percent non-par status: $5 (100 x .05)
Adjustment total $5.00
MPFS allowed amount $100-$5.00= $95.00
Limiting charge allowed= $95.00 x 115 percent= $109.25

Non-par non-assigned claim with EHR adjustment:

Original fee schedule amount: $100
5 percent non-par status: $5 (100 x .05)
1 percent EHR negative adjustment $.95 (95 x.01)
Adjustment total $5.95
MPFS allowed amount $100-$5.95= $94.05
Limiting charge allowed= $94.05 x 115 percent= $108.16

Non-par non-assigned claim with PQRS adjustment:

Original fee schedule amount: $100
5 percent non-par status: $5 (100 x .05)
1.5 percent PQRS negative adjustment $1.43 (95 x.015)
Adjustment total $ 6.43
MPFS allowed amount $100-$6.43= $93.57
Limiting charge allowed= $93.57 x 115 percent= $107.61

Non-par non-assigned claim with EHR + e-prescribing:

Original fee schedule amount: $100
5 percent non-par status: $5 (100 x .05)
2 percent PQRS negative adjustment $1.90 (95 x.02)
Adjustment total $ 6.90
MPFS allowed amount $100-$6.90= $93.10
Limiting charge allowed= $93.10 x 115 percent= $107.07

Non-par non-assigned claim with EHR without 2014 e-Prescribing adjustment + PQRS:

Original fee schedule amount: $100
5 percent non-par status: $5 (100 x .05)
1 percent EHR negative adjustment $.95 (95 x .01)
EHR adjustment total $5.95
MPFS allowed amount $100-$5.95= $94.05
1.5 percent PQRS negative adjustment $1.41 ($94.05 x .015)
PQRS adjustment total $94.05-$1.41=$92.64
MPFS allowed amount $92.64
Limiting charge allowed= $92.64 x 115 percent= $106.54

Non-par non-assigned claim with EHR with 2014 e-Prescribing adjustment + PQRS:

Original fee schedule amount: $100
5 percent non-par status: $5 (100 x .05)
2 percent EHR negative adjustment $1.90 (95 x .02)
EHR adjustment total $6.90
MPFS allowed amount $100-$6.90= $93.10
1.5 percent PQRS negative adjustment $1.40 (93.10 x .015)
PQRS adjustment total $93.10-$1.40=$91.70
MPFS allowed amount $91.70
Limiting charge allowed= $91.70 x 115 percent= $105.46

Additional information

Information about the EHR incentive programs is available at *http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html*.

Information about "Physician Quality Reporting System (PQRS) Payment Adjustment Information" is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html*.

The official instruction, CR 8667, issued to your MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1384OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work. You can also find a link to your MAC's website at this page.

MLN Matters® Number: MM8667
Related Change Request (CR) #: CR 8667
Related CR Release Date: May 16, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R1384OTN
Implementation Date: October 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.

April update to the 2014 Medicare physician fee schedule database

***Note**: This article was revised May 16, 2014, to reflect the revised change request (CR) 8664 issued April 22. The article is revised to adjust Table 2 under "CR 8664 summary of changes" to clarify the effective dates for HCPCS code 77293 to be from January 1 to December 31, 2014. The CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the April 2014 Medicare B Connection, Pages 11-13.*

Provider types affected

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

Provider action needed

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

Background

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

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

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

CR 8664 summary of changes

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

Table 1: Short description corrections for HCPCS codes G0416-G0419

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

Table 2: Adjust the facility and non-facility PE RVUs for HCPCS code *77293* (global and TC) via CMS update files.See Table 2 (Page 12).

Table 3: HCPCS code G9361 will be added to your Medicare contractor system.

Field	Indicator/descriptor
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

See **MPFSDB,** next page

MPFSDB

From previous page

Field	Indicator/descriptor
Non-facility PE used for OPPS payment amount	0.00
Facility PE used for OPPS payment amount	0.00
MP used for OPPS payment amount	0.00
Type of service	9
Long descriptor	Medical indication for induction [Documentation of reason(s) for elective delivery or early induction (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-premature, prolonged maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/ delivery, malposition and malpresentation of fetus, late pregnancy, prior uterine surgery, or participation in clinical trial)]

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

HCPCS	Short descriptor	Phys diag supv	Effective date
70450 TC	CT head/brain w/o dye - phys diag supv correction (TC)	01	1/1/2014
70460 TC	CT head/brain w/ dye - phys diag supv correction (TC)	02	1/1/2014
70551 TC	MRI brain stem w/o dye - phys diag supv correction (TC)	01	1/1/2014
70552 TC	MRI brain stem w/ dye - phys diag supv correction (TC)	02	1/1/2014
70553 TC	MRI brain stem w/o & w/dye - phys diag supv correction (TC)	02	1/1/2014
72141 TC	MRI neck spine w/o dye - phys diag supv correction (TC)	01	1/1/2014
72142 TC	MRI neck spine w/ dye - phys diag supv correction (TC)	02	1/1/2014
72146 TC	MRI chest spine w/o dye - phys diag supv correction (TC)	01	1/1/2014
72147 TC	MRI chest spine w/dye - phys diag supv correction (TC)	02	1/1/2014
72148 TC	MRI lumbar spine w/o dye - phys diag supv correction (TC)	01	1/1/2014
72149 TC	MRI lumbar spine w/dye - phys diag supv correction (TC)	02	1/1/2014
72156 TC	MRI neck spine w/o & w/dye - phys diag supv correction (TC)	02	1/1/2014
72157 TC	MRI chest spine w/o & w/dye - phys diag supv correction (TC)	02	1/1/2014
72158 TC	MRI lumbar spine w/o & w/dye - phys diag supv correction (TC)	02	1/1/2014
72191 TC	CT angiograph pelv w/o&w/dye - phys diag supv correction (TC)	02	1/1/2014
74174 TC	CT angio abd&pelv w/o&w/dye - phys diag supv correction (TC)	02	1/1/2014
74175 TC	CT angio abdom w/o & w/dye - phys diag supv correction (TC)	02	1/1/2014
93880 TC	Extracranial bilat study - phys diag supv correction (TC)	01	1/1/2014
93882 TC	Extracranial uni/ltd study - phys diag supv correction (TC)	01	1/1/2014
77001 TC	Fluoroguide for vein device - phys diag supv correction (TC)	03	1/1/2014
77002 TC	Needle localization by xray - phys diag supv correction (TC)	03	1/1/2014

See **MPFSDB,** next page

MPFSDB

From previous page

HCPCS	Short descriptor	Phys diag supv	Effective date
77003 TC	Fluoroguide for spine inject - phys diag supv correction (TC)	03	1/1/2014

Additional information

The official instruction, CR 8664, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2934CP.pdf*.

