Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

June 2014

In this issue

Open payments (the Sunshine Act) update

Portal registration begins

The Centers for Medicare & Medicaid Services (CMS) Enterprise Portal is now available for physicians and teaching hospital representatives to begin the registration process (phase 1). Note that registration in the Enterprise Portal is a separate process from registration in the open payments system. Enterprise portal registration is a required first step to allow for registration in the open payments system when it becomes available in phase 2.

Although registration in the enterprise portal and the open payments system is a voluntary process, it is required if the physician or teaching hospital wants to be able to review and dispute any of the data reported about them by applicable manufacturers and applicable group purchasing organizations (GPOs). Registration for physicians and teaching hospitals will be conducted in two phases for this first open payments reporting year:

Phase 1 (available now): Includes user registration in the CMS Enterprise Portal. Use the *"Phase 1 Step-by-Step CMS Enterprise Portal Registration for Physicians and Teaching Hospitals" presentation* for guidance on how to complete this portion of the registration; this resource is also posted on the physicians and teaching hospitals pages of the *"Open Payments" website*.

Phase 2 (begins in July): Includes physician and teaching hospital registration in the open payments system, and allows them to review and dispute data submitted by applicable manufacturers and applicable GPOs prior to public posting of the data. **Note**: Any data that is disputed, if not corrected by industry, will still be made public but will be marked as disputed. Learn more about the review and dispute process.

Physician and teaching hospital registration in the CMS enterprise portal is complete once you receive acknowledgement that your request for open payments system access has been received. *You will not be able to access the open payments system before phase 2 begins in July*, so if you attempt to access open payments through the enterprise portal, the radio buttons and functions that you will see on the "Welcome to Open Payments" main screen will not be operational until the system opens for phase 2 in July.

User guide

The *open payments user guide* has been extensively updated and is now available as a one-stop-shop resource for providing industry, physicians, and teaching hospitals with a comprehensive understanding of open payments

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Contents

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

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

About the 'Medicare B Connection'

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example,

"Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.
- In addition to the above, other sections include:
- . **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

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

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

Advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Quarterly update to the correct coding initiative edits, version 20.3

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8662 which informs Medicare contractors about the release of the latest package of CCI edits, version 20.3, which will be effective October 1, 2014. Make sure that your billing staffs are aware of these changes.

Background

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

Version 20.3 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: column one/column two correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits. CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file on each website. The edits previously contained in the mutually exclusive edit file are **not** being deleted but are being moved to the column one/column two correct coding edit file.

Additional information

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

The official instruction, CR 8662 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2969CP.pdf*.

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

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Implementation Date: 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.

Common and appropriate uses of modifier 59

Provider types affected

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

Provider action needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of modifier *59*. The article only clarifies existing policy. Make sure that your billing staffs are aware of the proper use of modifier *59*.

Background

The Medicare national correct coding initiative (NCCI) includes procedure-to-procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/*Current Procedural Terminology* (*CPT*®) codes should not be reported together either in all situations or in most situations.

For PTP edits that have a correct coding modifier indicator (CCMI) of "0," the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of "1," the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the *National Correct Coding Initiative Policy Manual*, Chapter 1, for general information about the NCCI program, PTP edits, CCMIs, and NCCI-associated modifiers. This manual can be retrieved from the download section at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are "separate and distinct." Modifier *59* is an important NCCI-associated modifier that is often used incorrectly.

The *CPT*® manual defines modifier *59* as follows:

"**Distinct procedural service**: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier *59* is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier *59* best explains the circumstances, should modifier *59* be used. **Note**: Modifier *59* should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier *25*."

Modifier *59* and other NCCI-associated modifiers **should not be used** to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

1. **Modifier *59* is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.**

One of the common uses of modifier *59* is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or encountered on the same day, and that cannot be described by one of the more specific anatomic NCCI-associated modifiers – i.e., RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3.) From an NCCI perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. However, NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered to be separate and distinct. Modifier *59* should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites. For example:

- Treatment of the nail, nail bed, and adjacent soft tissue (See example 4.)
- Treatment of posterior segment structures in the eye (See example 5.)
- Arthroscopic treatment of structures in adjoining areas of the same shoulder (See example 6.)

2. **Modifier *59* is used appropriately when the procedures are performed in different encounters on the same day.**

Another common use of modifier *59* is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day and that cannot be described by one of the more specific NCCI-associated modifiers – i.e., *24, 25, 27, 57, 58, 78*, *79*, or *91*. (See example 7) As noted in the *CPT*® definition, modifier *59* should only be used if no other modifier more appropriately

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describes the relationship of the two procedure codes.

3. Modifier *59* is used inappropriately if the basis for its use is that the narrative description of the two codes is different.

One of the common misuses of modifier *59* is related to the portion of the definition of modifier *59* allowing its use to describe a "different procedure or surgery." The code descriptors of the two codes of a code pair edit usually represent different procedures, even though they may be overlapping. The edit indicates that the two procedures should not be reported together if performed at the same anatomic site and same patient encounter as those procedures would not be considered to be "separate and distinct." The provider should not use modifier *59* for such an edit based on the two codes being "different procedures." (See example 8.) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier *59* may be appended to indicate that they are different procedures on that date of service.

4. Other specific appropriate uses of modifier *59*

There are three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter, i.e.:

A. Modifier *59* is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier *59* that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier *59* may be used to identify the services. (See example 9.)

B. Modifier *59* is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 10.) If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

C. Modifier *59* is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 11.) If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

Use of modifier *59* does not require a different diagnosis for each HCPCS/*CPT*® coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier *59*. The HCPCS/*CPT*® codes remain bundled unless the procedures are performed at different anatomic sites or separate patient encounters or meet one of the other three scenarios described above.

Examples of modifier *59* usage

Following are some examples developed to help guide physicians and providers on the proper use of modifier *59* (Please remember that Medicare policy is that modifier *59* is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.):

Example 1: Column 1 code/column 2 code – *17000*/*11100*

- *CPT*® *17000* – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
- *CPT*® *11100* – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Modifier *59* may be reported with code *11100* if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. If the procedures are performed on different sides of the body, modifiers RT and LT or another

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pair of anatomic modifiers should be used, not modifier *59*.

Example 2: Column 1 code/column 2 code – *47370*/*76942*

- *CPT® 47370* – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
- *CPT® 76942* – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

CPT® 76942 should not be reported and modifier *59* should not be used if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure. Code *76942* may be reported with modifier *59* if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

Example 3: Column 1 code/column 2 code – *93453*/*76000*

- *CPT® 93453* – Combined right and left heart catheterization including intraprocedural injections(s) for left ventriculography, imaging supervision and interpretation, when performed
- *CPT® 76000* – Fluoroscopy (separate procedure), up to one hour physician time, other than *71023* or *71034* (eg, cardiac fluoroscopy)

CPT® 76000 should not be reported and modifier *59* should not be used for fluoroscopy that is used in conjunction with a cardiac catheterization procedure. Modifier *59* may be reported with code *76000* if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

Example 4: Column 1 code/column 2 code – *11055*/*11720*

- *CPT® 11055* – Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- *CPT® 11720* – Debridement of nail(s) by any method(s); one to five

CPT® 11720 should not be reported and modifier *59* should not be used if a nail is debrided on the same toe from which a hyprkeratotic lesion has been removed. Modifier 59 may be reported with code *11720* if multiple nails are debrided and a corn that is on the same foot and that is not adjacent to a debrided toenail is pared.

