

C Medicare B CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

September 2014



2014-2015 influenza resources

Provider types affected

All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

What you need to know

- Keep this special edition *MLN Matters*® article and refer to it throughout the 2014-2015 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the New Year.
- Remember to immunize yourself and your staff.

Introduction

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

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You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare's coverage of the annual flu shot.

As a reminder, please help prevent the spread of flu by immunizing yourself and your staff!

Know what to do about the flu!

Educational products for health care professionals

The *Medicare Learning Network*® (MLN®) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

MLN influenza-related products for health care professionals

- ***MLN Matters*® article MM8890: Influenza Vaccine Payment Allowances – Annual Update for 2014-2015 Season** – <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8890.pdf>

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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

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About the 'Medicare B Connection'

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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



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

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

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

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

Medicare Part B advance beneficiary notices

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

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

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

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

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing* manual provides instructions regarding the notice that these providers issue to beneficiaries in

advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN

must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44>.

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



ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Specific modifiers for distinct procedural services

Provider types affected

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

Provider action needed

Stop – impact to you

New coding requirements related to Healthcare Common Procedure Coding System (HCPCS) modifier 59 could impact your reimbursement.

Caution – what you need to know

Change request (CR) 8863 notifies MACs and providers that the Centers for Medicare & Medicaid Services (CMS) is establishing four new HCPCS modifiers to define subsets of the 59 modifier, a modifier used to define a “distinct procedural service.”

Go – what you need to do

Make sure your billing staffs are aware of the coding modifier changes.

Background

The Medicare National Correct Coding Initiative (NCCI) has procedure-to-procedure (PTP) edits to prevent unbundling of services, and the consequent overpayment to physicians and outpatient facilities. The underlying principle is that the second code defines a subset of the work of the first code. Reporting the codes separately is inappropriate. Separate reporting would trigger a separate payment and would constitute double billing.

CR 8863 discusses changes to HCPCS modifier 59, a modifier which is used to define a “distinct procedural service.” Modifier 59 indicates that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled.

The 59 modifier is the most widely used HCPCS modifier. Modifier 59 can be broadly applied. Some providers incorrectly consider it to be the “modifier to use to bypass (NCCI).” This modifier is associated with considerable abuse and high levels of manual audit activity; leading to reviews, appeals and even civil fraud and abuse cases.

The primary issue associated with the 59 modifier is that it is defined for use in a wide variety of circumstances, such as to identify:

- Different encounters;
- Different anatomic sites; and
- Distinct services.

The 59 modifier is:

- Infrequently (and usually correctly) used to identify a separate encounter;



- Less commonly (and less correctly) used to define a separate anatomic site; and
- More commonly (and frequently incorrectly) used to define a distinct service.

The 59 modifier often overrides the edit in the exact circumstance for which CMS created it in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.

CR 8863 provides that CMS is establishing the following four new HCPCS modifiers (referred to collectively as X {EPSU} modifiers) to define specific subsets of the 59 modifier:

- XE separate encounter, a service that is distinct because it occurred during a separate encounter,
- XS separate structure, a service that is distinct because it was performed on a separate organ/structure,
- XP separate practitioner, a service that is distinct because it was performed by a different practitioner, and
- XU unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

See **MODIFIERS**, next page

MODIFIERS

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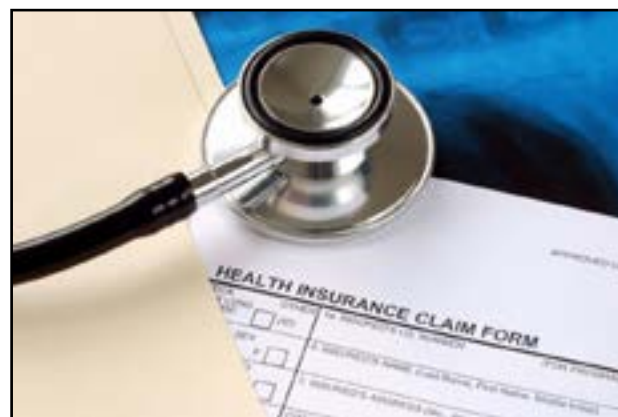
CMS will continue to recognize the 59 modifier, but notes that *Current Procedural Terminology (CPT®)* instructions state that the 59 modifier should not be used when a more descriptive modifier is available. While CMS will continue to recognize the 59 modifier in many instances, it may selectively require a more specific X{EPSU} modifier for billing certain codes at high risk for incorrect billing. For example, a particular NCCI PTP code pair may be identified as payable only with the XE separate encounter modifier but not the 59 or other X{EPSU} modifiers. The X{EPSU} modifiers are more selective versions of the 59 modifier so it would be incorrect to include both modifiers on the same line.

The combination of alternative specific modifiers with a general less specific modifier creates additional discrimination in both reporting and editing. As a default, at this time CMS will initially accept either a 59 modifier or a more selective X{EPSU} modifier as correct coding, although the rapid migration of providers to the more selective modifiers is encouraged.

However, please note that these modifiers are valid even before national edits are in place. MACs are not prohibited from requiring the use of selective modifiers in lieu of the general 59 modifier, when necessitated by local program integrity and compliance needs.

Additional information

The official instruction, CR 8863, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.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: MM8863

Related Change Request (CR) #: CR 8863

Related CR Release Date: August 15, 2014

Effective Date: January 1, 2015

Related CR Transmittal #: R1422OTN

Implementation Date: January 5, 2015

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January 2015 update to the national correct coding initiative edits, version 21.0

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) 8781, which informs MACs about the release of the latest package of correct coding initiative (CCI) edits, version 21.0, which will be effective January 1, 2015. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology*

manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of NCCI edits, version 21.0, effective January 1, 2015, will soon be available to MACs via the CMS data center (CDC). A test file will be available to them on or about November 2, 2014, and a final file will be available to them on or about November 17, 2014.

Version 21.0 will include all previous versions and updates from January 1, 1996, to the present. In the past, NCCI was organized in two tables: column 1/column 2 correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column 1/column 2 correct coding edits 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 1/column 2 correct coding edits file for active or previously deleted edits. CMS no longer publishes a mutually exclusive edit file on

See NCCI, next page

It's time to correct your claims on the 'SPOT'

Online clerical reopening requests now available

The SPOT's new online **Claim Reopening** feature offers busy providers the opportunity to submit Part B clerical reopening requests without visiting the post office or picking up the telephone. Now, they can correct their claims on the SPOT.

The SPOT offers registered users the time-saving advantage of not only viewing claim data online but also the option of correcting clerical errors on their eligible Part B claims quickly, easily, and securely – **online**.

Correct claims faster on the 'SPOT'

It's easy to use the SPOT's new **Claim Reopening** feature:

Step one: Access your claim through **Claim Status** or search by **ICN** in **Claim Reopenings**. Once you have found your claim, you won't have to worry about determining which line items are eligible for reopening; the SPOT will do it for you **automatically**.

Step two: Select the **request type** based upon the fields you wish to correct: *Date(s) of Service, Procedure Code, Modifier, or Diagnosis Code*. The type of reopening request selected will determine which fields are editable.

Note: **Units Billed** will be an editable field in a future enhancement to **Claim Reopenings** on the SPOT.

Step three: Edit applicable field(s). The SPOT's intuitive display will show you which fields may be edited; editable fields will be displayed on a white background.



Step four: Review your changes, and submit your request. Once you have submitted your request, you will receive a confirmation email that will outline the changes you made. Please allow **48-72 hours** before checking **Claim Status**.

Coming soon: Secure Mail

The addition of **Claim Reopenings** to the SPOT's array of features is only a preview of more exciting changes scheduled to be implemented on First Coast's most popular provider resource in 2014.

What's next? **Secure Mail** will offer users the opportunity to not only submit key forms and support documentation seamlessly through the SPOT but also to access their own secure mailbox.

So, if you don't have your SPOT account, don't waste time: [Register today](#). After all, we *all make mistakes* ... now you can **fix them faster** on the SPOT.

Stay connected to 'the SPOT'

Follow us on [Twitter @theSPOTportal](#)

Please [click here](#) to view First Coast's eNews archive for the SPOT.

NCCI

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its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column 1/column 2 correct coding edits 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 1/column 2 correct coding edits file. Refer to the CMS NCCI Web page for additional information at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>.

Additional information

The official instruction, CR 8781 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3044CP.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.

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Related Change Request (CR) #: CR 8781
Related CR Release Date: August 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3044CP
Implementation Date: January 5, 2015

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Ambulance

Ambulance inflation factor for 2015 and productivity adjustment

Provider types affected

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

Provider action needed

Change request (CR) 8895 furnishes the 2015 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. Make sure that your billing staffs are aware of the change.

Background

CR 8895 furnishes the 2015 ambulance inflation factor (AIF) for determining the payment limit for ambulance services required by Section 1834(l)(3)(B) of the Social Security Act (the Act).

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity (MFP) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The MFP for 2015 is 0.70 percent and the CPI-U for 2015 is 2.10 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for 2015 is 1.40 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule. The 2015 ambulance fee schedule file will be available to MACs in November 2014. It may be updated with each quarterly



common working file (CWF) update.

Additional information

The official instruction, CR 8895 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3057CP.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: MM8895
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 Related CR Release Date: August 29, 2014
 Effective Date: January 1, 2015
 Related CR Transmittal #: R3057CP
 Implementation Date: January 5, 2015

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Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. is proud of its exclusive E/M interactive worksheet, available at <http://medicare.fcso.com/EM/165590.asp>. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our website feedback form, available at <http://medicare.fcso.com/Feedback/160958.asp>.