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

MLN Matters® Number: MM8664 *Revised*
Related Change Request (CR) #: CR 8664
Related CR Release Date: April 22, 2014
Effective Date: January 1, 2014
Related CR Transmittal #:R2934CP
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.

Table 2

HCPCS	Mod	Status	Description	Non-facility PE RVUs	Facility PE RVUs	Global	Effective date
77293		A	Respirator motion mgmt simul	9.96	NA	ZZZ	Jan 1 to March 31, 2014
77293	TC	A	Respirator motion mgmt simul	9.16	NA	ZZZ	Jan 1 to March 31, 2014
77293		A	Respirator motion mgmt simul	10.72	NA	ZZZ	Correction April 1, 2014. RVU change effective January 1 to December 31, 2014.
77293	TC	A	Respirator motion mgmt simul	9.92	NA	ZZZ	Correction April 1, 2014. RVU change effective January 1 to December 31, 2014.

Radiology

FDG PET scan for solid tumors (fully replaces MM8468)

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8739, which advises MACs, effective for dates of service on or after June 11, 2013, to cover three fluorodeoxyglucose (FDG) positron emission tomography (PET) scans when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by your MAC. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) has reconsidered Section 220.6, of the *National Coverage Determinations (NCD) Manual* to end the prospective data collection requirements across all oncologic indications

See **FDG,** next page

FDG

From previous page

of FDG PET in the context of CR 8739. The term FDG PET includes PET/computed tomography (CT) and PET/magnetic resonance (MRI).

CMS is revising the *NCD Manual*, Section 220.6, to reflect that CMS has ended the coverage with evidence development (CED) requirement for (2-[F18] fluoro-2-deoxy-D-glucose) FDG PET, PET/CT, and PET/MRI for all oncologic indications contained in Section 220.6.17 of the *NCD Manual*. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (Healthcare Common Procedure Coding System (HCPCS) code A9552) only.

Note: For clarification purposes, as an example, each different cancer diagnosis is allowed one (1) initial treatment strategy (PI modifier) FDG PET scan and three (3) subsequent treatment strategy (PS modifier) FDG PET Scans without the KX modifier. The fourth FDG PET scan and beyond for subsequent treatment strategy for the same cancer diagnosis will always require the KX modifier. If a different cancer diagnosis is reported, whether reported with a PI modifier or a PS modifier, that cancer diagnosis will begin a new count for subsequent treatment strategy for that beneficiary. A beneficiary's file may or may not contain a claim for initial treatment strategy with a PI modifier. The existence or non-existence of an initial treatment strategy claim has no bearing on the frequency count of the subsequent treatment strategy (PS modifier) claims.

Providers may refer to Attachment 1 of CR 8739 for a list of appropriate diagnosis codes.

Effective for claims with dates of service on or after June 11, 2013, Medicare will accept and pay for FDG PET oncologic claims billed to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors for all oncologic conditions **without** requiring the following:

- Q0 modifier: Investigational clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);
- Q1 modifier: routine clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);
- V70.7: Examination of participant in clinical research; or
- Condition code 30 (institutional claims only).

Effective for dates of service on or after June 11, 2013, MACs will use the following messages when denying claims in excess of **three** for PET FDG scans for subsequent treatment strategy when the KX modifier is not included, identified by *CPT*® codes *78608, 78811, 78812, 78813, 78814, 78815*, or *78816*, modifier PS, HCPCS A9552, and the same cancer diagnosis code:

- **Claim adjustment reason code (CARC) 96**: "Non-Covered Charge(s). **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **Remittance advice remarks code (RARC) N435**: "Exceeds number/frequency approved/allowed within time period without support documentation."
- **Group code PR** assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

MACs will not search their files to adjust claims processed prior to implementation of CR 8739. However, if you have such claims and bring them to the attention of your MAC, the MAC will adjust such claims if appropriate.

Synopsis of coverage of FDG PET for oncologic conditions

Effective for claims with dates of service on and after June 11, 2013, the chart below summarizes national FDG PET coverage for oncologic conditions:

FDG PET for cancers tumor type	Initial treatment strategy (formerly "diagnosis" & "staging"	Subsequent treatment strategy (formerly "restaging" & "monitoring response to treatment"
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head and neck (not thyroid, CNS)	Cover	Cover
Lymphoma	Cover	Cover
Non-small cell lung	Cover	Cover
Ovary	Cover	Cover
Brain	Cover	Cover
Cervix	Cover with exceptions*	Cover
Small cell lung	Cover	Cover
Soft tissue sarcoma	Cover	Cover
Pancreas	Cover	Cover
Testes	Cover	Cover
Prostate	**Non-cover**	Cover
Thyroid	Cover	Cover
Breast (male and female)	Cover with exceptions*	Cover
Melanoma	Cover with exceptions*	Cover

See **FDG,** next page

FDG

From previous page

FDG PET for cancers tumor type	Initial treatment strategy (formerly "diagnosis" & "staging"	Subsequent treatment strategy (formerly "restaging" & "monitoring response to treatment"
All other solid tumors	Cover	Cover
Myeloma	Cover	Cover
All other cancers not listed	Cover	Cover

***Cervix**: Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.

***Breast**: Nationally non-covered for initial diagnosis and/or staging of axillary lymph nodes. Nationally covered for initial staging of metastatic disease. All other indications for initial anti-tumor treatment strategy for breast cancer are nationally covered.

***Melanoma**: Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.

Additional information

The official instruction, CR 8739, issued to your MAC regarding this change, is available at in two transmittals at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2932CP.pdf* and *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R168NCD.pdf*.

MLN Matters® Number: MM8739
Related Change Request (CR) #: CR 8739
Related CR Release Date: May 28, 2014
Effective Date: June 11, 2013
Related CR Transmittal #: R2932CP, R168NCD
Implementation Dates: May 19, 2014 - MAC Non-Shared System Edits; July 7, 2014 - CWF development/testing, FISS requirement development; October 6, 2014 - CWF, FISS, MCS shared system edits

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.