Example 5: Column 1 code/column 2 code – *67210*/*67220*

- *CPT® 67210* – Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
- *CPT® 67220* – Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

CPT® 67220 should not be reported and modifier *59* should not be used if both procedures are performed during the same operative session because the retina and choroid are contiguous structures of the same organ.

Example 6: Column 1 code/column 2 code – *29827*/*29820*

- *CPT® 29827* – Arthroscopy, shoulder, surgical; with rotator cuff repair
- *CPT® 29820* – Arthroscopy, shoulder, surgical; synovectomy, partial

CPT® 29820 should not be reported and modifier *59* should not be used if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not modifier *59*.

Example 7: Column 1 code/column 2 code – *93015*/*93040*

- *CPT® 93015* – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- *CPT® 93040* – Rhythm ECG, one to three leads; with interpretation and report

Modifier *59* may be reported if the rhythm ECG is performed at a different encounter than the cardiovascular stress test. If a rhythm ECG is performed during the cardiovascular stress test encounter, *CPT® 93040* should not be reported and modifier *59* should not be used. In this case, the procedures are performed in different encounters on the same day.

Example 8: Column 1 code/column 2 code – *34833*/*34820*

- *CPT® 34833* – Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral
- *CPT® 34820* – Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral

CPT® 34833 is followed by a *CPT®* manual instruction that states: "(Do not report *34833* in addition to *34820*)." Although the *CPT®* descriptors for *34833* and *34820* describe different procedures, they should not be reported together for the same side. Modifier *59* should not be appended to either code to report the two procedures for the same side of the body. If the two procedures were performed on different sides of the body, they may be reported with modifiers LT and RT as appropriate. However, the use is inappropriate if the basis for its use is that the narrative description of the two codes is different.

Example 9: Column 1 code/column 2 code – *97140*/*97530*

- *CPT® 97140* – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- *CPT® 97530* – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

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Modifier *59* may be reported if the two procedures are performed in distinctly different 15 minute intervals. *CPT*® *97530* should not be reported and modifier *59* should not be used if the two procedures are performed during the same 15 minute time interval. In this case, the procedures are performed in different encounters on the same day.

Example 10: Column 1 code/column 2 code – *37220*/*75710*

- *CPT*® *37220* – Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- *CPT*® *75710* – Angiography, extremity, unilateral, radiological supervision and interpretation

Modifier 59 may be reported with *CPT*® *75710* if a diagnostic angiography has not been previously performed and the decision to perform the revascularization is based on the result of the diagnostic angiography. The *CPT*® manual defines additional circumstances under which diagnostic angiography may be reported with an interventional vascular procedure on the same artery. Modifier *59* is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

Example 11: Column 1 code/column 2 code – *32551*/*71020*

- *CPT*® *32551* – Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open
- *CPT*® *71020* – Radiologic examination, chest, 2 views, frontal and lateral

Modifier *59* may be reported if, later in the day following the insertion of a chest tube, the patient develops a high fever and a chest x-ray is performed to rule out pneumonia. *CPT*® code *71020* should not be reported and modifier *59* should not be used for a chest x-ray that is performed following insertion of a chest tube in order to verify correct placement of the tube. Modifier *59* is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

Additional information

- The CMS Web page on the national correct coding initiative edits is available at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.
- The *CPT*® manual includes the definition of modifier 59, as well as *CPT*® codes used with modifier 59. The manual is available at *http://www.ama-assn.org/ama*.

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

***Note**: This article was revised June 9, 2014, to emphasize that coding "CT" in front of the clinical trial number applies **only** to paper claims. The "CT" is not to be coded on electronic claims. All other information remains the same. This information was previously published in the May 2014 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 change request (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 data base.

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*.

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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 (use CT only on paper claims) 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) (**do not use CT on the electronic claim, e.g., 12345678**) 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/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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work.

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

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Ambulatory Surgical Center

July 2014 update of the ASC payment system

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8786 and is a recurring update that describes changes to and billing instructions for various payment policies implemented in the July 2014 ASC update as well as updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure your billing staff is aware of the changes.

Key points of CR 8786

One new brachytherapy source shown below is assigned for payment under the ASC payment system.

New brachytherapy source code, effective July 1, 2014

HCPCS	Short descriptor	Long descriptor	ASC PI
C2644	Brachytx cesium-131 chloride	Brachytherapy source, cesium-131 chloride solution, per millicurie	H2

New category III *CPT*® codes

The American Medical Association (AMA) releases category III *Current Procedural Terminology* (*CPT*®) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2014 update, the Centers for Medicare & Medicaid Services (CMS) is implementing 27 category III *CPT*® codes that the AMA released in January 2014 for implementation on July 1, 2014. Four of the 27 category III *CPT*® codes are separately payable under the ASC payment system and are shown below. Payment rates for these services can be found in the July 2014 ASC update addenda that are posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

Category III *CPT*® codes, implemented as of July 1, 2014

CPT® code	Short descriptor	Long descriptor	July ASC PI
0348T	RSA spine exam	*Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed)*	Z2
0349T	RSA upper extr exam	*Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow and wrist, when performed)*	Z2
0350T	RSA lower extr exam	*Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed)*	Z2
0356T	Insrt drug device for iop	*Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each*	R2

Billing for drugs, biologicals, and radiopharmaceuticals

Payments for separately payable drugs and biologicals based on average sales price (ASP) are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2014 release of the ASC drug file. The updated payment rates below, effective July 1, 2014, will be included in the July 2014 update of the ASC Addendum BB, which will be posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

New HCPCS codes, effective July 1, 2014, for certain drugs and biologicals separately payable under ASC payment system

HCPCS code	2014 Short descriptor	2014 Long descriptor	ASC PI
C9022	Injection, elosulfase alfa	Injection, elosulfase alfa, 1mg	K2

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HCPCS code	2014 Short descriptor	2014 Long descriptor	ASC PI
C9134	Factor XIII A-subunit recomb	Factor XIII (antihemophilic factor, recombinant), Tretten, per 10 i.u.	K2
Q9970*	Inj Ferric	Injection, ferric carboxymaltose, 1 mg	K2

*HCPCS code C9441 (Injection, ferric carboxymaltose, 1 mg) will be deleted and replaced with HCPCS code Q9970 effective July 1, 2014.

Updated payment rates for certain HCPCS codes, effective October 1, 2013, through December 31, 2013

The payment rate for one HCPCS code was incorrect in the October 2013 ASC drug file. The corrected payment rate is listed below. Suppliers who think they may have received an incorrect payment for dates of service October 1, 2013, through December 31, 2013, may request that their MAC adjust the previously processed claims.

Updated payment rates for certain HCPCS codes, effective October 1, 2013, through December 31, 2013

HCPCS code	Short descriptor	Corrected payment rate	ASC PI
J2788	Rho d immune globulin 50 mcg	25.15	K2

Updated payment rates for certain HCPCS codes, effective January 1, 2014, through March 31, 2014

The payment rate for one HCPCS code was incorrect in the January 2014 ASC drug file. The corrected payment rate is listed below. Suppliers who think they may have received an incorrect payment for dates of service January 1, 2014, through March 31, 2014, may request that their MAC adjust the previously processed claims.

Updated payment rates for certain HCPCS codes, effective January 1, 2014, through March 31, 2014

HCPCS code	Short descriptor	Corrected payment rate	ASC PI
J0775	Collagenase, clost hist inj	38.49	K2

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

Additional information

The official instruction, CR 8786 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2970CP.pdf*.