Cardiac Services

New physician specialty code for interventional cardiology

Provider types affected

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

What you need to know

CR 8812, from which this article is taken, provides notice that the Centers for Medicare & Medicaid Services (CMS) is establishing a new physician specialty code for interventional cardiology. The CR is also changing the description of specialty code 62, and updating the names associated to specialty codes 88 and 95. Make sure your billing staffs are aware of these changes.

Background

Physicians who enroll in the Medicare program self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855B) or via the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). Non-physician practitioners who enroll with Medicare are assigned a Medicare specialty code. These Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. They become associated with the claims that physician or non-physician practitioners submit; and are used by CMS for programmatic and claims processing purposes.

CR 8812 establishes a new physician specialty code for interventional cardiology (C3). CR 8812 is also removing the word "clinical" from the description of specialty code 62 (psychologist (billing independently)), and is changing the description of specialty code 88 to "unknown provider," and of specialty code 95 to "unknown supplier". The changes to the descriptions for codes 88 and 95 align their names with their intended usages.



Additional information

The official instruction, CR 8812, issued to your MAC regarding this change is available in two transmittals at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3073CP.pdf> and <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R238FM.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: MM8812
Related Change Request (CR) #: CR 8812
Related CR Release Date: September 23, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3073CP, R238FM
Implementation Date: January 5, 2015

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Cardiac rehabilitation programs for chronic heart failure

Note: This article was revised on September 4, 2014, to reflect changes to change request (CR) 8758. In the article, the transmittal numbers, the CR release date, and the Web addresses for accessing the transmittals are revised. All other information remains the same. This information was previously published in the [August 2014 Medicare B Connection](#), Pages 9-10.

Provider types affected

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

What you need to know

Stop – impact to you

Effective for dates of service on and after February 18, 2014, Medicare covers cardiac rehabilitation services for beneficiaries with stable, chronic heart failure.

Caution – what you need to do

This article, based on CR 8758, informs you that, effective for dates of service on and after February 18, 2014, Medicare covers cardiac rehabilitation services for beneficiaries with stable, chronic heart failure, defined as patients with left ventricular ejection fraction of 35 percent

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CARDIAC

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or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least six weeks. Stable patients are defined as patients who have not had recent (\leq six weeks) or planned (\leq six months) major cardiovascular hospitalizations or procedures.

Go – what you need to do

Make sure your billing staffs are aware of these changes.

Background

On June 4, 2013, the Centers for Medicare & Medicaid Services (CMS) initiated a national coverage analysis (NCA) to expand Medicare coverage of cardiac rehabilitation for beneficiaries diagnosed with chronic heart failure.

Items and services furnished under a cardiac rehabilitation (CR) program may be covered under Medicare Part B per Section 1861(s)(2)(CC) and 1861(eee)(1) of the Social Security Act. Among other things, Medicare regulations define key terms, address the components of a cardiac rehabilitation program, establish the standards for physician supervision, and limit the maximum number of program sessions that may be furnished. These regulations may be viewed at 42 *Code of Federal Regulations* (CFR), Section 410.49, available at <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A2.0.1.2.10>.

CR services mean a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment, outcomes assessment, and other items/services as determined by the Secretary under certain conditions.

The regulations describe the cardiac conditions that would enable a beneficiary to obtain CR services. Specifically, coverage is permitted for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months
- A coronary artery bypass surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- A heart or heart-lung transplant

Effective for dates of service on or after February 18, 2014, this CR adds stable, chronic heart failure to the list of

cardiac conditions above that would enable a beneficiary to obtain cardiac rehabilitation services.

CMS may add “other cardiac conditions as specified through a national coverage determination” (42 CFR Section 410.49(b)(vii).

Any cardiac indication not specifically identified in 42 CFR 410.49(b)(l)(vii) or identified as covered in any national coverage determination (NCD) is considered non-covered.

Also, note that MACs will not search for and adjust claims processed prior to the implementation of CR 8758. However, your MAC will adjust such claims that you bring to their attention.

Additional Information

CR 8758 consists of four transmittals, each of which relates to a Medicare manual. The transmittal related to the *National Coverage Determination Manual* is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R171NCD.pdf>. The transmittal related to the *Medicare Claims Processing Manual* is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3058CP.pdf>, the transmittal related to the *Medicare Program Integrity Manual* is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R539PI.pdf>, and the transmittal related to the *Medicare Benefit Policy Manual* is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R193BP.pdf>.

You may also want to review *MLN Matters*® article MM6850, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm6850.pdf> for more information on cardiac rehabilitation services.

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](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNMattersArticles/index.html) under - How Does It Work.

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 Related Change Request (CR) #: CR 8758
 Related CR Release Date: August 29, 2014
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 Related CR Transmittal #: R171NCD, R3058CP, R539PI, and R193BP
 Implementation Date: August 18, 2014

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Consolidated Billing

Annual update of HCPCS codes used for home health consolidated billing enforcement

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs) and other providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

Provider action needed

Change request (CR) 8893, from which this article is taken, provides annual home health (HH) consolidated billing updates, effective January 1, 2015. It announces that Healthcare Common Procedure Coding System (HCPCS) code A4459 (Manual pump enema system, includes balloon, catheter and all accessories, reusable, any type) is added to the HH consolidated billing non-routine supply code list. You should make sure that your billing personnel are aware of this update.

Background

The HH consolidated billing code list is updated annually, to reflect the annual changes to the HCPCS code set itself, and additional updates may occur as often as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. These updates are required by changes to the coding system itself, not because the services subject to HH consolidated billing are being redefined. Therefore you should note that the new codes identified in each update describe the same services that were used to determine the applicable HH PPS payment rates; and that the updates do not add any additional services.

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

CR 8893 provides annual home health (HH) consolidated billing updates, effective January 1, 2015. It announces



that HCPCS code A4459 (Manual pump enema system, includes balloon, catheter and all accessories, reusable, any type) is added to the HH consolidated billing non-routine supply code list. Code A4459 is added because of its similarity to code A4458, which has been subject to HH consolidated billing since 2003.

There are no changes to the HH consolidated billing therapy code list in this update.

Additional information

The official instruction, CR 8893 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3035CP.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.

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Related CR Transmittal #: R3035CP
Implementation Date: January 5, 2015

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Drugs and Biologicals

Influenza vaccine payment allowances - annual update for 2014-2015 season

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8890, which informs MACs about the availability of payment allowances for seasonal influenza virus vaccines. These payment allowances are updated on an annual basis effective August 1st of each year. Make sure that your billing staffs are aware of these changes.

Background

This recurring update notification provides the payment allowances for the following seasonal influenza virus vaccines, when payment is based on 95 percent of the average wholesale price (AWP).

CPT® 90655: payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90656: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90657: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90661: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90685: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90686: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90687: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90688: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

HCPCS Q2035: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

HCPCS Q2036: Payment allowance is pending. Effective dates: August 1, 2014 – July 31, 2015

HCPCS Q2037: Payment allowance is pending. Effective dates: August 1, 2014 – July 31, 2015

HCPCS Q2038: Payment allowance is pending. Effective dates: August 1, 2014 – July 31, 2015

Payment for the following CPT® or HCPCS codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary, during the effective dates indicated below:



CPT® 90654: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90662: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90672: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90673: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

HCPCS Q2039: flu vaccine adult – not otherwise classified payment allowance is to be determined by the local claims processing contractor with effective dates of August 1, 2014 – July 31, 2015.

Payment allowances for codes for products that have not yet been approved will be provided when the products have been approved and pricing information becomes available to CMS.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files.

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

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Intravenous immune globulin demonstration

Note: This article was revised August 28, 2014, to amend some of the billing instructions, particularly with regard to date of service on the Q2052 claim line. Also, some questions and answers related to supplier eligibility are added to the article. This information was previously published in the [August 2014 Medicare B Connection, Pages 13-15](#).

Provider types affected

This *MLN Matters*® article is intended for suppliers submitting claims to durable medical equipment Medicare administrative contractors (DME MACs) for intravenous immune globulin (IVIG) drugs and services to Medicare beneficiaries.

Suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

Provider action needed

In this article, the Centers for Medicare & Medicaid Services (CMS) alerts providers to a three year demonstration to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of primary immune deficiency disease (PIDD). CMS has designed the IVIG demonstration to pay a bundled payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of PIDD. The demonstration will begin paying for services as of October 1, 2014, and will continue for three years, as long as funding remains available.

Background

Depending on the circumstances, traditional fee-for-service (FFS) Medicare covers some, or all, components of home infusion services. By special statutory provision, Medicare

Part B covers IVIG for persons with PIDD who wish to receive the drug at home. Medicare does not separately pay for any services or supplies to administer the drug if the person is not homebound, and is otherwise receiving services under a Medicare Home Health episode of care. As a result, many beneficiaries have chosen to receive the drug at their doctor's office, in an outpatient hospital setting, or to self-administer the drug subcutaneously. Beneficiaries may also alternate between settings or drug formulations, if necessary, to accommodate travel or other personal situations.

IVIG demonstration

The "Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012" authorized the demonstration under Part B of Title XVIII of the Social Security Act. The demonstration is limited to no more than 4,000 beneficiaries, and the \$45 million budget covers benefit costs, as well as administrative expenses for implementation and evaluation. Participation is voluntary and may be terminated by the beneficiary at any time.

Under this demonstration, Medicare will issue under Part B a bundled payment for all items and services that are necessary to administer IVIG in the home to enrolled beneficiaries who are not otherwise homebound and receiving home health care benefits. In processing all services and supplies needed for the administration of IVIG, CMS is not making any changes to existing coverage determinations to receive the IVIG drug in the home or for services and supplies that are otherwise not covered under the traditional FFS Medicare Part B benefit.