Medical record documentation requirements for portable X-ray suppliers

Questionable billing patterns of portable X-ray suppliers were identified in a 2012 Office of Inspector General (OIG) report published in December 2011 in Office of Evaluation and Inspection (OEI) report *OEI-12-10-00190*. As noted in the OIG's audit report, portable X-ray data was evaluated based on eight characteristics describing questionable billing patterns developed by the OIG. As reported in the findings, for the 2009 claims data, "OIG identified 20 suppliers that exceeded thresholds on at least two of the characteristics of questionable billing and exceeded the OIG's threshold for the combined score. Thirteen of these suppliers were located in the Miami, Florida area."

Based on the OIG findings, First Coast Service Options Inc. (First Coast) conducted data analysis followed by targeted medical review activities. First Coast's data analysis and medical record review has identified billing and coverage issues related to portable X-ray services provided in Florida when services are rendered in the patient's home, skilled nursing facility, assisted living facility, etc. This article is intended to provide a high-level overview of coverage requirements and the medical record documentation that is necessary to support payment under the portable X-ray benefit. This article is not intended to address all requirements related to portable X-ray services (e.g., physician supervision, technician requirements, etc.). Suppliers of portable X-ray services should refer to the applicable statutory, regulatory and manual guidance for comprehensive information regarding program and supplier requirements.

The statutory authority for coverage of suppliers of portable X-ray services is found in §1861(s)(3) of the Social Security Act (the Act). The regulations are found in Title 42 of the Code of Federal Regulations, 42 CFR 486.100-486.108. The Centers for Medicare & Medicaid Services (CMS) Internet-only manual (IOM) Publication 100-04, Ch. 15, Section 80.4-80.4.5 further defines CMS' portable X-ray coverage requirements, including the limitation of what type of portable X-rays are covered under Medicare

See **X-RAY,** next page

X-RAY

From previous page

as well as the procedures and examinations not covered under the portable X-ray provision. The focus of this article is to address the documentation requirements necessary to support coverage of portable X-ray services.

Section 486.106 of Title 42 CFR outlines Medicare's condition for coverage with regard to the referral for service and preservation of records. This section clearly outlines Medicare's requirements related to ordering of portable X-ray services and the documentation necessary to support coverage. In summary, all portable X-ray services performed for Medicare beneficiaries must be ordered by a physician or a nonphysician practitioner as provided in §410.32(a) or by a nonphysician practitioner as provided in §410.32(a)(2), and records must be properly preserved. Requirements related to the content of the order are discussed under item one below. In addition to the order, the supplier must maintain a patient record of the date of the portable X-ray examination, the name of the patient, a description of the procedures ordered and performed, the referring physician or nonphysician practitioner, the operator(s) of the portable X-ray equipment who performed the examination, the physician to whom the radiograph was sent, and the date it was sent.

During the medical record review process of portable X-ray claims, the following documentation is required to support services billed to Medicare. Documentation that: 1) meets the order requirements related to portable X-ray services; 2) provides information specific to the individual patient (e.g., the specific condition at the time of service) that supports why the X-ray needed to be performed as a "portable" service; 3) supports the X-ray service itself was medically reasonable and necessary; and 4) supports the service was actually performed (X-ray results) and used in the treatment of the patient. Each of these items is discussed in more detail below.

1. **General order requirements** – The order from the qualified licensed physician or nonphysician practitioner (NPP) acting within the state scope of law must be written, signed and must specify the reason a portable X-ray test is required. The area of the body to be exposed, the number of radiographs to be obtained, and the views needed must also be included in the order, as well as a statement concerning the condition of the patient, indicating why portable X-ray services are necessary.
2. **Specific indication for a "portable" service** – The order must document the specific "condition(s)" present for that patient, at the time of service, which makes portable X-ray services medically necessary. The presence of a pre-typed generic statement used on all patients, for all situations, not providing any indication of the clinical "reason" the patient could not travel for X-ray services is not sufficient. The medical record must support the clinical reason.
3. **Medical necessity for the X-ray being performed** – As per the Act, section 1862(a)(1)(A), payment cannot be made for a service that is not considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The physician or NPP's written, signed order and supporting medical record must support a medically reasonable and necessary condition for performing the X-ray service. If the X-ray is being performed as a "follow-up," the medical necessity for that follow-up service must be documented in the medical record.
4. **Records must support the service was performed (X-ray results/interpretation) and used in the treatment of the patient** – 42 CFR 410.32 Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests, requires, "All diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician treating the beneficiary; that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary."

   Therefore, medical records must provide the test results and document that these results were provided to the ordering physician/NPP and that he/she uses those results in the management of the patient. In reviewing records for diagnostic services, Medicare is looking for documentation demonstrating the ordering provider reviewed the results to make patient treatment decisions. Examples include a notation written and signed by the ordering physician/NPP on the interpretation report, X-ray results discussed in the treating provider's progress note, a notation by staff in a facility record that the ordering provider was notified of the results and any subsequent changes in treatment orders (if any), etc.

Medical record documentation and documentation requests

During the review of portable X-ray services, suppliers raised a concern regarding the ability to obtain medical record documentation required to support medical necessity from ordering providers and/or facilities. *CMS IOM Pub. 100-08, Ch. 3, Section 3.2.3.B* articulates the provider/supplier's responsibility for obtaining medical records.

Contractors are authorized to collect medical documentation by the Act. Section 1833(e) states "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." Section 1815(a) states "…no such payments shall be made to any provider unless it has furnished such information as the

See **X-RAY,** next page

X-RAY

From previous page

Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

Section 3.2.3.3 further dictates the Medicare administrative contractor's (MAC's) responsibility:

> "Unless otherwise specified, the MAC, recovery auditor (RA) and zone program integrity contractor (ZPIC) shall request information from the billing provider/supplier. The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested by the MAC, comprehensive error rate testing program (CERT), RA and ZPIC. The MAC, ZPIC and RA have the discretion to send a separate additional documentation request (ADR) to third party entities involved in the beneficiary's care. They shall not solicit documentation from a third party unless they first or simultaneously solicit the same information from the billing provider or supplier."