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

MLN Matters® Number: MM8786
Related Change Request (CR) #: CR 8786
Related CR Release Date: May 23, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R2970CP
Implementation Date: July 7, 2014

Laboratory/Pathology

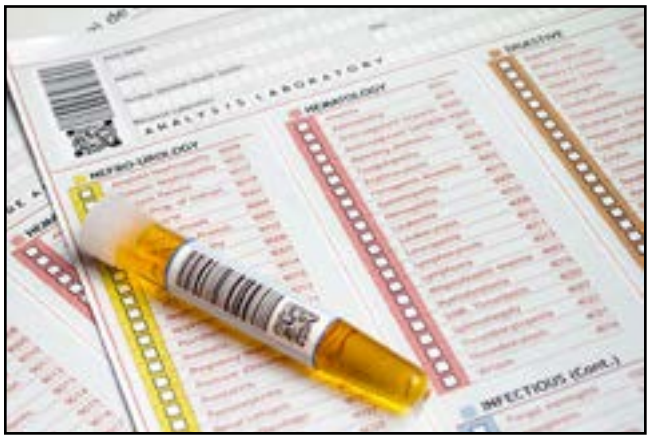
Changes to the laboratory NCD software

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8797 which informs MACs that the laboratory national coverage determination (NCD) edit software will be updated to continue the processing of ICD-9 diagnosis codes. Make sure your billing staffs are aware of these changes.



Background

The laboratory NCD edit software will be updated to continue the processing of the ICD-9 diagnosis codes. On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary of Health and Human Services may not adopt ICD-10 codes prior to October 1, 2015. This requires Health Insurance Portability & Accountability Act of 1996 (HIPAA) covered entities to continue to use ICD-9-CM at least through September 30, 2015. Also, CR 8797 announces there are no updates to the laboratory NCD code lists for this quarter.

Additional information

The official instruction, CR 8797 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2976CP.pdf*.

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

MLN Matters® Number: MM8797
Related Change Request (CR) #: CR 8797
Related CR Release Date: June 13, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2976CP
Implementation Date: October 6, 2014

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Medicare Physician Fee Schedule Database

July 2014 physician fee schedule database update

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8773 which amends the payment files that were issued to MACs based upon the 2014 Medicare physician fee schedule (MPFS) final rule as modified by the "Pathway for SGR Reform Act of 2013" (Section 101) passed on December 18, 2013, and further modified by Section 101 of the "Protecting Access to Medicare Act of 2014" on April 1, 2014. Make sure your billing staffs are aware of these changes.

Background

The Social Security Act (Section 1848 (c)(4) (available at *http://www.socialsecurity.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 based on current law and the 2014 MPFS final rule, the MPFS database (MPFSDB) has been updated using the 0.5 percent update conversion factor, effective January 1, 2014, to December 31, 2014.

Payment files were issued to MACs based upon the 2014 MPFS final rule, published in the Federal Register on December 10, 2013, which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html*, and as modified by Section 101 of the "Pathway for SGR Reform Act of 2013" passed on December 18, 2013, and further modified by Section 101 of the "Protecting Access to Medicare Act of 2014" on April 1, 2014, for MPFS rates to be effective January 1, 2014, to December 31, 2014.

The summary of Healthcare Common Procedure Coding System (HCPCS) code additions for the July 2014 update are shown in the following table:

HCPCS	Short descriptor	Procedure status
Q9970	Inj Ferric Carboxymaltos 1mg	E
Q9974	Morphine epidural/intratheca	E
S0144	Inj, Propofol, 10mg	I
S1034	Art pancreas system	I
S1035	Art pancreas inv disp sensor	I
S1036	Art pancreas ext transmitter	I
S1037	Art pancreas ext receiver	I

HCPCS	Short descriptor	Procedure status
0347T	Ins bone device for rsa	C
0348T	Rsa spine exam	C
0349T	Rsa upper extr exam	C
0350T	Rsa lower extr exam	C
0351T	Intraop oct brst/node spec	C
0352T	Oct brst/node i&r per spec	C
0353T	Intraop oct breast cavity	C
0354T	Oct breast surg cavity i&r	C
0355T	Gi tract capsule endoscopy	C
0356T	Insrt drug device for iop	C
0358T	Bia whole body	C
0359T	Behavioral id assessment	C
0360T	Observ behav assessment	C
0361T	Observ behav assess addl	C
0362T	Expose behav assessment	C
0363T	Expose behav assess addl	C
0364T	Behavior treatment	C
0365T	Behavior treatment addl	C
0366T	Group behavior treatment	C
0367T	Group behav treatment addl	C
0368T	Behavior treatment modified	C
0369T	Behav treatment modify addl	C
0370T	Fam behav treatment guidance	C
0371T	Mult fam behav treat guide	C
0372T	Social skills training group	C
0373T	Exposure behavior treatment	C
0374T	Expose behav treatment addl	C

All the additional codes listed in the above table are effective as of July 1, 2014. For full details on the above codes, including on descriptors, place of service codes, co-surgery indicators, etc. see the tables in CR 8773. The Web address for CR 8773 is in the *Additional Information* section.

In addition to the codes that were added, codes J2271 (Morphine SO4 injection 100mg) and J2275 (Morphine sulfate injection) have a change in their procedure status code from E to I, effective July 1, 2014.

Also, Section 651 of Medicare Modernization Act (MMA) required the Secretary of Health and Human Services to conduct a demonstration for up to 2 years to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. The demonstration expanded Medicare coverage to include: "(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and (B) diagnostic and other services that

See **MPFSDB**, next page

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a chiropractor is legally authorized to perform by the state or jurisdiction in which such treatment is provided." The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of MMA mandates the Secretary to ensure that "the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented." The costs of this demonstration were higher than expected and CMS has been recovering costs by deducting 2 percent from payments for chiropractic services. Since CMS has determined that the costs are fully recovered, the July update eliminates the 2 percent reduction for *CPT*® codes *98940, 98941*, and *98942* that was utilized for the first half of 2014, effective July 1, 2014.

Additional information

The official instruction, CR 8773 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2974CP.pdf*.

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

MLN Matters® Number: MM8773
Related Change Request (CR) #: CR 8773
Related CR Release Date: June 6, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R2974CP
Implementation Date: July 7, 2014

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General Coverage

Successful results from CMS ICD-10 acknowledgement testing week

Additional testing scheduled for next year

This past March, the Centers for Medicare & Medicaid Services (CMS) conducted a successful ICD-10 testing week. Testers submitted more than 127,000 claims with ICD-10 codes to the Medicare fee-for-service (FFS) claims systems and received electronic acknowledgements confirming that their claims were accepted.

Approximately 2,600 participating providers, suppliers, billing companies and clearinghouses participated in the testing week, representing about five percent of all submitters. Clearinghouses, which submit claims on behalf of providers, were the largest group of testers, submitting 50 percent of all test claims. Other testers included large and small physician practices, small and large hospitals, labs, ambulatory surgical centers, dialysis facilities, home health providers, and ambulance providers.

Nationally, CMS accepted 89 percent of the test claims, with some regions reporting acceptance rates as high as 99 percent. The normal FFS Medicare claims acceptance rates average 95-98 percent. Testing did not identify any issues with the Medicare FFS claims systems.