The demonstration only applies to situations where the beneficiary requires IVIG for the treatment of PIDD, or is currently receiving subcutaneous immune globulin to treat PIDD and wishes to switch to IVIG. This demonstration does not apply if the immune globulin is intended to be administered subcutaneously. Only those beneficiaries with PIDD who are eligible to receive IVIG under

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Note: MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims prior to the implementation date of CR 8890. However, they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 8890, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3059CP.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.

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Related CR Release Date: September 3, 2014
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Related CR Transmittal #: R3059CP
Implementation Date: No later than November 24, 2014

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the current Medicare benefit (have Part B, and have traditional FFS Medicare) will be eligible to enroll in the demonstration and have the services paid under the new demonstration.

This demonstration will not change how subcutaneous administration of immune globulin (SCIG) is covered and paid for under the traditional Medicare FFS program. Also, nothing in this demonstration will impact how IVIG is paid by Medicare for beneficiaries who are covered under a home health episode of care.

Beneficiaries participating in the demonstration shall not be restricted in any way from receiving Medicare covered IVIG, and non-demonstration Medicare covered related services from different providers at different times should they so choose. For example, a beneficiary receiving services under the demonstration at home may choose to switch and receive them at a doctor's office or outpatient department at any time. The beneficiary may switch back to receiving services under the demonstration as long as they are otherwise still eligible, and funding remains available.

Beneficiaries under hospice shall not be excluded from this demonstration, and their demonstration claims shall be processed in the same manner as other Medicare (non-demonstration) claims for hospice patients.

Beneficiaries covered under a home health episode of care may apply to participate in the demonstration but will not be eligible to have services paid for under the demonstration until after the home health episode of care has ended. Similarly, beneficiaries who are participating in the demonstration and subsequently become eligible to receive services under a home health episode of care will not be eligible to have services paid for under the demonstration for the period of time they are covered under such episodes.

Providers/suppliers billing for the services and supplies covered under the demonstration must meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of services related to home infusion of IVIG.

Beneficiary eligibility

In order to pay for the new demonstration covered services, the following requirements must be met:

1. The beneficiary must be enrolled in the demonstration (on the eligibility file provided by NHIC, Corp., the implementation support contractor);
2. The beneficiary must be eligible to have the IVIG drug paid for at home (has a diagnosis of PIDD) under the traditional Medicare benefit;
3. The beneficiary must be enrolled in Medicare Part B and not be enrolled in a Medicare advantage plan (i.e. have traditional FFS Medicare coverage);
4. The beneficiary must not be covered on the



date of service in a home health episode (In such circumstances, the services are covered under the home health episode payment.)

5. The place of service must be the beneficiary's home or a setting that is "home like."

Billing details

A new "Q" code has been established for services, supplies, and accessories used in the home under the Medicare IVIG demonstration:

Q2052 (long description): Services, supplies, and accessories used in the home under Medicare Intravenous immune globulin (IVIG) demonstration.

Q2052 (short description): IVIG demo, services/supplies.

The code is for use with the IVIG demo only and the jurisdiction for this code is DME MAC.

The new demonstration service code (Q2052) must be billed as a separate claim line on the same claim for the IVIG drug itself.

Specialty pharmacies will bill for the IVIG drug itself when intended for home administration by beneficiaries who are not homebound and not covered under a home health benefit episode. For those beneficiaries participating in the demonstration, specialty pharmacies shall bill for the demonstration covered services on the same claim as the drug itself. Claims for the demonstration bundled service (Q2052) billed in the absence of the "J" code for the IVIG drug will not be payable. The new demonstration covered services will be paid as a bundle and will be subject to coinsurance and deductible in the same manner as other Part B services.

For 2014, the nationwide Medicare allowable for Q2052 will be \$300 each time the IVIG is administered. While this is expected to be approximately monthly, it can be more or less frequent depending upon a patient's medical need.

As with all DMEPOS claims, specialty pharmacies will bill these claims to the appropriate DME MAC jurisdiction based on the beneficiary's state.

The following "J" codes (as updated by CR 8724) represent immune globulin drugs that are administered

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intravenously and payable in 2014 under Medicare Part B for services rendered in the home (or home-like setting) for beneficiaries with PIDD:

Privigen, (J1459), Bivigam (J1556), Gammaplex (J1557), Gamunex (J1561), Immune globulin not otherwise specified (J1566 and J1599), Octagam (J1568), Gammagard liquid (J1569), and Flebogamma (J1572). Immune globulin drugs covered under Medicare Part B for administration in the home for patients with PIDD are subject to change; coverage of any drugs under the demonstration shall not differ from drugs that are eligible for payment under Part B for beneficiaries not enrolled in the demonstration.

Note: If the claim for IVIG is not otherwise payable under Medicare Part B, the Q2052 claim line is not payable under the demonstration. The claim for Q2052 must have the same place of service code on the claim line as the IVIG (J code) for which it is applicable. In cases where the drug is mailed or delivered to the patient prior to administration, the date of service for the administration of the drug (the "Q2052" claim line) may be no more than 30 calendar days after the date of service on the drug claim line.

If multiple administrations of IVIG are submitted on a single claim, each date of service for the administration of the drug (Q2052) must be on a separate claim line. If these requirements are not met, the claim will not be processed and Medicare will return a group code of CO (contractual obligation), a remittance advice remarks code (RARC) of M51 (Missing/incomplete/invalid procedure code(s)) and a claim adjustment remarks code (CARC) of B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated).

If a claim is submitted with the HCPCS Q2052 code and the beneficiary is not enrolled in the demonstration on the date of service, the claim will be denied with a RARC of M138 (Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.), a CARC of 96 (non-covered charge(s)), and a group code of CO.

Coverage of demonstration services shall be subject to the usual coordination of benefit process and the usual Medicare secondary payer process as well.

Questions and answers relating to supplier eligibility

Question: Is the DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) supplier required to be certified to bill the A/B MACs in order to provide the nursing component of the Q2052 - services, supplies and accessories used in the home under the Medicare IVIG demonstration?

Answer: No. The DMEPOS supplier must currently be able to bill the DME MACs (enrolled and current with the national supplier clearinghouse) and meet all regulatory



and statutory requirements. If a state requires licensure to furnish certain items or services, a DMEPOS supplier: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by state law. A supplier may not contract with any entity that is currently excluded from the Medicare program, any state health care programs or from any other federal procurement or non-procurement programs.

Question: Can the supplier/pharmacy contract or subcontract nursing services for the administration of the IVIG to bill the Q2052 - services, supplies and accessories used in the home under the Medicare IVIG demonstration?

Answer: Yes. If a state requires licensure to furnish certain items or services, a supplier/pharmacy: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by state law.

A supplier may not contract with any entity that is currently excluded from the Medicare program, any state health care programs, or from any other federal procurement or non-procurement programs.

How beneficiaries can apply for the IVIG demonstration

To participate in this demonstration the beneficiary must complete and submit an application form. All applications must be signed by the beneficiary as well as his or her physician. Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration.

CMS has contracted with NHIC, Corp., DME MAC jurisdiction A, to help administer the demonstration. NHIC will review all applications for eligibility and will create and upload an enrollment file to be used by CMS' claim processing systems.

CMS will conduct an initial enrollment period from August 8 through September 12, 2014. Completed applications must be received by NHIC, Corp. no later than 5:00 pm ET on September 12, 2014, to be considered. Incomplete applications will be returned to the beneficiary and will not

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be reviewed. Beneficiaries will be notified by September 30, 2014, whether or not they have been accepted. Since the number of beneficiaries and funds available to implement this demonstration are limited, not all beneficiaries who are eligible may be accepted if more eligible beneficiaries apply than can be served with the funds available. If the number of eligible beneficiaries that apply during the initial enrollment period is below the statutory limits, then additional applications will continue to be accepted after the September 12, 2014, deadline on a rolling basis until enrollment and/or funding limits are reached.

The enrollment application and the application completion guide are available at: <http://www.medicarenhic.com> or through the IVIG demo hotline at: (844)-625-6284.

Completed applications may be submitted by fax or mail to NHIC, Corp. at the following address:

Applications may be mailed to:

NHIC, Corp.
IVIG Demo
P.O. Box 9140
Hingham, MA. 02043-9140

For overnight mailings:

NHIC, Corp

IVIG Demo
75 William Terry Dr.
Hingham, MA. 02043

Applications may be faxed to:

Fax 781-741-3533

Additional information

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

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Laboratory/Pathology

Annual clotting factor furnishing fee update 2015

Provider types affected

This MLN Matters® article is intended for physicians and other providers billing Medicare administrative contractors (MACs) for services related to the administration of clotting factors to Medicare beneficiaries.

Provider action needed

Change request (CR) 8891 announces that for 2015 the clotting factor furnishing fee of \$0.197 per unit is included in the published payment limit for clotting factors. For dates of service of January 1, 2015, through December 31, 2015, the clotting factor furnishing fee of \$0.197 per unit is added to the payment when no payment limit for the clotting factor is included in the average sales price (ASP) or not otherwise classified (NOC) drug pricing files. Please be sure your billing staffs are aware of this fee update.

Background

The Medicare Modernization Act section 303(e)(1) added Section 1842(o)(5)(C) of the Social Security Act which requires that a furnishing fee will be paid for items and services associated with clotting factor.

The Centers for Medicare & Medicaid Services includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on

the ASP Medicare Part B drug pricing file or the NOC pricing file, your MAC must make payment for the clotting factor as well as make payment for the furnishing fee.

Additional information

The official instruction, CR 8891, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3055CP.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.

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

Provider types affected

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

Provider action needed

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

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all covered health care entities follow the same standard for submitting and processing electronic claims transactions. According to the instructions for use of the American National Standards Institute (ANSI) X12 837 professional electronic claim transaction, suppliers must submit the NPI that matches the name and address of the servicing provider/supplier identified on the claim.