As noted above, the contractor is required to solicit records from the billing provider and may solicit records from secondary providers either simultaneously or after the request to the billing provider has been sent, at their discretion, other than clinical labs (which is dictated by CFR based on negotiated clinical lab rulemaking). Therefore, it is Medicare's expectation that portable X-ray suppliers should work with their ordering entities to establish an efficient process for transfer of records. The ordering entity should also understand its responsibility in providing those records to suppliers, as outlined in CMS IOM Pub. 100-08, Ch. 3:

3.3.2.1.1.C. Financial Liability

> The physician or licensed/certified medical professional (LCMP) should be aware that inadequate medical record documentation could lead to a financial liability for the Beneficiary and/or Supplier, should the reviewer determine that a claim is not supported.
>
> In addition, the physician/LCMP should be aware that when ordering an item or service to be furnished by another entity, section 1842(p)(4) of the Act requires adequate documentation supporting medical necessity be provided to the entity at the time the item or service be ordered. Physicians/LCMPs who fail to submit documentation upon a supplier's request may trigger increased MAC or RA review of the physician/LCMP's evaluation and management service.
>
> The MAC cannot dictate where/how medical necessity information is documented but the information must be readily gleaned from the patient's medical record. The type of medical record documentation that contains medical necessity information may vary based on the care setting (e.g., office, skilled nursing facility (SNF), home, etc.)

During medical record review, First Coast has found that records submitted to support coverage for portable X-ray may be lacking in one or more of the above requirements.

Source: *Questionable Billing Patterns of Portable X-ray Suppliers (OEI-12-10-00190)*; *CMS IOM Pub. 100-08, Chapter 3*

Fluorodeoxyglucose (FDG) positron emission tomography (PET) for solid tumors

Note: *This article was rescinded and replaced by MLN Matters® article MM8739. The related CR 8468 was also rescinded and replaced by CR 8739. MM8739 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8739.pdf. This information was previously published in the February 2014 Medicare B Connection, Pages 33-34.*

MLN Matters® Number: MM8468 *Rescinded*
Related Change Request (CR) #: CR 8468
Related CR Release Date: February 6, 2014
Effective Date: June 11, 2013
Related CR Transmittal #: R2873CP/R162NCD
Implementation Date: March 7, 2014: Non-shared System Edits, July 7, 2014: Shared System Edits

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.

General Coverage

Preventing duplicate claim denials

Effective July 1, 2013, new claim system edits may result in additional duplicate claim denials to your practice. Please share this information with your billing companies, vendors and clearing houses. The Centers for Medicare & Medicaid Services (CMS) instructed Medicare contractors to enhance claim system edits to include same claim details in its history review of duplicate procedures and/or services. The edits search within paid, finalized, pending and same claim details in history. This means that unless applicable modifiers are included in your claim, the edits detect duplicate and repeat services within the same claim and/or based on a previously submitted claim.

To minimize a potential increase in duplicate claim denials, please review your billing software and procedures to ensure that you are billing correctly. Some services on a claim may appear to be duplicates when, in fact, they are not. Please use modifiers, as applicable, to identify procedures and services that are not duplicates. A complete list of modifiers can be found in the *Current Procedural Terminology* (*CPT*®) codebook. The following are a few examples of modifiers that may be used to indicate repeat or distinct procedures and services on a claim:

- **Modifier 76** may be used to indicate a repeat procedure or service by the same provider, subsequent to the original procedure or service.
- **Modifier 91** may be used to indicate repeat clinical diagnostic laboratory tests. This modifier is added only when additional test results are medically necessary on the same day.

- **Modifier 59** may be used, as applicable, to identify procedures or services that are normally reported together but are appropriate to be billed separately under certain circumstances. Modifier 59 indicates a procedure or service by the same provider, distinct or independent from other services, performed on the same day.

Note: Procedures, services and modifiers submitted on your claim should be supported by documentation in the patient's medical record.

Sources: CMS *MLN Matters*® *MM8121*, *CMS Internet-only manual (IOM), Publication 100-04, Chapter 1, Section 120-Detection of duplicate claims*, and the American Medical Association's (AMA) 2013 *Current Procedural Terminology* (*CPT*®) codebook.

Register for free, hands-on Internet-based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. Select from the following session dates: July 29, July 30, or August 21, 2014.

Implementation of phase III CORE 360 CARCs and RARCs rule – version 3.0.5

Provider types affected

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

What you need to know

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

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE electronic funds transfer (EFT) and electronic remittance advice (ERA) operating rule set that must be implemented by January 1, 2014, under the Affordable Care Act.

Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C – Administrative Simplification – to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

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

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

Additional information

The official instruction, CR 8711, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1378OTN.pdf*.

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

MLN Matters® Number: MM8711
Related Change Request (CR) #: CR 8711
Related CR Release Date: May 2, 2014
Effective Date: September 2, 2014
Related CR Transmittal #: R1378OTN
Implementation Date: September 2, 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.

Manual update regarding appeal of claims decisions

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8588, which updates the *Medicare Claims Processing Manual* (Chapter 29 (Appeals of Claims Decisions)) with various policy clarifications. Make sure that your billing staffs are aware of these updates.

Background

CR 8588 revises the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 29 (Appeals of Claims Decisions)) and adds various policy clarifications regarding appeals of claims decisions. These revisions include the following:

- A definition of spouse following the June 2013 Supreme Court ruling that invalidated Section 3 of the Defense of Marriage Act (DOMA) (Section 110)
- Clarification of existing instructions in regard to the following:
  - The submission of appointment of representative written instruments (Section 270.1.3)
  - The handling and reporting of defective or missing appointment instruments (Section 270.1.6), and
  - Signature requirements for appointment of representative instruments (Section 270.1.2)

A copy of the revised *Medicare Claims Processing Manual* (Chapter 29 (Appeals of Claims Decisions)) is included as an attachment to CR 8588.

Additional information

The official instruction, CR 8588, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2926CP.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/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM8588
Related Change Request (CR) #: CR 8588
Related CR Release Date: April 11, 2014
Effective Date: July 14, 2014
Related CR Transmittal #: R2926CP
Implementation Date: July 14, 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.

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

Note: *This article was rescinded May 7, 2014, since the related change request 8602 was rescinded. This information was previously published in the March 2014 Medicare B Connection, Pages 33-34*.