This testing week allowed an opportunity for testers and CMS alike to learn valuable lessons about ICD-10 claims processing. In many cases, testers intentionally included such errors in their claims to make sure that the claim would be rejected, a process often referred to as negative testing. To be processed correctly, all claims must have a valid diagnosis code that matches the date of service and a valid national provider identifier. Additionally, the claims using ICD-10 had to have an ICD-10 companion qualifier code and the claims using ICD-9 had to use the ICD-9 qualifier code. Claims that did not meet these requirements were rejected.

HHS expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015. Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the anticipated October 1, 2015 implementation date.

Submitters should contact their local *Medicare administrative contractor (MAC)* for more information about acknowledgment testing. However, those who submit claims may want to delay acknowledgement testing until after October 6, 2014, when Medicare updates its systems.

CMS will be conducting end-to-end testing in 2015. Details about this testing will be released soon.

CMS releases ICD-10 conversion and coding revisions with ICD-9 updates to NCDs

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8691 which is the first maintenance update of ICD-10 conversions and coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, and CR 8197. Links to related *MLN Matters*® articles MM7818, MM8109, and MM8197 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly recurring updates. No policy-related changes are included with these recurring updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these changes to the following 29 NCDs:

20.5 ECU Using Protein A Columns, 20.7 PTA, 20.20 ECP Therapy, 20.29 HBO Therapy, 50.3 Cochlear Implants, 70.2.1 Diabetic Peripheral Neuropathy, 80.2 Photodynamic Therapy, 80.2.1 OPT, 80.3 Photosensitive Drugs, 80.3.1 Verteporfin, 100.1 Bariatric Surgery, 110.8.1 Stem Cell Transplants, 110.4 Extracorpreal Photopheresis, 110.10 IV Iron Therapy, 150.3 Bone Mineral Density, 160.18 VNS, 160.24 Deep Brain Stimulation, 160.27 TENS for CLBP, 180.1 MNT, 190.1 Histocompatibility Testing, 190.8 Lymphocyte Mitogen Response Assay, 190.11 Home PT/INR, 210.1 PSA Screening Tests, 210.2 Screening Pap/Pelvic Exams, 210.3 Colorectal Cancer Screens, 210.10 Screening for STIs, 250.4 Treatment for AKs, 250.3 IVIG for Autoimmune Blistering Disease, 250.5 Dermal Injections for Facial LDS.

Background

The purpose of CR 8691 is to both create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, plus all associated coding infrastructure such as HCPCS/*CPT*® codes, reason/remark codes, frequency edits, place of service (POS)/type of bill (TOB)/provider specialties, etc. The requirements described in CR 8691

reflect the operational changes that are necessary to implement the conversion of the Medicare systems from ICD-9 to ICD-10 specific to the 29 NCD spreadsheets attached to CR 8691.

Additional information

The official instruction, CR 8691 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1388OTN.pdf*. Note that there are 29 spreadsheets attached to CR 8691 and those spreadsheets relate to 9 NCDs and provide pertinent policy/coding information necessary to implement ICD-10.

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: MM8691
Related Change Request (CR) #: CR 8691
Related CR Release Date: May 23, 2014
Effective Date: July 1, 2014 (ICD-9 updates, local system edits), October 1, 2014 (designated ICD-9 shared system edits), October 1, 2015 (or whenever ICD-10 is implemented) (ICD-10 updates) determined for ICD-10
Related CR Transmittal #: R1388OTN
Implementation Date: July 7, 2014 (designated ICD-9 updates, local system edits, October 6, 2014 (or whenever ICD-10 is implemented (ICD-10 updates), to be determined for ICD-10

Percutaneous image-guided lumbar decompression for lumbar spinal stenosis

Provider types affected

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

Provider action needed

Effective for claims with dates of service on and after January 9, 2014, Medicare will only allow coverage with evidence development (CED) for percutaneous image-guided lumbar decompression (PILD) for lumbar spinal stenosis (LSS) for beneficiaries enrolled in an approved clinical trial.

Background

PILD is a procedure that was proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. It is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (e.g., fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epiduragram.

The Centers for Medicare & Medicaid Services (CMS) currently does not cover PILD; and moreover, after careful consideration, determines that PILD for lumbar spinal stenosis LSS is not reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act (the Act).

However, CMS has determined that effective for claims with dates of service on or after January 9, 2014, Medicare will cover PILD only when it is provided in a clinical study under section 1862(a)(1)(E) of the Act, through CED, for beneficiaries with LSS who are enrolled in an approved clinical study that meets the criteria described in the *National Coverage Determinations (NCD)* manual at NCD 150.13.

Specific payment actions

On or after January 9, 2014, effective for hospital outpatient procedures on type of bill (TOB) 13x or 85x, and for professional claims billed with a place of service (POS) 22 (outpatient) or 24 (ambulatory surgical center), Medicare will allow CED for PILD (procedure code 0275T) for LSS, ICD-9 diagnosis range 724.01-724.03, or ICD-10 diagnosis range M48.05-M48.07, only when billed with:

a) Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) and condition code 30 either in the primary or secondary positions; and

b) Modifier Q0; and

c) An eight-digit clinical trial number listed at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html*.

On or after January 9, 2014, effective for hospital outpatient procedures on type of bill (TOB) 13x or 85x, your MAC will reject claims for PILD, procedure code 0275T for LSS, ICD-9 diagnosis range 724.01-724.03, or ICD-10 diagnosis range M48.05-M48.07, when billed without:

a) Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) in either the primary/secondary positions;

b) Modifier Q0, condition code 30 (institutional claims only); and,

c) An eight-digit clinical trial number listed on the CMS website.

When rejecting these claims, they will use:

a) **Claims adjustment reason code (CARC) 50**: These are non-covered services because this is not deemed a "medical necessity" by the payer;

b) **Remittance advice remarks code (RARC) N386**: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD; and

c) **Group code**: Contractual obligation (CO).

- MACs will return the professional PILD claim as unprocessable when billed with a diagnosis code other than 724.01-724.03 (ICD-9) or M48.05-M48.07 (ICD-10), using:

a) **CARC B22**: "This payment is adjusted based on the diagnosis;"

b) **RARC N704**: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."; and

c) **Group code**: Contractual obligation (CO).

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- MACs will return the professional PILD claim as unprocessable when billed in a place of service other than 22 (outpatient) or 24 (ambulatory surgical center), using:

a) **CARC 58**: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service;"

b) **RARC N704**: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."; and

c) **Group code**: Contractual obligation (CO).

- MACs will return the professional PILD claim as unprocessable if it does not contain the required clinical trial diagnosis code V70.7 (ICD-9) or Z00.6 (ICD-10) in either the primary/secondary positions, using:

a) **CARC B22**: "This payment is adjusted based on the diagnosis;"

b) **RARC M76**: "Missing/incomplete/invalid diagnosis or condition;"

c) **RARC N704**: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted." and

d) **Group code**: Contractual obligation (CO).

- MACs will return the professional PILD claim as unprocessable when billed without Modifier Q0, using:

a) **CARC 4**: "The procedure code is inconsistent with the modifier used or a required modifier is missing;"

b) **RARC N657**: "This should be billed with the apporpriate code for these services.";

c) **RARC N704**: "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;" and

d) **Group code**: Contractual obligation (CO).