On anti-markup and reference laboratory claims, physicians and other suppliers are required to identify the supplier's name, address, and ZIP code in Item 32 of the CMS-1500 claim, or the corresponding loop and segment of the ANSI X12 837 professional electronic claim format. The NPI of the physician or supplier who actually performed the service is required in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the ANSI X12 837 professional electronic claim transaction.

However, prior to the implementation of the Provider Enrollment, Chain, and Ownership System (PECOS), MACs used systems that were specific to each MAC and did not allow MACs from one state to view provider enrollment information from another state. This systems limitation prevented MACs from being able to share information about existing providers/suppliers, and increased the potential for fraud. As a result, physicians and suppliers that were enrolled in another MAC's jurisdiction could not validate the NPI in Item 32a of the CMS-1500 claim form or on the ANSI X12 837 professional electronic claim format, because the function was not available in PECOS.

Since the NPI of the physician/supplier that actually performed the test may not be available to the billing physician or supplier, the *Medicare Claims Processing Manual* currently instructs physicians and suppliers to



submit their own NPI with the name and address of the actual performing physician or supplier in Item 32a (and its electronic equivalent) when billing for reference laboratory services, or services subject anti-markup, when the performing physician or supplier is enrolled in another contractor's jurisdiction.

Effective January 1, 2015, changes to PECOS will allow MACs the ability to verify all physician and supplier NPIs, regardless of the jurisdiction in which they are enrolled. Therefore, beginning January 1, 2015, physicians and suppliers billing anti-markup and reference laboratory claims must report the NPI of the physician or supplier who actually performed the service in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the American National Standards Institute (ANSI) X12 837 professional electronic claim format. This new requirement applies to all claims, including claims for services where the performing physician/supplier is out of the processing MAC's jurisdiction.

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

MACs will return as unprocessable a claim:

- Where the NPI in Item 32a (or its electronic equivalent) does not belong to the entity whose name and address are identified in Item 32 (or its electronic equivalent)
- For a reference laboratory or anti-markup service that is performed outside the MAC's billing jurisdiction when submitted without the name, address, and ZIP code of the performing physician/supplier in Item 32, and the NPI of the performing physician/supplier in Item 32a of the CMS-1500 claim form, or on the ANSI X12 837 professional electronic claim format, in the appropriate loops/segments
- For a reference laboratory or anti-markup service performed outside the contractor's billing jurisdiction when the NPI in Item 32A (or its electronic equivalent) does not match the name and address of a valid

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Sample collection fee adjustment for clinical laboratory fee schedule and laboratory services

Provider types affected

This *MLN Matters*® article is intended for independent clinical laboratories, skilled nursing facilities (SNFs) and home health agencies (HHAs) submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

Change request (CR) 8837 provides instructions to MACs for adjusting payment for a sample collected by a laboratory from an individual in a SNF or on behalf of a HHA. Make sure your billing staffs are aware of these changes.

Background

CR 8837 applies to Section 1833(h)(3)(A) of the Social Security Act, as amended by Section 216 of the Protecting Access to Medicare Act (PAMA) (P.L. 113-93), and the *Medicare Claims Processing Manual*, Chapter 16, Section 60.1, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf>.

When a sample is collected by a laboratory from an individual in a SNF or from an individual on behalf of a HHA, the Healthcare Common Procedure Coding System (HCPCS) code, G0471 (Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a SNF or by a laboratory on behalf of a HHA) is used. Effective April 1, 2014, the nominal fee is increased by \$2, from \$3 to \$5, in accordance with the Protecting Access to Medicare Act (PAMA).

The “sample collection fee” is raised from \$3.00 to \$5.00 **only** when the following statements apply:

- The sample is being collected by a laboratory technician that is employed by the laboratory that is performing the test, and
- The sample is from an individual in either a SNF or a HHA.

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

Additional information

The official instruction, CR 8837 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3056CP.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: MM8837
Related Change Request (CR) #: CR 8837
Related CR Release Date: August 29, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R3056CP
Implementation Date: December 1, 2014

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

MACs use the following codes for claims returned as unprocessable:

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

Additional information

The official instruction, CR 8806, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3047CP.pdf>.

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3047CP.pdf>.

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

MLN Matters® Number: MM8806
Related Change Request (CR) #: CR 8806
Related CR Release Date: August 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3047CP
Implementation Date: Claims received on or after January 1, 2015

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

Screening for hepatitis C virus in adults

Provider types affected

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

What you need to know

Change request (CR) 8871 states, effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) will cover screening for hepatitis C virus (HCV) consistent with the grade B recommendations by the United States Preventive Services Task Force (USPSTF) for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. Make sure your billing staffs are aware of these changes.

Background

HCV is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the western world.

Prior to June 2, 2014, CMS did not cover screening for HCV in adults. Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of “additional preventive services” through the national coverage determination (NCD) process.

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) when ordered by the beneficiary’s primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. **Adults at high risk** for HCV infection. “High risk” is defined as persons with a current or past history of illicit injection drug use, and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.

2. **Adults who do not meet the high risk** definition as defined above, but who were born from 1945 through 1965. A single, once-in-a-lifetime screening test is covered for these individuals.

The determination of “high risk for HCV” is identified by the primary care physician or practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

General claim processing requirements for claims with dates of service on and after June 2, 2014

1. New G code G0472, short descriptor - Hep screen high risk/ other and long descriptor- Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used.
2. Beneficiary coinsurance and deductibles do not apply to code G0472.
3. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:
 - HCPCS G0472
4. For those determined to be high-risk initially, claims must be submitted with:
 - HCPCS G0472
 - ICD-9 diagnosis code V69.8, other problems related to life style/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented)
5. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
 - HCPCS G0472,
 - ICD diagnosis code V69.8/Z72.89, and
 - ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented).

Note: Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

Institutional billing requirements

Effective for claims with dates of service on and after June
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2, 2014, institutional providers may use types of bill (TOB) 13x and 85x when submitting claims for HCV screening, HCPCS G0472. Medicare will deny G0472 service line-items on other TOBs using the following messages:

- **Claim adjustment reason code (CARC) 170** – Payment denied when performed/billed by this type of provider. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks code (RARC) N95** – This provider type/provider specialty may not bill this service.

The service is paid on the following basis:

- **Outpatient hospitals** – TOB 13x – based on clinical diagnostic lab fee schedule;
- **Critical access hospitals (CAHs)** – TOB 85x – based on reasonable cost; and
- **CAH method II** – TOB 85x – based on 115 percent of the lesser of the Medicare physician fee schedule (MPFS) amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

Professional billing requirements

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCPCS G0472, only when services are submitted by the following provider specialties found on the provider's enrollment record:

- 01 – General practice
- 08 – Family practice
- 11 – Internal medicine
- 16 – Obstetrics/gynecology
- 37 – Pediatric medicine
- 38 – Geriatric medicine
- 42 – Certified nurse midwife
- 50 – Nurse practitioner
- 89 – Certified clinical nurse specialist
- 97 – Physician assistant

Medicare will deny claims submitted for these services by providers other than the specialty types noted above. When denying such claims, Medicare will use the following messages:

- **CARC 184** – The prescribing/ordering provider is not eligible to prescribe/order the service. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- **RARC N574** – Our records indicate the ordering/referring provider is of a type/specialty that cannot order/refer. Please verify that the claim ordering/referring information is accurate or contact the ordering/referring provider.
- **Group code CO** (contractual obligation) if claim received without GZ modifier.

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCV screening, G0472, only when submitted with one of the following place of service (POS) codes:

- 11 – Physician's office
- 22 – Outpatient hospital
- 49 – Independent clinic
- 71 – State or local public health clinic

Medicare will deny claims submitted without one of the POS codes noted above with the following messages:

- **CARC 171** – Payment denied when performed by this type of provider in this type of facility. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N428** – Not covered when performed in this place of service.

Other billing information for both professional and institutional claims

On both institutional and professional claims, Medicare will deny claims line-items for HCPCS G0472 with dates of service on or after June 2, 2014, where it is reported more than once in a lifetime for beneficiaries born from 1945 through 1965 and who are not high risk. Medicare will also line-item deny when more than one HCV screening is billed for the same high-risk beneficiary prior to their annual eligibility criteria being met. In denying these claims, Medicare will use:

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached.
- **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 www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code** – CO if claim received without GZ modifier.

When applying the annual frequency limitation, MACs will allow both a claim for a professional service and a claim for a facility fee.

In addition, remember that the initial HCV screening for beneficiaries at high risk must also contain ICD-9 diagnosis code V69.8 (ICD-10 code Z72.89 once ICD-10 is implemented). Then, for the subsequent annual screenings

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for high risk beneficiaries, you must include ICD-9 code V69.8 and 304.91 (ICD-10 of Z72.89 and F19.20). Failure to include the diagnosis code(s) for high risk beneficiaries will result in denial of the line item. In denying these payments, Medicare will use the following:

- **CARC** – This (these) diagnosis(es) is (are) not covered. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **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 www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code CO** if claim received without GZ modifier.

Additional information

The official instruction, CR 8871, was issued to your MAC regarding this change via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3063CP.pdf>. The second transmittal updates the *NCD Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.pdf>.

MLN Matters® Number: MM8871

Related Change Request (CR) #: CR 8871

Related CR Release Date: September 5, 2014

Effective Date: June 2, 2014

Related CR Transmittal #: R3063CP and R174NCD

Implementation Date: January 5, 2015

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Medicare Physician Fee Schedule Database

October update to the 2014 Medicare physician fee schedule database

Provider types affected

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

Provider action needed

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

Background

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

In order to reflect appropriate payment policy as included

in the 2014 MPFS final rule, the Medicare physician fee schedule database (MPFSDB) has been updated with October changes. These rates are effective through December 31, 2014.