MLN Matters® Number: MM8602 *Rescinded*
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

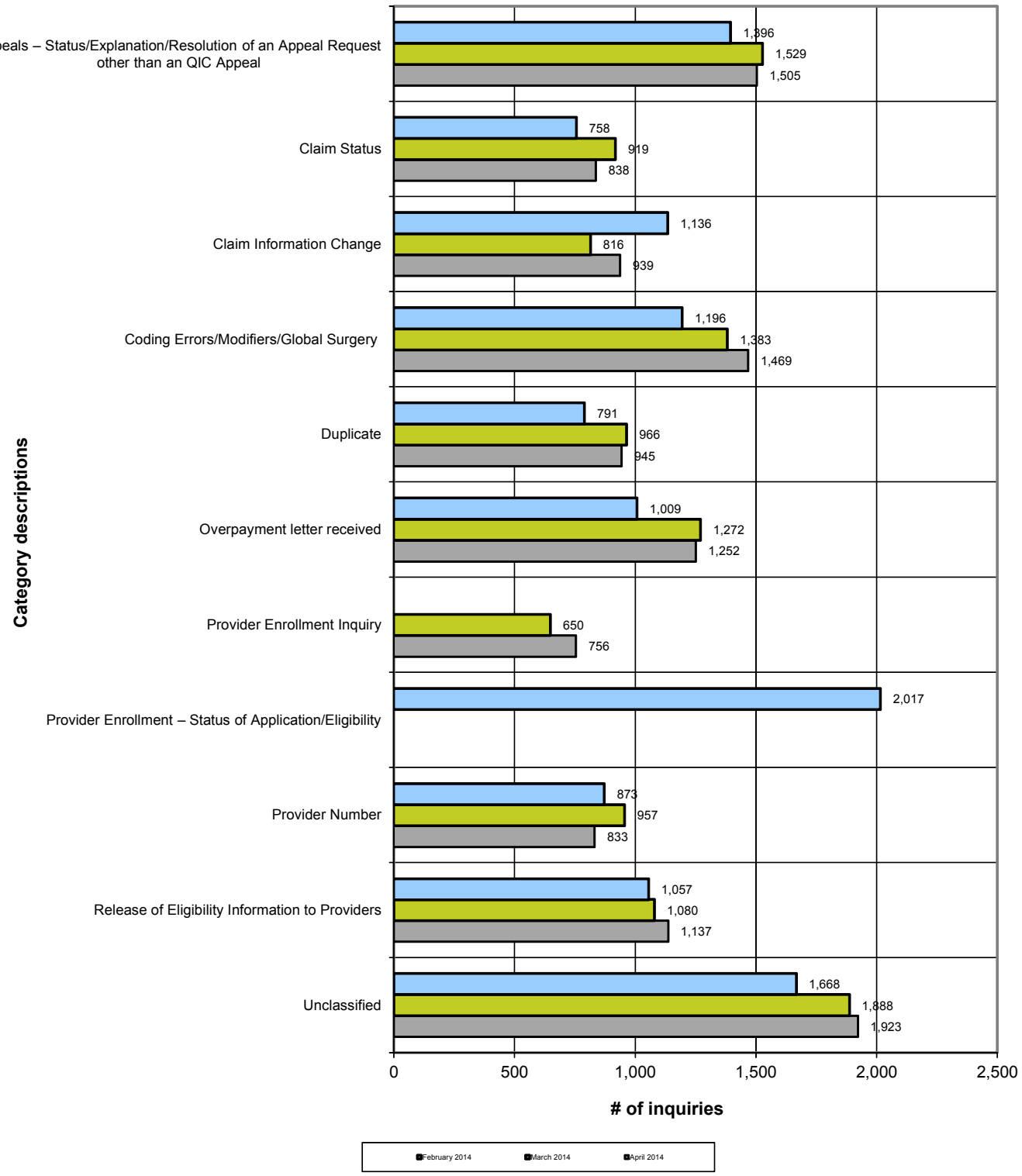
Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended 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.

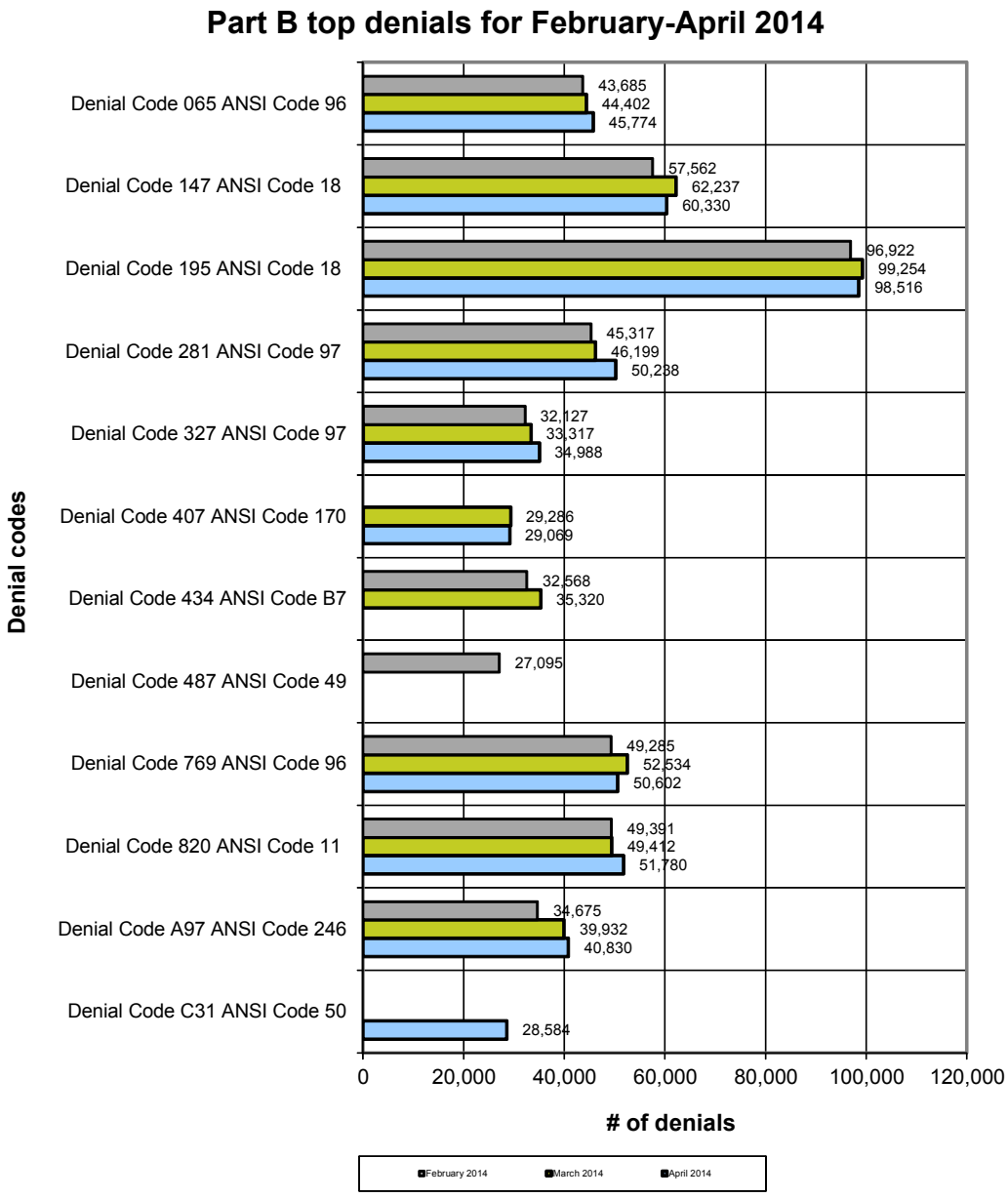
Top inquiries, denials, and return unprocessable claims

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 February-April 2014.