MACs will accept the numeric, eight-digit clinical trial identifier number preceded by the two alpha characters of "CT" when placed in Field 19 of paper Form CMS-1500, or when entered **without** the "CT" prefix in the electronic 837P in loop 2300 REF02 (REF01=P4). **Note**: The "CT" prefix is required on a paper claim, but it is not required on an electronic claim.

- For PILD claims submitted without a clinical trial identifier number, they will follow the requirements outlined in CR 8401, Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims, released on October 30, 2013. You can find the associated *MLN Matters*® article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf*.

MACs will not search their files to adjust claims already processed, but will adjust claims that you bring to their attention.

Finally, you should note that endoscopically assisted laminotomy/laminectomy, which requires open and direct visualization, as well as other open lumbar decompression procedures for LSS, are not within the scope of this NCD.

Additional information

The official instruction, CR 8757, issued to your MAC, consists of two transmittals. The first updates the *Medicare National Coverage Determinations* manual and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R167NCD.pdf*. The second transmittal updates the *Medicare Claims Processing* manual and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2959CP.pdf*.

MLN Matters® Number: MM8757
Related Change Request (CR) #: CR 8757
Related CR Release Date: May 16, 2014
Effective Date: January 9, 2014
Related CR Transmittal #: R167NCD and R2959CP
Implementation Date: October 6, 2014

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Check the status of claim redeterminations online

Don't wait up learn the status of your appeal. You may check on its status at your convenience -- online, which enables providers to check the status on active redeterminations to confirm if the appeal has been received by First Coast Service Options.

Claim status category and claim status codes update

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8684 which informs the MACs of the changes to claim status category codes and claim status codes. Make sure that your billing personnel are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the x12 276/277 health care claim status request and response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1, more recent HIPAA named versions). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the x12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each x12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*.

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

These code changes will be used in the editing of all x12 276 transactions processed on or after the date of implementation and are to be reflected in

x12 277 transactions issued on and after the date of implementation of CR 8684.

Additional information

The official instruction, CR 8684 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2967CP.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: MM8684
Related Change Request (CR) #: CR 8684
Related CR Release Date: May 23, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2967CP
Implementation Date: October 6, 2014

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Medicare Learning Network®

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

Enhancement to Part B interactive voice response system

First Coast Service Options Inc. (First Coast) is pleased to announce the latest enhancement to our Part B interactive voice response (IVR) reopening option. Beginning Friday, June 20 providers may perform a clerical reopening on claim detail lines that have denied for missing or invalid ordering or referring provider information.

If your claim denied for this reason, you may now call the IVR and select this new option to perform a clerical reopening. The IVR will prompt you for the ordering or referring provider's first initial, first four letters of the last name, and their national provider identifier (NPI) number. The IVR will then verify that the provider information you entered into the IVR matches up with the information in the *Provider Enrollment, Chain, and Ownership System (PECOS)*.

As a reminder, all providers who order or referring Medicare patients should be enrolled as an ordering or referring provider within PECOS. For more information on becoming an ordering or referring provider for Medicare patients, please *click here*.

Modifying the daily CWF to MBD file to include diagnosis codes on the HETS 270/271 transactions

***Note**: This article was rescinded May 20, 2014, as a result of a revision to change request (CR) 8456, issued on May 16. The CR revision eliminated the need for provider education. As a result, this article is rescinded. This information was previously published in the February 2014 Medicare B Connection, Page 46.*

MLN Matters® Number: MM8456 *Rescinded*
Related Change Request (CR) #: CR 8456
Related CR Release Date: May 16, 2014

Effective Date: October 1, 2014
Related CR Transmittal #: R1386OTN
Implementation Date: October 6, 2014

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SUNSHINE

From front page

requirements and the open payments system. The user guide includes definitions, screenshots, tools, and tips to provide users with a better understanding of how to operationalize the collection, reporting, and review of open payments data. The contents are conveniently organized by user group (industry, physician, or teaching hospital), making it easy to identify what is most applicable for you. The *open payments user guide* can be accessed on the *Open Payments Program Fact Sheets and User Guides Web page*, other open payments website pages, and in the open payments system.

Live help desk

For more information about open payments, please visit the *Open Payments website*. If you have any questions, you can submit an email to the help desk at *openpayments@cms.hhs.govopenpayments@cms.hhs.gov*; or call 855-326-8366 for live help desk support Monday through Friday, from 7:30 a.m. to 6:30 p.m. CT, excluding Federal holidays.

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).

Outstanding medical records create superior patient outcomes

Communication tool

Physicians have been taught throughout their training that the medical record is their best insurance policy to communicate the quality of their analytical skills, problem-solving ability, and as a controlling guide for the complexity of patient care.

Evidence emerging from increasing use of electronic health records confirms that, when properly applied, the medical record will:

- Reduce patient care errors,
- Reduce rates of missing clinical information,
- Advance evidence-based clinical decision-making,
- Reduce costs by preventing duplicative and contraindicated services,
- Provide for care coordination across the spectrum of providers, and
- Enhance the quality of patient outcomes (See references 1-13, below)

Quality of records

When the contribution of rigorously structured medical records was studied in a critical-care setting (acute coronary syndrome) in an extensive cross-section of U.S. hospitals (more than 200), the results were dramatic: Substantial incremental differences in survival and discharge health status were observed when high standards of clinical records were maintained (14).

In contrast, inferior patient records produced the opposite outcomes in all of the above categories.

The American College of Medical Quality (ACMQ) has further refined concepts of quality of care and medical documentation (15).

Auditing for medical necessity

Beginning with the original statute mandated by the 1965 (Medicare) provisions of the Social Security Act, and further elaborated by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), the doctrine of **medical necessity** controls coverage and payment policy by federal healthcare payers (16). Medical necessity in turn is evidenced by a variety of criteria, including criteria for effectiveness, appropriateness to the patient's presentation, relevance to a disease process, non-provision for strictly physician convenience, etc. (17-20).

Accordingly, a nexus was established between medical necessity documentation and the vehicle of the medical record as a tool for care coordination, evidence of services, risk minimization, and outcome enhancement.

The above considerations led to the medical record audits mandated by CMS, identified as Comprehensive Error Rate Testing, or CERT (20, 21). The CERT program requires post-pay audits of medical records to establish that services were 1) provided and 2) of medical necessity, with the authority to recoup payments where evidence for these services is inadequate for a medically-trained reviewer.

It is therefore accurate to consider the CERT audit as a tool to ascertain service provision **and** as a mechanism to improve overall patient quality outcomes.

Finally, a 2014 report from the Health and Human Services Office of the Inspector General (OIG) placed Part A providers on notice that exaggerating patient complexity and morbidity to justify higher payments would be the subject of auditing activity. Exaggeration of the medical necessity for services based on poor documentation may incorrectly inflate a DRG weight leading to facility overpayment (22). The discovery of such practices may result in recoupment or more severe sanctions; such have been the results of other OIG actions against health care suppliers and providers (23).