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

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

In addition, note the following changes:

- For HCPCS codes 55970 and 55980, CMS will change their procedure status codes from "N" (Noncovered service by Medicare) to C (Carrier priced), and its global surgery codes from "XXX" to "YYY", effective May 30, 2014 (All other indicators should remain the same.).
- For HCPCS code A9586, CMS will change its procedure status code changed from "N" (Noncovered service by Medicare) to "C" (Carrier priced), and its global surgery code from "XXX" to "YYY", effective

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September 27, 2013 (All other indicators should remain the same. See CR 8526.).

- HCPCS code G0471 “Ven blood coll SNF/HHA” is added to the MPFS with a procedure status code of X, effective April 1, 2014.
- HCPCS code 0275T “Perq lamot/lam lumbar” is revised to the 2014 physician fee schedule with a procedure status code of “R” (Restricted), effective January 9, 2014 (See CR 8757).
- CMS is changing the short descriptor for G9361 to read “Med Ind for induction”, effective January 1, 2014.

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

Additional information

Surgery

Ventricular assist services for bridge-to-transplant and destination therapy

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8803 which instructs that, effective for claims with dates of service on and after October 30, 2013, the Centers for Medicare & Medicaid Services (CMS) is modifying the criteria for coverage of ventricular assist devices (VADs) as bridge-to-transplant (BTT) and is modifying the facility criteria for coverage as destination therapy (DT). Make sure your billing staffs are aware of these changes.

Background

CR 8803 states that Medicare covers VADs for the following three general indications:

1. **Postcardiotomy:** Postcardiotomy refers to the placement of VADs following open-heart surgery.
2. **Bridge-to-transplantation (BTT):** Coverage for BTT is restricted to patients listed for heart transplantation; and,
3. **Destination therapy (DT):** Coverage for DT is restricted to patients who are not candidates for heart transplantation, require mechanical cardiac support, and who meet specific clinical criteria.

The official instruction, CR 8888, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3064CP.pdf>.

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

MLN Matters® Number: MM8888

Related Change Request (CR) #: CR 8888

Related CR Release Date: September 10, 2014

Effective Date: October 1, 2014

Related CR Transmittal #: R3064CP

Implementation Date: October 6, 2014

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Note: VADs implanted as DT are only covered when implanted in a facility that is approved by CMS to provide this procedure.

Effective for claims with dates of service on and after October 30, 2013, CMS has determined that the evidence is adequate to conclude that VAD implantation is reasonable and necessary with the following modifications to current CMS policy at 20.9.1:

- **VADs for BTT:** CMS clearly identifies that the patient must be active on the wait list maintained by the Organ Procurement and Transplantation Network and removes the general time requirement that patients receive a transplant as soon as medically reasonable.
- **VADs for DT:** CMS expands the credentialing requirement to allow credentialing by other organizations approved by Medicare and include requirements for a multidisciplinary team. CMS removes mandatory participation in the INTERMACS registry, but encourages facilities to track patient outcomes.

Note that coverage for items and services under the Social Security Act (the Act) (Section 1862(a)(1)(A); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm) in these situations will be made by your MAC within its jurisdiction.

CR 8803 revises the *Medicare National Coverage Determinations (NCD) Manual* (Chapter 1) by revising Section 20.9 (Artificial Hearts and Related Devices) and adding a new sub-section (20.9.1) titled “Ventricular Assist Devices.”

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CR 8803 also revises the *Medicare Claims Processing Manual* (Chapter 32, Section 320 (Artificial Hearts and Related Devices). ICD-10 codes related to these services are included in this manual update. The revised portions of these two manuals are available as attachments to CR 8803.

All other indications for the use of VADs not otherwise listed remain non-covered, except in the context of category B investigational device exemption clinical trials (42 CFR 405) or as a routine cost in clinical trials defined under Section 310.1 of the *NCD Manual*.

This policy does not address coverage of VADs for right ventricular support, biventricular support, use in beneficiaries under the age of 18, use in beneficiaries with complex congenital heart disease, or use in beneficiaries with acute heart failure without a history of chronic heart failure. Coverage under Section 1862(a)(1)(A) of the Act for VADs in these situations will be made by your MAC.

Additional Information

The official instruction, CR 8803, consists of two transmittals issued to your MAC. The first transmittal

updates the *NCD Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R172NCD.pdf>. The second transmittal updates the *Medicare Claims Processing Manual* and is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3054CP.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: MM8803

Related Change Request (CR) #: CR 8803

Related CR Release Date: August 29, 2014

Effective Date: October 30, 2013

Related CR Transmittal #: R172NCD and R3054CP

Implementation Date: September 30, 2014

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Therapeutic Services

New manual correction for extracorporeal photopheresis

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8808 which clarifies certain requirements for providers that are effective for claims with dates of service on or after April 30, 2012, the Centers for Medicare & Medicaid Services (CMS) covers extracorporeal photopheresis for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation only when provided under a clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. Make sure your billing staffs are aware of the changes.

Background

CR 8808 reformats language in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 32, Section 190, to make instructions clearer and to avoid misinterpretation. Additionally, ICD-9 diagnosis code 996.88 (complications of transplanted organ, stem cell) and ICD-10 diagnosis code T86.5 (complications of stem cell transplant) are added for correctness and to align with

coding implemented in CR 8197, TR1199, dated March 14, 2013, and effective and implemented July 1, 2013. An article related to CR 8197 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8197.pdf>.

Accordingly, Chapter 32, Section 190.3, of the *Medicare Claims Processing Manual* is reformatted to clearly state that:

- Medicare coverage for extracorporeal photopheresis is restricted to the inpatient or outpatient hospital settings specifically for BOS, and not for the other covered diagnosis (including chronic graft versus hosts disease) which remain covered in the hospital inpatient, hospital outpatient, and non-facility (physician-directed clinic or office settings) settings.
- MACs will deny claims for extracorporeal photopheresis for BOS when the service is not rendered to an inpatient or outpatient setting of a hospital, including critical access hospitals using the following codes:
 - **Claim adjustment reason code (CARC) 96** – non-covered charge(s). At least one remark code must be provided (may be comprised of either the NCPDP reject reason [sic] code, or RARC that is not an ALERT.)

Note: Refer to the 835 Healthcare Policy Identification

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Segment (loop 2110 service payment information REF), if present;

- **CARC 171** – Payment is denied when performed/ billed by this type of provider in this type of facility. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 service payment information REF), if present;
- **RARC N428** – Not covered when performed in this place of service. (A/MACs only) ; and
- **Group code CO** (contractual obligations) or **PR** (patient responsibility) dependent on liability.
- MACs will return to provider/return as unprocessable claims for BOS containing HCPCS procedure code 36522 along with one of the following ICD-9-CM diagnosis codes: 996.84, 491.9, 491.20, 491.21, and 496 but is missing diagnosis code V70.7 (as primary/ secondary diagnosis, institutional only), condition code 30 (institutional claims only), clinical trial modifier Q0/ Q1, and value code D4 with an eight-digit clinical trial identifier number (A/MACs only). In doing so, MACs will use the following messages:
 - **CARC 4** – The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
 - **RARC N517** – Resubmit a new claim with the requested information.

Additional information

The official instruction, CR 8808, issued to your MAC



regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3050CP.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: MM8808

Related Change Request (CR) #: CR 8808

Related CR Release Date: August 22, 2014

Effective Date: September 23, 2014

Related CR Transmittal #: R3050CP

Implementation Date: September 23, 2014

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Modification of therapy functional reporting edit for discharge status

Outpatient therapy functional reporting requirements are designed to gather data reported by therapy providers and practitioners furnishing outpatient therapy services.

The Centers for Medicare & Medicaid Services (CMS) will make a system modification in response to the many inquiries regarding therapy functional reporting (THFR). This modification will be effective September 15, 2014. As a result of the modification, CMS believes

this will significantly reduce the number of THFR claim rejections.

Note: This does not impact editing for G code pairing. You will still need to report the discharge status G codes.

As a result of this change, providers who believe that their previous claims were erroneously returned or rejected due to a missing discharge date should resubmit those claims for re-processing on/after September 15, 2014.

General Coverage

CERT: SNF certifications and re-certifications

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and non-physician practitioners (NPPs) who bill for services provided to Medicare beneficiaries in SNFs.

Provider action needed

This *MLN Matters*® special edition SE1428 alerts providers that a major reason for claims being denied is failure to obtain certification and recertification statements from physicians or NPPs. The routine admission order established by a physician is not a certification of the necessity for post hospital extended care services for purposes of the program. Your billing staff needs to be aware of the requirements outlined below.

Background

The SNF inpatient improper payment rate increased from 4.8 percent during the 2012 reporting period to 7.7 percent during the 2013 report period. A major source of improper payments stems from SNFs failure to obtain certification and recertification statements from physicians or NPPs.

What is an acceptable certification statement?

An acceptable certification statement must contain the following information:

- The individual needs skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services;
- Such services are required on a daily basis;
- Such services can only practically be provided in a SNF or swing-bed hospital on an inpatient basis;
- Such services are for an ongoing condition for which the individual received inpatient care in a hospital; and
- A dated signature of the certifying physician or NPP.

What is an acceptable re-certification statement?

An acceptable recertification statement must contain the following information:

- The reasons for the continued need for post hospital SNF care;
- The estimated time the individual will need to remain in the SNF;
- Plans for home care, if any;
- If the reason for continued need for services is a condition that arose after admission to the SNF (and while being treated for an ongoing condition for which the individual received inpatient care in a hospital) this must be indicated; and
- A dated signature of the recertifying physician or NPP.