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

Part B top inquiries for February-April 2014





What to do when your claim is denied

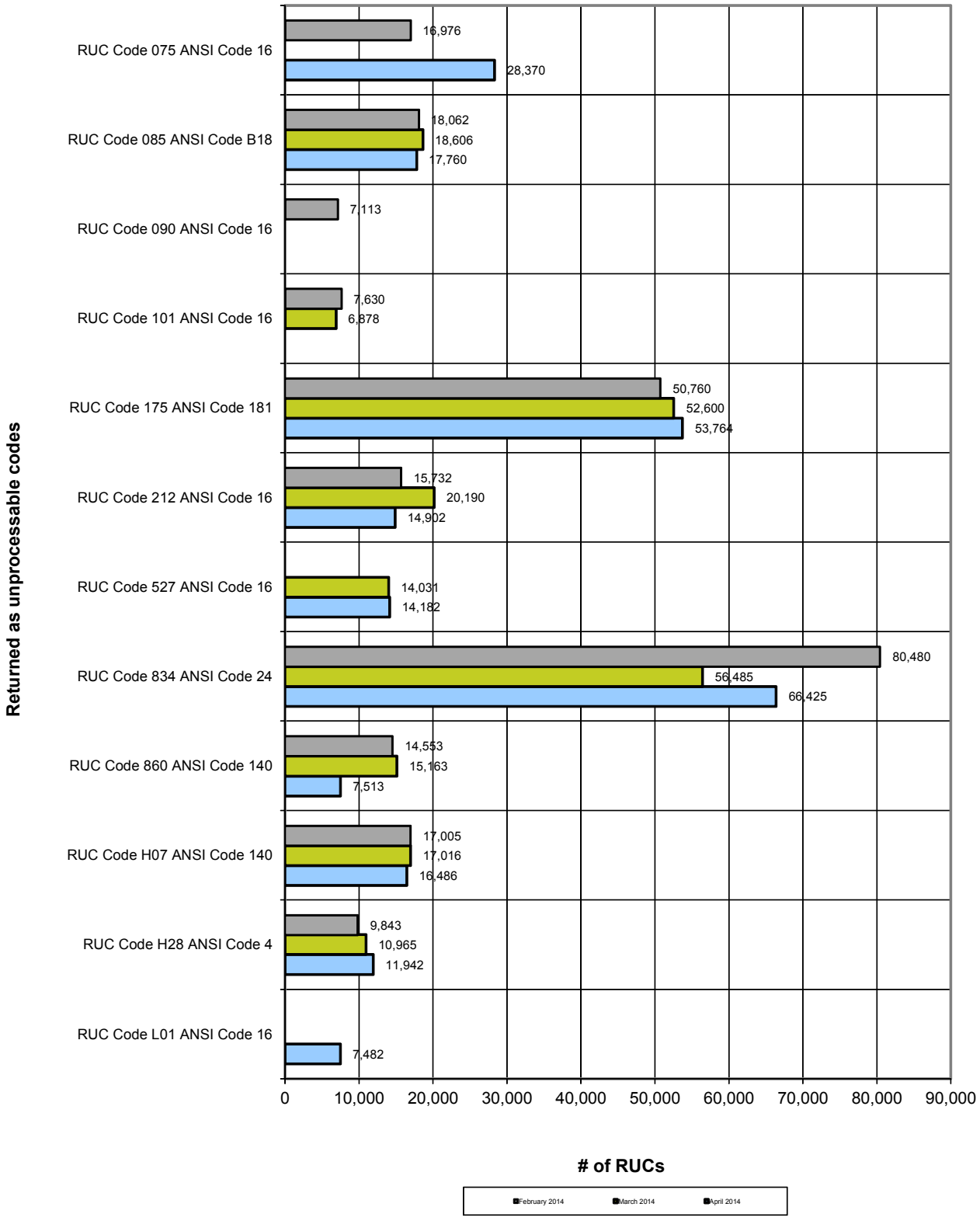
Before contacting customer service, check claim status though the IVR. The IVR will release necessary details around claim denials.

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

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

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

Part B top return as unprocessable claims for February-April 2014



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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Find out first: Subscribe to First Coast eNews

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

Revisions to LCDs

Collagenase clostridium histolyticum (Xiaflex®) – revision to the Part B LCD

LCD ID number: L31243 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for collagenase clostridium histolyticum (Xiaflex®) was revised to include the indication of Peyronie's disease, which was FDA-approved December 6, 2013. The "Indications and Limitations of Coverage and/ or Medical Necessity" section of the LCD was revised to add the indication of Peyronie's disease; the "ICD-9 Codes that Support Medical Necessity" section was updated to add the correlating diagnosis code 607.85. Also, the following sections were updated to include language on Peyronie's disease: "Documentation Requirements," "*CPT*®/HCPCS Codes," and "Utilization Guidelines." In addition, the "Sources of Information and Basis for Decision" section was updated, as well as, the "Coding Guidelines" attachment.

In addition, the "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD was also revised to clarify verbiage related to Dupuytren's contractures and anticoagulation medication.

Effective date

The revision related to the FDA approval for Peyronie's disease is effective for claims processed on or after May 13, 2014, for services rendered on or after December 06, 2013. The revision related to Dupuytren's contractures is effective for services rendered on or after May 13, 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*.

Doxorubicin, liposomal (Doxil/Lipodox) – revision to the Part B LCD

LCD ID number: L29157 (Florida)
LCD ID number: L29419 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for doxorubicin, liposomal (Doxil/Lipodox) was revised to include the off-label indication of endometrial carcinoma. The "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD was revised to include this off-label indication, and the "ICD-9 Codes that Support Medical Necessity" section was updated to add the correlating diagnosis code 182.0. In addition, the "Sources of Information and Basis of Decision" section was updated.