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See **RECORDS**, next page

RECORDS

From previous page

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Quarterly provider update

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

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

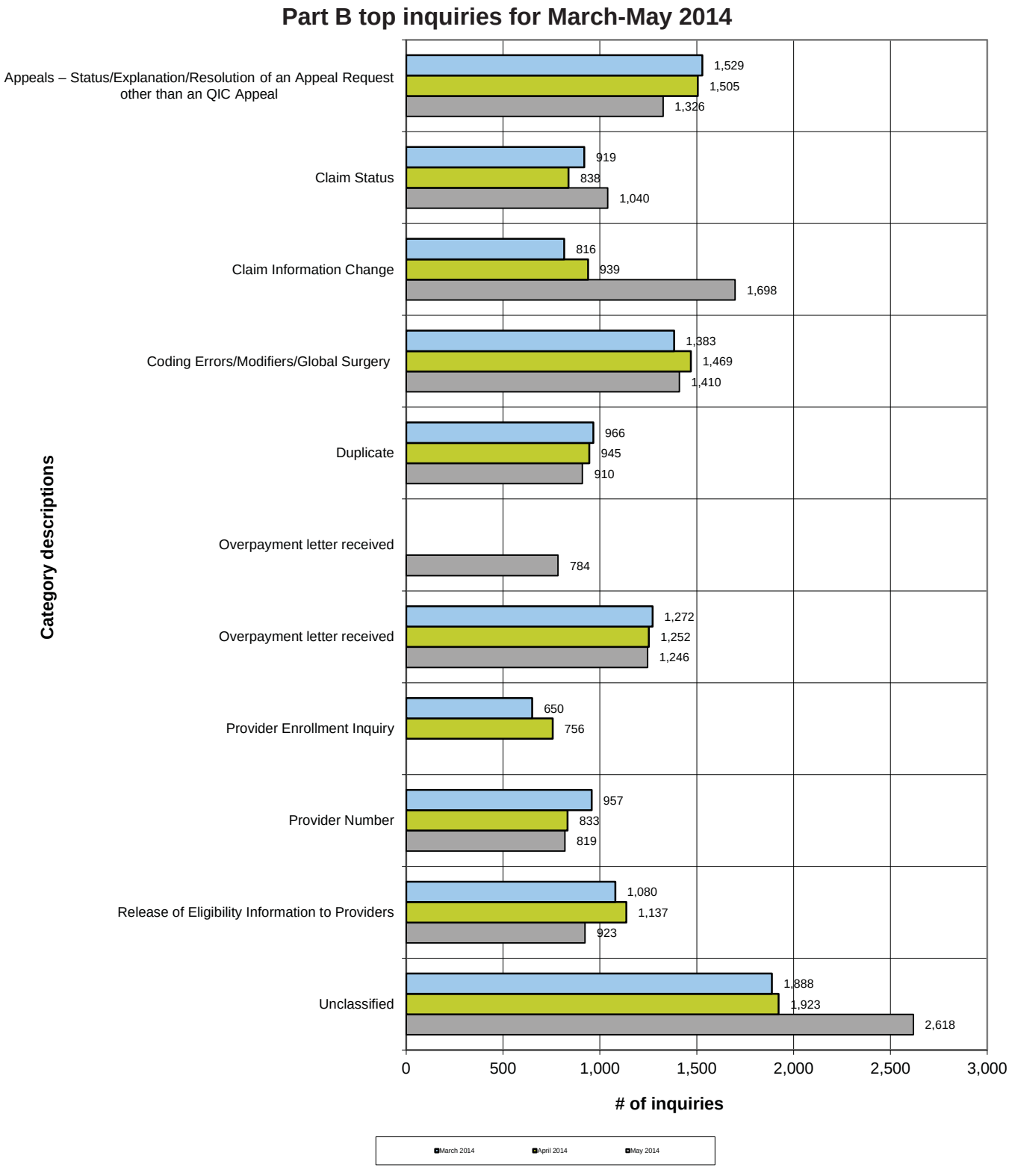
CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at *http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html*.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

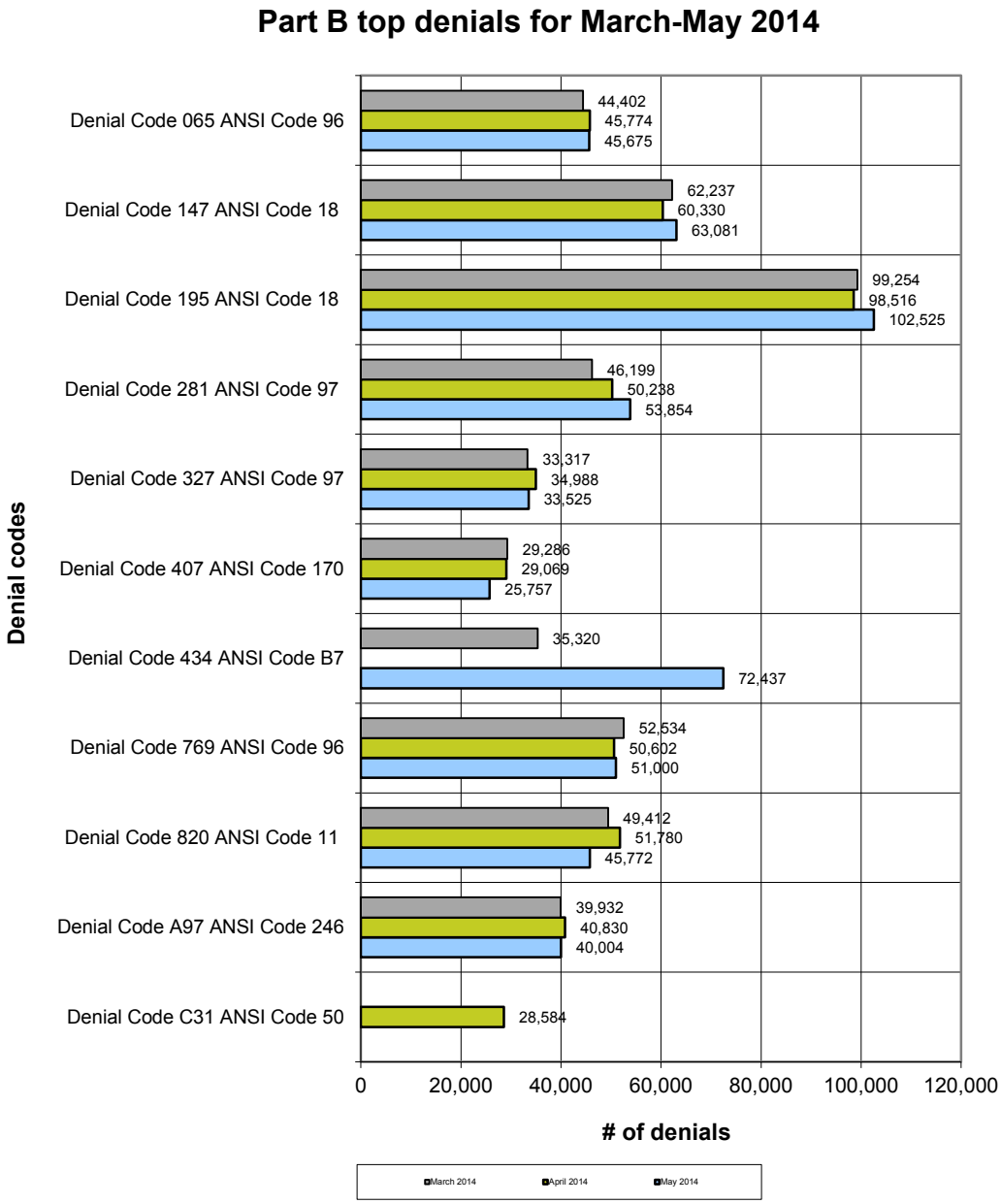
Claims and Inquiry Summary Data

Top inquiries, rejects, and 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 March-May 2014.