How and when to document the certification and recertification statements

- There is no specific format or procedure for documentation of the certification or recertification statement(s) but they must include the content listed above. For example (if appropriate) the physician or NPP could sign and date a statement that:
 1. All of the required information is included in the individual's medical record; and
 2. Continued post hospital extended care services are medically necessary.
- The following are the required timeframes for physicians or NPPs to document the certification or recertification statement(s):
 1. The certification must be obtained at the time of admission or as soon thereafter as is reasonable and practicable.
 2. The first recertification is required no later than the 14th day of post hospital SNF care.
 3. Subsequent recertifications are required at least every 30 days after the first recertification.

Note: SNFs are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an isolated oversight or lapse. Delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the SNF considers relevant for purposes of explaining the delay.

Examples of CERT findings

Below are examples of CERT review findings of incorrect certifications and recertifications:

- A physician order dated the day of admission to the

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SNF stated “resident certified as skilled (Medicare).” There was no indication of the need for daily skilled care, for inpatient services or for services for an ongoing condition for which the individual received inpatient care in a hospital care. Therefore the certification was not complete.

- A record selected by CERT for medical review did not have a certification or recertification statement. In response to a request for additional documentation, the facility submitted an initial certification and a recertification dated after the dates of service for the claim. There was no explanation of the reason(s) for the delayed certification. Therefore, the medical record did not meet Medicare requirements.
- A SNF medical record contained a 30-day recertification dated prior to the claim’s dates of service. There was no initial certification. A request for further documentation resulted in an initial certification and a 14-day recertification, both signed six months after the claim’s dates of service. In addition, the 30-day recertification was returned with a new date, also well after the claim dates of services. There was no explanation of the reason(s) for the delayed certification. This documentation did not meet the requirements for SNF certification and recertification.

Additional information

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

For more information about SNF claim denials you may review the *Code of Federal Regulations* (CFR) at <http://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol3/CFR->

[2010-title42-vol3-sec424-20](#), click on *Downloads* and choose which volume to review.

- You may also want to review the following documents:
 - The *Physician Certification and Recertification for Extended Care Services* in the *Medicare Benefit Policy Manual*, Chapter 8, Section 40 at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf>.
 - The *SNF Inpatient Part A Billing and SNF Consolidated Billing* in the *Medicare Claims Processing Manual*, Chapter 6, at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf>.
 - The *Skilled Nursing Facility Prospective Payment System* fact sheet at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/snfprospaymtfctsht.pdf>.
 - The *Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart* at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SNFSpellIllnesschrt.pdf>.

MLN Matters® Number: SE1428
 Related Change Request (CR) #: NA
 Related CR Release Date: NA
 Effective Date: NA
 Related CR Transmittal #: NA
 Implementation Date: NA

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Get ready for ICD-10

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

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

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

Online ICD-10 guide

ICD-10 basics for large medical practices



Revised modification to the medically unlikely edit program

Provider types affected

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

Provider action needed

Change request (CR) 8853 informs MACs about additional modifications being updated in the medically unlikely edit (MUE) program. The updates include clarifications, general processing instructions, and detailed explanations of MUE requirements and specifications. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the medically unlikely edit (MUE) program on January 1, 2007, to reduce the Medicare Part B paid claims error rate. At the onset or implementation of the MUE program, regarding the adjudication process, the MUE value for a Healthcare Common Procedure Coding System (HCPCS) code was only adjudicated against the units of service (UOS) reported on each line of a claim. On April 1, 2013, CMS modified the MUE program so that some MUE values would be date of service edits rather than claim line edits. At that time, CMS introduced a new data field to the MUE edit table termed “MUE adjudication indicator” or “MAI”. CMS is currently assigning a MAI to each HCPCS code. CR 8853 contains current and updated background information for these modifications, including general processing instructions.

MUEs for HCPCS codes with a MAI of “1”

MUEs for HCPCS codes with a MAI of “1” will continue to be adjudicated as a claim line edit.

MUEs for HCPCS codes with a MAI of “2”

MUEs for HCPCS codes with a MAI of “2” are absolute date of service edit. These are “per day edits based on policy”. HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers and the MACs.

Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the Health Insurance Portability & Accountability Act of 1996 (HIPAA) mandated coding descriptors and CMS approved

coding guidance as well as specific guidance in CMS and National Correct Coding Initiatives (NCCI) manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for *Current Procedural Terminology (CPT®) 94002* “ventilation assist and management . . . initial day” because such usage could not accurately describe two initial days of management occurring on the same DOS as would be required by the code descriptor.

Note: Although the qualified independent contractors (QICs) and the administrative law judges (ALJs) are not bound by sub-regulatory guidance, they do give deference to it and are being made aware that CMS considers all edits with an MAI of 2 to be firm limits based on subregulatory guidance, while some MUE edits with an MAI “2” may be based directly on regulation or statute.



MUEs for HCPCS codes with a MAI of “3”

MUEs for HCPCS codes with a MAI of “3” are date of service edits. These are “per day edits based on clinical benchmarks”. If claim denials based on these edits are appealed, MACs may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have prepayment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE for a HCPCS code with an MAI of “3” during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

General processing instructions

- Since ambulatory surgical center (ASC) providers (specialty code 49) cannot report modifier 50, the MUE value used for editing will be doubled for HCPCS codes with an MAI of “2” or “3” if the bilateral surgery indicator for the HCPCS code is “1”.
- CMS will continue to set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, MACs are not expected to identify claims but should reopen impacted claims that you bring to their attention.
- Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to your MAC

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not the NCCI/MUE contractor. MACs adjudicating an appeal for a claim denial for a HCPCS code with an MAI of "1" or "3" may pay correctly coded correctly counted medically necessary UOS in excess of the MUE value.

- Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an advance beneficiary notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of "3", MACs will review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under Section 1862(a)(1)). This may also be true for certain edits with an MAI of "1." CMS interprets the notice delivery requirements under Section 1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under Section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is **not** appropriate.
- CMS reminds providers to report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS. When modifier 50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be denied for incorrect coding. MACs may reopen or allow resubmission of those claims in accordance with their policies and with the policy in Chapter 34, Section 10.1, of the *Medicare Claims Processing Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf>. Clerical errors (which includes minor errors and omissions) may be treated as reopenings.
- CMS encourages providers to change and resubmit their own claims where possible and to change their coding practices, but during reopening MACs may,



when necessary, correct the claim to modifier 50 from an equivalent two units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR.

- CMS also reminds providers to use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.
- On your remittance advice, MACs will continue to use group code CO (contractual obligation), and remark codes N362 and MA01 for claims that fail the MUE edits, when the UOS on the claim exceed the MUE value, and deny the entire claim line(s) for the relevant HCPCS code.

Additional information

The official instruction, CR 8853, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1421OTN.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: MM8853
 Related Change Request (CR) #: CR 8853
 Related CR Release Date: August 15, 2014
 Effective Date: January 1, 2015
 Related CR Transmittal #: R1421OTN
 Implementation Date: January 5, 2015

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Avoid deactivation of Medicare payments

Find out whether you have been sent a revalidation request by using the search option featured on First Coast Service Options' popular enrollment status lookup, available at <http://medicare.fcso.com/Enrollment/NPIandPTANLetterInput.asp>. You may search for revalidation requests by entering your NPI or your PTAN.

ICD-10 acknowledgement testing

Provider types affected

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

Provider action needed

Change request (CR) 8858 instructs MACs to promote three specific acknowledgement testing weeks with providers, and provide data and statistics to the Centers for Medicare & Medicaid Services (CMS) to demonstrate readiness for the International Classification for Disease, 10th Edition Clinical Modification (ICD-10) transition. Make sure that your billing staffs are aware of these ICD-10 testing opportunities.

Background

The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing ICD-10. All covered entities must be fully compliant on October 1, 2015.

CR 8858 instructs all MACs and the DME MAC common electronic data interchange (CEDI) contractor to promote ICD-10 acknowledgement testing with trading partners during three separate testing weeks, and to collect data about the testing. These testing weeks will be:

November 17 – 21, 2014

March 2 – 6, 2015

June 1 – 5, 2015

The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 implementation. While submitters may acknowledgement test ICD-10 claims at any time through implementation, the ICD-10 testing weeks have been created to generate awareness and interest, and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

These testing weeks will allow trading partner's access to MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on the CMS website, the CEDI website and each MAC's website.

Key points of the testing process for CR 8858

- Test claims with ICD-10 codes must be submitted with

current dates of service since testing does not support future dates of service.

- Claims will be subject to existing national provider identifier (NPI) validation edits.
- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Test claims will be subject to all existing EDI front-end edits, including submitter authentication and NPI validation.
- Testing will not confirm claim payment or produce a remittance advice.
- MACs and CEDI will be appropriately staffed to handle increased call volume on their electronic data interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. ET, during this week.
- Your MAC will announce and promote these testing weeks via their listserv messages and their website.

Additional information

The official instruction, CR 8858, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1423OTN.pdf>.

The EDI help desk numbers for institutional claim submitters are available at <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartA.pdf> and the numbers for professional claims submitters are available at <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartB.pdf>.

MLN Matters® Number: MM8858

Related Change Request (CR) #: CR 8858

Related CR Release Date: August 22, 2014

Effective Date: 30 days from issuance (see test dates)

Related CR Transmittal #: R1423OTN

Implementation Date: November 17 through 21, 2014, for the November testing week; March 2 through 6, 2015, for the March testing week; June 1 through 5, 2015, for the June testing week;

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October 2014 healthcare provider taxonomy codes update

Provider types affected

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

What you need to know

Change request (CR) 8866 implements the National Uniform Claim Committee (NUCC) healthcare provider taxonomy codes (HPTC) code set that is effective October 1, 2014, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

Background

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

Both the current Accredited Standards Committee (ASC) X12 837 institutional and professional technical report type 3 (TR3s) require the NUCC HPTC set be used to identify provider specialty information on a health care claim. The standards do not mandate the reporting of provider specialty information via a HPTC on every claim, nor for every provider to be identified by specialty.