Effective date

The LCD revision is effective for services rendered **on or after May 1, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Noncovered services – revision to the Part B LCD

LCD ID number: L29288 (Florida)
LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)

The following *Current Procedural Terminology*® (*CPT*®) codes were evaluated and determined not to meet the Medicare reasonable and necessary threshold for coverage. Therefore, Category III *CPT*® codes *0335T, 0336T, 0337T, 0340T, 0341T, 0342T* and *0346T* have been added to the "*CPT*®/HCPCS-codes" section of the LCD.

Any denied claim would have Medicare's appeal rights. The second level of appeal (qualified independent contractor) requires review by a clinician to uphold any denial. Providers should submit for review all the relevant medical documentation and case specific information of merit and/or new information in the public domain.

Any interested stakeholder can request a reconsideration of an LCD after the notice period. In the case of the noncovered services, LCD the stakeholder will receive a list of the articles and related information in the public domain that were addressed by the Medical Policy department in making the noncoverage decision. If the stakeholder has new information based on the evaluation of the list, LCD reconsideration can be initiated. It is the responsibility of the interested stakeholder to request the evidentiary list from the contractor and to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the website.

Effective date

This LCD revision is effective for services rendered **on**

See **NONCOVERED,** next page

NONCOVERED

From previous page

or after June 30, 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*.

Therapy services billed by physicians/nonphysician practitioners – revision to the Part B LCD

LCD ID number: L32807 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for therapy services by physicians/nonphysician practitioners was effective for services rendered on or after October 09, 2012, for Florida, Puerto Rico, and the U.S. Virgin Islands. Since that time, the LCD was updated to reflect current Centers for Medicare & Medicaid Services (CMS) language based on change request (CR) 8458 (manual updates to clarify skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), home health (HH), and outpatient (OPT) coverage pursuant to *Jimmo vs Sebelius*).

Effective date

This LCD revision is effective for services rendered **on or after January 07, 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*.

Therapy and rehabilitation services – revision to the Part B LCD

LCD ID number: L29289 (Florida) LCD ID number: L29399 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for therapy and rehabilitation services was most recently revised January 01, 2014. Since that time, the LCD was updated to reflect current Centers for Medicare & Medicaid Services (CMS) language based on change request (CR) 8458 (manual updates to clarify skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), home health (HH), and outpatient *(OPT)* coverage pursuant to *Jimmo vs Sebelius*).

Effective date

This LCD revision is effective for services rendered **on or after January 07, 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*.

Transcranial magnetic stimulation (TMS) for major depressive disorder – revision to the Part B LCD

LCD ID number: L33676 (Florida/Puerto Rico/ U.S. Virgin Islands)

This local coverage determination (LCD) for transcranial magnetic stimulation (TMS) was revised under the "Indications and limitations of coverage and/or medical necessity" section of the LCD, to clarify the appropriate training and certification requirements of the psychiatrist, neurologist, and the technician performing TMS therapy. The prescribing and supervising psychiatrist and neurologist must have met all of the following criteria:

- Completed a fellowship or residency in psychiatry or neurology
- Completed and demonstrated proficiency in TMS device at a University based training course or a company sponsored training course.
- Provides personal supervision for the initial individual motor threshold determinations, treatment parameter definition, and TMS treatment course planning and documentation supportive of the level of supervision.
- Subsequent delivery and management of TMS sessions may be performed by a psychiatrist or neurologist and/or an appropriately trained technician under the direct supervision of the professional provider, psychiatrist, or neurologist, to ensure the patient has someone in attendance at all times during the TMS session.
- During subsequent delivery and management of TMS sessions the providing psychiatrist or neurologist must

See **TMS,** next page

TMS

From previous page

meet face to face with the patient when there is a change in the individual's mental status and /or other significant change in clinical status.

- **Note**: A technician must be directly supervised by a professional provider that is a psychiatrist or neurologist.

In addition, further revisions were made to the "Indications of Coverage", "Coverage Limitations and "Documentation Requirements" sections of the LCD.

Effective date

This LCD is effective for services rendered **on or after July 7, 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*.

Vestibular function tests – revision to the Part B LCD

LCD ID number: L29305 (Florida) LCD ID number: L29407 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for vestibular function tests has been revised to clarify the qualifications and training for diagnostic tests, (*Current Procedural Terminology*® (*CPT*®) codes *92540-92547*), to be congruent with Centers for Medicare & Medicaid Services (CMS) language in the *Medicare Benefit Policy Manual*, Publication 100-02, Chapter 15, Section 80: 80.3-80.3.1. This revision is based on a correspondence seeking clarification regarding the qualifications of the individual who can perform the technical portion of vestibular function tests. Also, First Coast Service Options, Inc. (First Coast) further revised the language within the indications and limitations of coverage section of the LCD.

This LCD has been revised to outline indications and limitations of coverage and/or medical necessity, training and expertise, limitations, and utilization guidelines for vestibular function tests. In addition, the coding guidelines were updated to be congruent with the revisions in the LCD.

Effective date

The LCD revision is effective for services rendered **on or after June 30, 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*.

Additional Information

CMS' contract award to First Coast will not result in changes to LCDs

On February 14, 2014, the Centers for Medicare & Medicaid Services (CMS) selected First Coast Service Options Inc. (First Coast) to continue to be the Medicare administrative contractor (MAC) for Florida, Puerto Rico and U.S. Virgin Islands. As a result of the transition to the new contract, effective June 16, 2014, jurisdiction 9 (J9) will be referred to as jurisdiction (JN).

The current MAC J9 LCDs will transition to MAC JN and will retain the same identifying numbers in CMS' Medicare coverage database (MCD). Since First Coast will retain the same contractor identification numbers that are currently listed in the MCD, no changes will be made to the content or to the method of accessing LCDs as result of the transition to JN.

First Coast looks forward to continuing to serve the beneficiary and provider communities in JN.

Note: The transition from J9 to JN will be completed by June 16, 2014.