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





What to do when your claim is denied

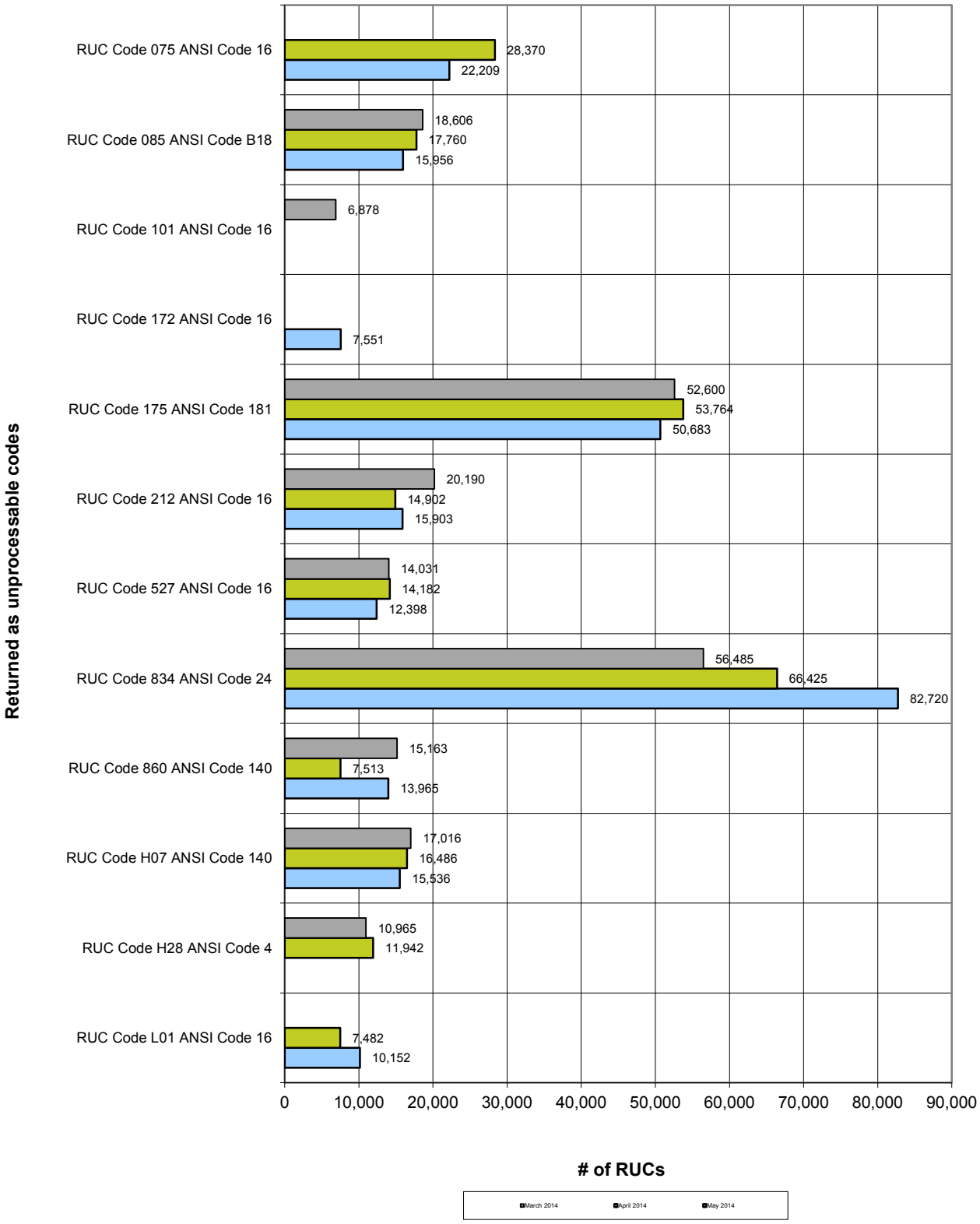
Before contacting customer service, check claim status though the IVR. The IVR will release necessary details around claim denials.

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

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

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

Part B top return as unprocessable claims for March-May 2014



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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Find out first: Subscribe to First Coast eNews

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

Revisions to LCDs

Ferrlecit® and Venofer® – revision to the Part B LCD

LCD ID number: L29174 (Florida)
LCD ID number: L29426 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Ferrlecit® and Venofer® was revised based on an update to the Food and Drug Administration (FDA) label for Venofer®. The "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the LCD for Venofer® were revised to remove language referring to "receiving supplemental erythropoietin therapy."

Effective date

This LCD revision is effective for claims processed **on or after June 3, 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 N (JN), please *click here*.

Topotecan hydrochloride (Hycamtin®) – revision to the Part B LCD

LCD ID number: L29290 (Florida)
LCD ID number: L29479 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for topotecan hydrochloride (Hycamtin®) 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 add 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 19, 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 N (JN), please *click here*.

Looking for LCDs converted to ICD-10?

A list of local coverage determinations (LCDs) converted to ICD-10 is available on the *LCDs by contractor index*.

Use the scroll box on the index to select your Medicare administrative contractor (MAC) and select the "Submit" button to view a list of states that the specified MAC services. You can then select your MAC name from the table to view the future translated LCDs.

See *MLN Matters® Special Edition article SE1421*, "How to Access Updates to ICD-10 Local Coverage Determinations in the CMS Medicare Coverage Database."

Additional Information

Widespread probe review for IVIG codes

First Coast Service Options (First Coast) performed a widespread probe for Intravenous Immune Globulin (IVIG) services that included the following codes:

- J1561 IVIG, (Gamunex-C-Gammaked), non-lyophilized (e.g., liquid), 500 mg
- J1568 IVIG, (Octagam), non-lyophilized (e.g., liquid), 500 mg
- J1569 IVIG, (Gammagard Liquid), non-lyophilized (e.g., liquid), 500 mg

All pertinent guidelines including: local coverage determinations (LCDs), local articles, coverage provisions in interpretive manuals or Internet Only Manuals (IOM), which includes medical review guidance in the PIM, CMS coding policies and AHA Coding Clinics were used in the medical review of the documentation submitted. This article outlines the review findings and provides specific references in LCD L29505 Intravenous immune globulin (IVIG) related to missing or incomplete documentation.

Indications and limitations of coverage and/or medical necessity

Intravenous immune globulin (IVIG) is a solution of human immunoglobulin specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens.

The use of intravenous immune globulin should be reserved for patients with serious defects of antibody function. The goal is to provide immunoglobulin G (IgG) antibodies to those who lack them. Medicare will provide coverage for intravenous immune globulin when it is used in treatment of the following conditions:

1. Immunodeficiency Disorders
    a) Primary Humeral Immunodeficiency Syndromes
    b) Idiopathic Thrombocytopenic Purpura (ITP)
    c) ITP in Patients with Human Immunodeficiency Virus (HIV) Disease
    d) IVIG in Children with Human Immunodeficiency Virus (HIV) Disease who do not have ITP
2. Neurological Disorders
3. Other Disorders
    a) Chronic Lymphocytic Leukemia
    b) Bone Marrow Transplantation (BMT)
    c) Kawasaki Disease (mucocutaneous Lymph Node Syndrome)
    d) Autoimmune Hemolytic Anemia
    e) Autoimmune Neutropenia
    f) Autoimmune Mucocutaneous Blistering Diseases

Medicare will also consider IVIG medically reasonable and necessary for the following off-label indication:

- Stiff-man syndrome.
- Hypogammaglobulinemia with NNI (non neutropenic infection) induced by certain agents (All criteria must be met):
- Recent treatment with rituximab in combination with cytotoxic chemotherapy

6. Laboratory proven hypogammaglobulinemia and an absolute neutrophil count over 1,000.
7. Acute infection requiring hospitalization or an infection lasting over two weeks in spite of antibiotics or an infection relapsing immediately after discontinuation of antibiotics.
8. Dose: 400-600 mg/kg one time that can be repeated at a standard interval based on laboratory assessment of IG levels and persistence of non-neutropenic infection.