The standard implementation guides state this information is:

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

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

The transactions and code sets final rule, published August 17, 2000, establishes that the maintainer of the code set determines its effective date. This rule also mandates that covered entities must use the nonmedical data code set specified in the standard implementation guide that is valid at the time the transaction is initiated. For implementation purposes, Medicare generally uses the date the transaction is received for validating a particular nonmedical data code set required in a standard transaction.

The HPTC set is maintained by the NUCC for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company



(WPC) website at www.wpc-edi.com/codes.

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

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

Additional information

The official instruction, CR 8866, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3037CP.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: MM8866
 Related Change Request (CR) #: CR 8866
 Related CR Release Date: August 22, 2014
 Effective Date: October 1, 2014
 Related CR Transmittal #: R3037CP
 Implementation Date: January 5, 2015 – If capable, MACs can implement this effective October 1, 2014.

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Claim status category and claim status codes update

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8735 which informs MACs about the changes to claim status category and claim status codes. Make sure your billing staffs 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 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/>.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the September/October 2014 committee meeting shall be posted on that site on or about November 1, 2014. MACs must complete entry of all applicable code text changes and new codes, and

terminate use of deactivated codes by the implementation date of CR 8735.

These code changes are to be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR 8735.

All MACs must comply with the requirements contained in the versions 004010X093A1 and 005010X212 of ASC X12 276/277 Implementation Guide as well as the 005101X214 of the ASC X12 277 health care claim acknowledgement implementation guide (inclusive of any published errata documents) and must use valid claim status category codes and claim status codes when sending 277 responses.

Additional information

The official instruction, CR 8735 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3043CP.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: MM8735
Related Change Request (CR) #: CR 8735
Related CR Release Date: August 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3043CP
Implementation Date: January 5, 2015

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Quarterly provider update

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

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

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

Implementation of phase III CORE 360 CARCs and RARCs rule

Provider types affected

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

Provider action needed

Change request (CR) 8838 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on operating rules for information exchange (CORE) defined code combinations per operating rule 360 - uniform use of CARCs and RARCs (835) rule. CAQH CORE will publish the next version of the code combination list on or about October 1, 2014. This update is based on July 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. Visit <http://www.wpc-edi.com/reference> for CARC and RARC updates and <http://www.caqh.org/CORECodeCombinations.php> for CAQH CORE defined code combination updates.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014 under the Patient Protection and Affordable Care Act of 2010. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended the Social Security Act by adding Part C – Administrative Simplification – to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

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



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

scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 8838, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3038CP.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: MM8838
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Fingerprint-based background check begins

Provider types affected

This *MLN Matters*® special edition article is intended for providers and suppliers subject to fingerprint-based background check, submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Fingerprint-based background checks will be required for all individuals with a five percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application.

Caution – what you need to know

The fingerprint-based background requirement was implemented August 6, 2014, and will be conducted in phases. Providers or suppliers will receive notification of the fingerprint requirements from their MAC. Initially, not all providers and suppliers in the “high” screening category will be a part of the first phase of the fingerprint-based background check requirement. See the *Background* section below for more details.

Go – what you need to do

If you receive notification of the fingerprint requirements, you will have 30 days from the date of the letter to be fingerprinted. Make sure that your staffs are aware of these requirements.

Background

The Centers for Medicare & Medicaid Services (CMS) awarded the fingerprint-based background check contract to Accurate Biometrics located in Chicago, Illinois July 8, 2014. Fingerprint-based background checks will be required for all individuals with a five percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application. The fingerprint-based background requirement was implemented August 6, 2014, and will be conducted in phases. Initially, not all providers and suppliers in the “high” screening category will be included in the first phase of the fingerprint-based background check requirement.

Applicable providers or suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a letter to the applicable providers or suppliers listing all five percent or greater owners who are required to be fingerprinted. The letter will be mailed to the provider or supplier’s correspondence address and the special payments address on file with Medicare.

Generally the relevant individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed. The relevant individuals will have 30 days from the date of the letter to be fingerprinted.

If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.

The relevant individuals should contact Accurate Biometrics prior to being fingerprinted to ensure the fingerprint results are accurately submitted to the Federal Bureau of Investigation (FBI) and properly returned to CMS. Accurate Biometrics may be contacted by phone (866-361-9944) or by accessing their

website at www.cmsfingerprinting.com if you have any questions.

If an initial enrollment application is received by the MAC and the provider or supplier is required to obtain a fingerprint-based background check, the MAC will not begin processing the application until the fingerprint-based background check has been completed and the results are received. The effective date of enrollment will be determined by the date the fingerprint results are received.

Additional information

For more information on the fingerprint-based background check requirement, view *MLN Matters*® article SE1417, “Implementation of Fingerprint-Based Background Checks,” available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf>.

You may also want to review MM7350 titled, “Implementation of Provider Enrollment Provisions in CMS-6028-FC” available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7350.pdf>.

MLN Matters® Number: SE1427
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.



Examining the differences between a NPI and a PTAN

Note: This article was revised September 5, 2014, to add the “Where Can I Find My PTAN?” section. All other information is the same. This information was previously published in the [May 2012 Medicare B Connection](#), pages 30–31.

Provider types affected

This *MLN Matters*® special edition article is intended for physicians, providers, and suppliers who are enrolled in Medicare.

What you need to know

This article explains the difference between a national provider identifier (NPI) and a provider transaction access number (PTAN). There are no policy changes in this article.

Background

New enrollees

All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare administrative contractor (MAC), the provider or supplier will also be issued a provider transaction access number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI.

Revalidation

Section 6401(a) of the Affordable Care Act established a requirement for all enrolled physicians, providers, and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Providers and suppliers receiving requests to revalidate their enrollment information have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the differences between the NPI and the PTAN.

National provider identifier (NPI)

The NPI is a **national** standard under the Health Insurance Portability and Accountability Act (HIPAA) administrative simplification provisions.

- The NPI is a unique identification number for covered health care providers.
- The NPI is issued by the National Plan and Provider Enumeration System (NPPES).
- Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions (for example, insurance claims) adopted under HIPAA.
- The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI does not carry information about healthcare providers, such as the state in which they live or their medical specialty. This reduces the chances of insurance fraud.
- Covered providers and suppliers must share their

NPI with other suppliers and providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Since May 23, 2008, Medicare has required that the NPI be used in place of all legacy provider identifiers, including the Unique Physician Identification Number (UPIN), as the unique identifier for all providers, and suppliers in HIPAA standard transactions. You should note that individual health care providers (including physicians who are sole proprietors) may obtain only one NPI for themselves (Entity Type 1 Individual). Incorporated individuals should obtain one NPI for themselves (entity type 1 individual) if they are health care providers and an additional NPI(s) for their corporation(s) (entity type 2 organization). Organizations that render health care or furnish health care supplies may obtain NPIs (entity type 2 organization) for their organizations and their subparts (if applicable). For more information about the NPI, visit the NPPES website at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

Provider transaction access number (PTAN)

A PTAN is a Medicare-only number issued to providers by MACs upon enrollment to Medicare. When a MAC approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

- The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using MAC self-help tools such as the interactive voice response (IVR) phone system, internet portal, on-line application status, etc.
- The PTAN's use should generally be limited to the provider's contacts with their MAC. Where can I find my PTAN? You can find your PTAN by doing any one of the following:
 1. View the letter sent by your MAC when your enrollment in Medicare was approved.
 2. Log into [Internet-based PECOS](#). Click on the “My Enrollments” button and then “View Enrollments”. Locate the applicable enrollment and click on the “View Medicare ID Report” link which will list all of the provider or supplier's active PTANs in one report.
 3. The provider (or, in the case of an organizational provider, an authorized or delegated official) shall send a signed written request on company letterhead to your [MAC](#); include your legal name/ legal business name, national provider identifier (NPI), telephone and fax numbers.

Relationship of the NPI to the PTAN

The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider's enrollment. If the

See **PTAN**, next page

PTAN

From previous page

provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANS are generally assigned.

Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the Provider Enrollment Chain & Ownership System (PECOS), the master provider and supplier enrollment system.

Protect Your Information in PECOS

All providers and suppliers should carefully review their PECOS records in order to protect themselves and their practices from identity theft. PECOS should only contain active enrollment records that reflect current practice and group affiliations. You can review and update your PECOS records in the following ways:

- Use Internet-based PECOS: Log on to Internet-based PECOS at <https://pecos.cms.hhs.gov/pecos/login.do>.
- Use the paper CMS 855 enrollment application (i.e., 855A, 855B, 855I, 855O, 855R, or 855S).
- **Note:** The Medicare contractor may not release provider specific information to anyone other than the individual provider, authorized/delegated official of the provider organization, or the contact person. The request must be submitted in writing on the provider's letterhead and signed by the individual provider, authorized/delegated official of the organization or the contact person.

The MLN® fact sheet titled "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)," provides guidelines and steps you can take to protect your identity while using Internet-based PECOS. This fact sheet is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProID_FactSheet_ICN905103.pdf.

[MLN/MLNProducts/downloads/MedEnroll_ProID_FactSheet_ICN905103.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProID_FactSheet_ICN905103.pdf).

Additional information

MLN Matters® special edition article SE1126 titled "Further Details on the Revalidation of Provider Enrollment Information," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf>.