Testosterone pellets (Testopel®) – revision to the Part B LCD "Coding Guidelines" attachment

LCD ID number: L33002 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for testosterone pellets (Testopel®) became effective for services rendered on or after January 29, 2013. First Coast Service Options Inc. (First Coast) identified upon pre-payment claims review that Healthcare Common Procedure Coding System (HCPCS) code J3490 (unclassified drugs) used for testosterone pellets (Testopel®) is being billed incorrectly. Also, the medical record for various claims did not support the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

As outlined under "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD testosterone pellets are considered medically reasonable and necessary for second line testosterone replacement therapy in males with congenital or acquired endogenous androgen absence or deficiency associated with primary or secondary hypogonadism when other standard replacement [intramuscular (IM), buccal, transdermal] has not been clinically effective for the given patient. The review of medical records revealed the following: Providers are not supporting the medical need for testosterone pellets with documentation of unsuccessful treatment of standard replacement (e.g., intramuscular (IM), buccal, transdermal); providers are not specifically addressing the reason(s) for a transition to pellets from other effective testosterone replacement and lastly some medical records did not include two total testosterone levels and free levels (when indicated) to establish the need for testosterone replacement. The medical record should include the Clinical Laboratory Improvement Amendments (CLIA) approved reference normal range for the total testosterone assay used.

For HCPCS code J3490, the pre-payment claims review also determined that providers are not entering the drug's name and dosage when submitting a claim. The provider must indicate the name, strength, and dosage of the drug in block 19 on the CMS-1500 (02/12) paper claim form (or in 2400.SV101-7 in the ANSI 837 claim file). For example, block 19 might state: testosterone pellets (Testopel®), 75 mg per pellet, implanted 225 mg (three pellets). If a compounded form of testosterone pellets is used, this must be indicated in block 19 with the name, strength, and dosage as described in the above example.

Providers are instructed to continue to bill HCPCS code J3490 for testosterone pellets (Testopel®) and *Current Procedural Terminology®* (*CPT®*) code *11980* (subcutaneous hormone pellet implantation) on the same claim. If these codes are not billed on the same claim the claim may be subject to prepayment review. Please note if HCPCS code J3490 is denied then the associated implantation code (*CPT®* code *11980*) will also be denied.

The LCD "Coding Guidelines" attachment has been revised to incorporate the billing instructions as stated above.

Effective date

The revision to the LCD "Coding Guidelines" attachment is effective for claims processed **on or after May 6, 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*.

Take advantage of First Coast's exclusive PDS report

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

Educational Events

Provider outreach and educational events – July 2014

PQRS 2014: What providers need to know to earn the incentive or avoid future payment adjustments

When: Monday, July 21 **Type of event:** Face-to-face
Time: 2:00-4:00 p.m.
http://medicare.fcso.com/Events/268757.asp

Medicare Speaks 2014 Fort Lauderdale

When: Tuesday-Wednesday, July 22-23 **Type of event:** Face-to-face
Time: 7:30 a.m.-4:45 p.m.
http://medicare.fcso.com/Medicare_Speaks/268748.pdf

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects™ Provider eNews

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

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

"MLN Connects™ Provider eNews': May 1, 2014 – *http://go.usa.gov/k7hh*

"MLN Connects™ Provider eNews': May 8, 2014 – *http://go.usa.gov/kSd5*

"MLN Connects™ Provider eNews': May 15, 2014 – *http://go.usa.gov/843H*

"MLN Connects™ Provider eNews': May 22, 2014 – *http://go.cms.gov/1jVHzTn*

Additional Resources

Medicare billing certificate programs

The programs are designed to provide education on Part A and Part B of the Medicare program. They each include required Web-based training courses, readings, and a list of helpful resources. Upon successful completion of each of the programs, you will receive a certificate in Medicare billing from CMS.

To participate in either the Part A or Part B provider type program, visit *http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html* and select "Web-Based Training (WBT) Courses." From the list of courses, select the Medicare billing certificate program for your provider type. Login (continuing user) or Register (new user) by clicking on the links at the top of the Course screen. On the next screen choose 'Web-Based Training Courses' and reselect your course. Click the "Take Course" button and you are ready to begin.

Register for free, hands-on Internet-based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. Select from the following session dates: July 29, July 30, or August 21, 2014.

Mail directory

Claims submissions

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

Participating providers

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

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

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

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

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

Communication

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

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

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

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

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

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

Durable medical equipment

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

Electronic media claims (EMC)

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

Additional development

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

Denied request for lack of response: Submit as a new claim, to:

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

Miscellaneous

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

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

and

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

Provider education

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

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

Limiting charge issues:

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

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

Medicare claims for Railroad retirees:

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

Fraud and abuse

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

Phone numbers

Providers

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

Interactive Voice Response (IVR):

1-877-847-4992

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary
Toll-Free: 1-800-MEDICARE

Hearing Impaired: 1-800-754-7820

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

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC
1-866-270-4909

Medicare Part A

Toll-Free:

1-888-664-4112

Medicare websites

Provider

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

http://medicare.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services

www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange

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

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

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

Provider enrollment

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

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

and

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

Durable medical equipment (DME)

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

Redeterminations

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

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

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

Congressional inquiries

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

Provider education

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

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Phone numbers

Provider customer service
1-866-454-9007

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

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE

Hearing Impaired: 1-800-754-7820

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

Education event registration
1-904-791-8103

Electronic data interchange
1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims
CGS Administrators, LLC
1-866-270-4909

Medicare Part A
Toll-Free: 1-888-664-4112

Medicare websites

Provider

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

http://medicare.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services

www.medicare.gov

Addresses

Claims

Additional documentation

General mailing

Congressional mailing

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

Redeterminations

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

Redeterminations on overpayment

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

Post-payment medical exams

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

Freedom of Information Act (FOIA) related requests

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

Medicare fraud and abuse

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

Provider enrollment

Mailing address changes

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

Electronic Data Interchange

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

Flu vaccinated list

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

Local coverage determinations

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

Debt collection

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

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

Overnight mail and other special handling postal services

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

Other Medicare contractors and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)

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

Regional Home Health & Hospice Intermediary

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

Railroad Medicare

Palmetto Government Benefit

Administrators

P. O. Box 10066

Augusta, GA 30999-0001

Phone numbers

Providers

Customer service – free of charge

Monday to Friday

8:00 a.m. to 4:00 p.m.

1-877-715-1921

For the hearing and speech impaired (TDD)

1-888-216-8261

Interactive voice response (IVR)

1-877-847-4992

Beneficiary

Customer service – free of charge

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

Hearing and speech impaired (TDD)

1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number

1-904-361-0407

Medicare Websites

Providers

First Coast – MAC J9

medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services

www.medicare.gov

Order form for Medicare Part B materials

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

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

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

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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