Overall widespread probe findings

J1561 had a total of 18 claims from three providers reviewed. Fourteen claims were denied for an overall error rate of 77.79 percent Denials reasons included missing critical information to determine medical necessity and accurate billing of services rendered such as patients weights. According to LCD L29205, an accurate weight in kilograms should be documented prior to each infusion.

J1568 had a total of 68 claims for 13 providers reviewed. Thirty-four claims were denied for an overall error rate of 46.85 percent. Denial reasons were related to missing or poor documentation that did not meet specific requirements of LCD L29205. Patients' weights were not documented in many of the records or records were missing information related to specific diagnosis requirements. IVIG is indicated for the prevention of recurrent bacterial infections and an immunoglobulin G level of less than 600 mg/dl in patients with hypogammaglobulinemia associated with B-cell chronic lymphocytic leukemia; some medical records did not support this guideline had been met.

J1569 had a total of 18 claims for three providers. Ten claims were denied for an overall error rate of 61.41 percent. Denial reasons for the claims reviewed were related to missing or poor documentation specifically related to the patients' weights. According to LCD L29205, an accurate weight in kilograms should be documented prior to each infusion.

References for additional information

LCD L29205 Intravenous Immune Globulin

CMS Internet-only manual (IOM) Pub. 100-04, *Claims Processing Manual*, *Chapter 17, Drugs and Biologicals*.

Finding ICD-10 LCDs in the Medicare coverage database

Provider types affected

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

Provider action needed

This *MLN Matters*® special edition article is intended to convey information on how to access updates to International Classification of Diseases, 10th Edition (ICD-10) local coverage determinations (LCDs) in the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database (MCD).

Background

MACs may develop an LCD to further define a national coverage determination (NCD) or in the absence of a specific NCD. An LCD is a coverage decision made at a MAC's own discretion to provide guidance to the public and the medical community within a specified geographic area. An LCD cannot conflict with an NCD. An LCD is an administrative and educational tool that can assist you in submitting correct claims for payment by:

- Outlining coverage criteria,
- Defining medical necessity, and
- Providing references upon which a policy (LCD) is based and codes that describe covered and/or noncovered services when the codes are integral to the discussion of medical necessity.

Medicare coverage database (MCD)

To access the CMS MCD, visit *http://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx*.

Use the following steps to access the list of LCDs with ICD-10 codes:

1. On the CMS MCD Homepage, click on the "Indexes" tab at the top of the page;
2. Select "Local Coverage";
3. Select one of the three display options for LCDs ("LCDs by Contractor," "LCDs by State," or "LCDs Listed Alphabetically");
4. If you choose LCDs by Contractor, click on that link;
5. Select a MAC;
6. In the Document types, checkmark the square for "Future LCDs/Future Contract Number LCDs";
7. Click the "Submit" button;
8. Click on the Contractor name; and
9. A list of Future Effective LCDs will display. Those LCDs with a 10/01/2014 Effective Date are ICD-10 LCDs.

Notes

1. The ICD-10 updates are labeled "future" as the policies are not yet in effect. These updates are subject to change as necessitated by code updates and policy revisions.
2. It is expected that the 10/01/2014, effective dates will be changed to 10/01/2015, mid-2014.

Printing documents on the CMS MCD

All documents on the CMS MCD may be printed. Use the following steps to print a document:

1. Open the document; and
2. In the upper right-hand corner, click on the "Print" button or use "Control + P". Alternatively, click on the "Need a PDF?" button and click on the "Save a Copy" icon on the bottom of your screen or use "Shift + Control + S".

Additional information

For an in-depth review on how to use the CMS MCD, refer to the *Medicare Learning Network*® publication titled "How to Use the Medicare Coverage Database" located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareCvrgeDatabase_ICN901346.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*.

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Related Change Request (CR) #: N/A
Related CR Release Date: N/A
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Related CR Transmittal #: N/A
Implementation Date: N/A

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.

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.

MLN Connects

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 29, 2014 – *http://go.usa.gov/8PgC*

"MLN Connects™ Provider eNews': June 5, 2014 – *http://go.cms.gov/S8OnGR*

"MLN Connects™ Provider eNews': June 12, 2014 – *http://go.usa.gov/8ugz*

"MLN Connects™ Provider eNews': June 19, 2014 – *http://go.cms.gov/UMqZky*

"MLN Connects™ Provider eNews': June 26, 2014 – *http://go.usa.gov/9m3B*

Find out first: Subscribe to First Coast *eNews*

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

Medicare Learning Network®

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

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

Mail directory

Claims submissions

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

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

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

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

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

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

Communication

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

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

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

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

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

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

Durable medical equipment

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

Electronic media claims (EMC)

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

Additional development

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

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

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

Miscellaneous

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

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

and

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

Provider education

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

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

Limiting charge issues:

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

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

Medicare claims for Railroad retirees:

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

Fraud and abuse

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

Phone numbers

Providers

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

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

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary
Toll-Free: 1-800-MEDICARE

Hearing Impaired: 1-800-754-7820

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

Education event registration (not toll-free):
1-904-791-8103

Electronic data interchange
1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

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

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

Medicare websites

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

http://medicare.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries
Centers for Medicare & Medicaid Services

www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange

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

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

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

Provider enrollment

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

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

and

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

Durable medical equipment (DME)

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

Redeterminations

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

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

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

Congressional inquiries

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

Provider education

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

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Phone numbers

Provider customer service
1-866-454-9007

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

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE

Hearing Impaired: 1-800-754-7820

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

Education event registration
1-904-791-8103

Electronic data interchange
1-888-670-0940

Option 1 -Transaction support
Option 2 - PC-ACE support
Option 4 - Enrollment support
Option 5 - 5010 testing
Option 6 - Automated response line

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

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

Medicare websites

Provider

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

http://medicare.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services

www.medicare.gov

Addresses

Claims

Additional documentation

General mailing

Congressional mailing

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

Redeterminations

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

Redeterminations on overpayment

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

Post-payment medical exams

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

Freedom of Information Act (FOIA) related requests

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

Medicare fraud and abuse

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

Provider enrollment

Mailing address changes

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

Electronic Data Interchange

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

Flu vaccinated list

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

Local coverage determinations

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

Debt collection

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

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

Overnight mail and other special handling postal services

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

Other Medicare contractors and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)

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

Regional Home Health & Hospice Intermediary

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

Railroad Medicare

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

Phone numbers

Providers

Customer service – free of charge

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

For the hearing and speech impaired (TDD)

1-888-216-8261

Interactive voice response (IVR)

1-877-847-4992

Beneficiary

Customer service – free of charge

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

Hearing and speech impaired (TDD)

1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number

1-904-361-0407

Medicare Websites

Providers

First Coast – MAC JN

medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services

www.medicare.gov

Order form for Medicare Part B materials

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

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

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

Mail this form with payment to:
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)