"Medicare Provider–Supplier Enrollment National Educational Products," contains a list of products designed to educate Medicare fee-for-service (FFS) providers about important Medicare enrollment information, including how to use Internet-based PECOS to enroll in the Medicare Program and maintain their enrollment information. This resource is available at http://www.cms.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.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: SE1216 *Revised*
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Implementation Date: N/A

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Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Tools to 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).

Editorial and technical updates to the 'NCD Manual'

Note: This article was revised September 8, 2014, to reflect the revised change request (CR) 8506 issued September 4. The CR release date, effective and implementation dates, transmittal number, and the Web address for accessing the CR are revised. All other information is unchanged. This information was previously published in the [February 2014 Medicare B Connection](#), Page 45.

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 8506 as an informational alert to providers that language-only changes – updates to the *Medicare National Coverage Determinations (NCD) Manual*, Pub 100-03 – were made.

The changes were made to comply with:

1. Conversion from ICD-9 to ICD-10;
2. Conversion from ASC X12 version 4010 to version 5010;
3. Conversion of former contractor types to MACs; and,
4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

Note: The edits made to the *NCD Manual* are technical/editorial only and in no way alter existing NCD policies.

Background

The edits to the *NCD Manual* (Publication 100-03) are part of a CMS-wide initiative to update its manuals and bring them in line with recently released instructions regarding the above-noted subject matter.



Additional information

The official instruction, CR 8506, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R173NCD.pdf>.

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

MLN Matters® Number: MM8506 *Revised*
Related Change Request (CR) #: CR 8506
Related CR Release Date: September 4, 2014
Effective Date: Upon ICD-10 Implementation
Related CR Transmittal #: R173NCD
Implementation: Upon ICD-10 Implementation

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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.

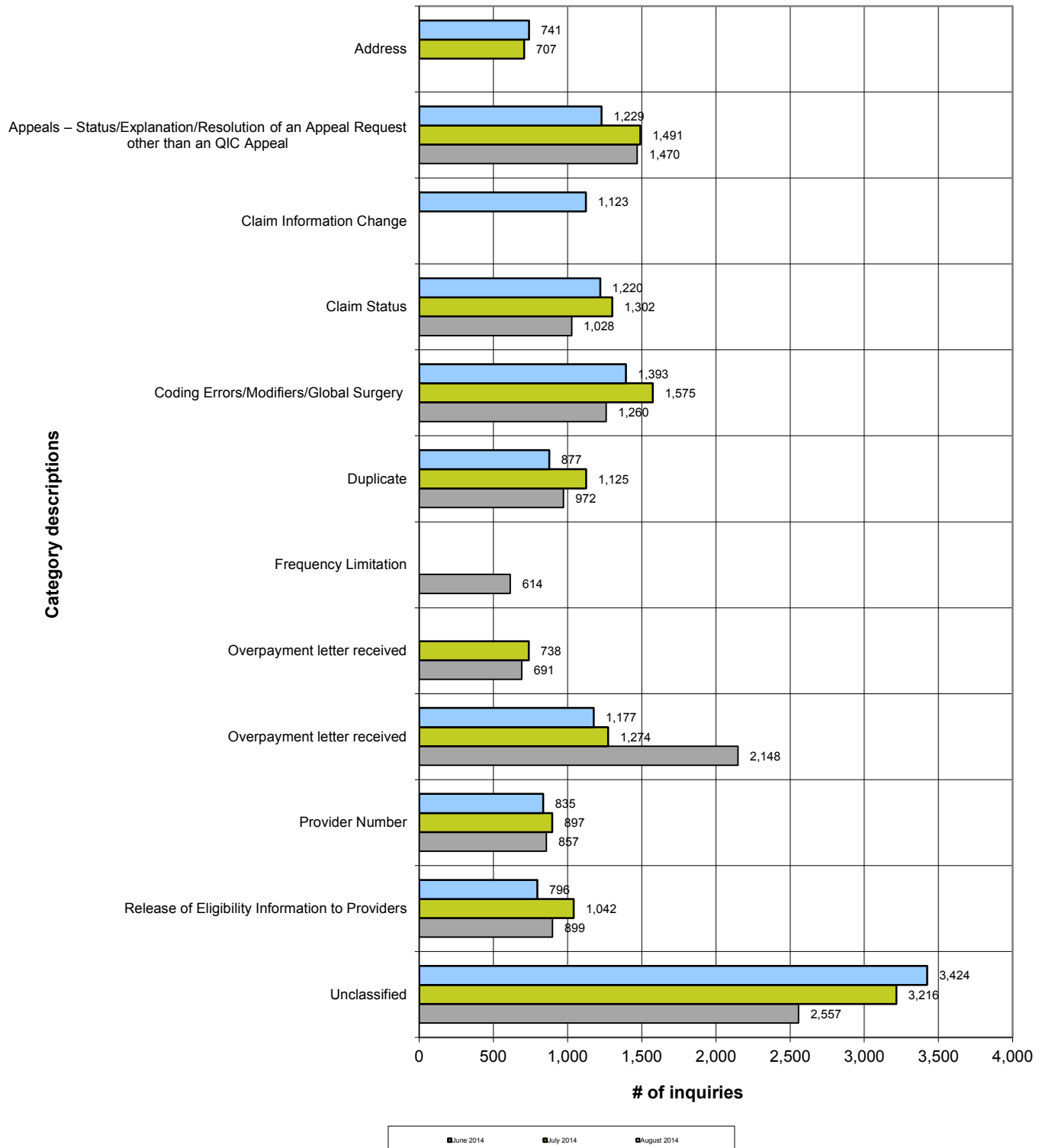
Claims and Inquiry Summary Data

Top inquiries, rejects, and return unprocessable claims

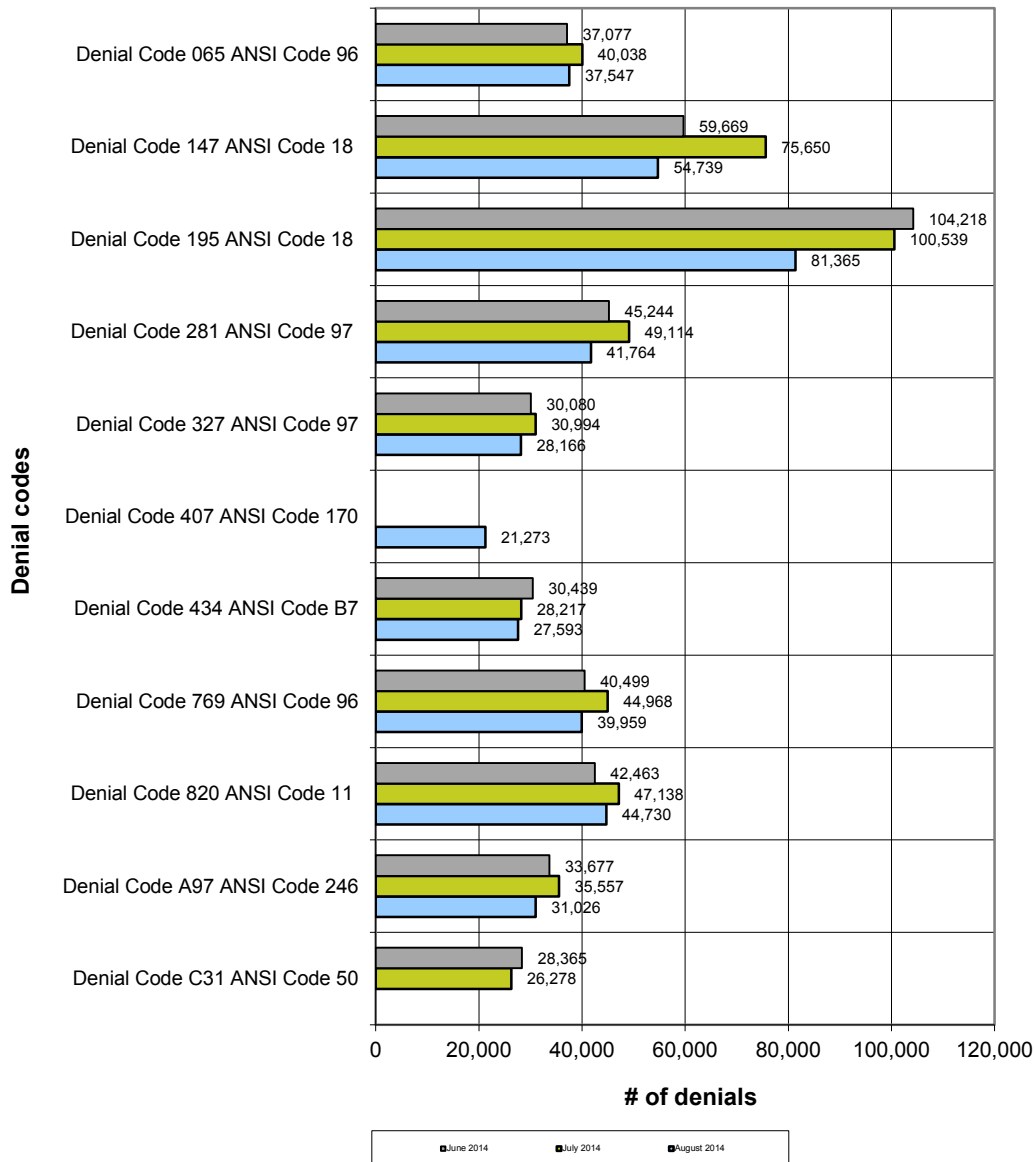
The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands June-August 2014.

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

Part B top inquiries for June-August 2014



Part B top denials for June-August 2014



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

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

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

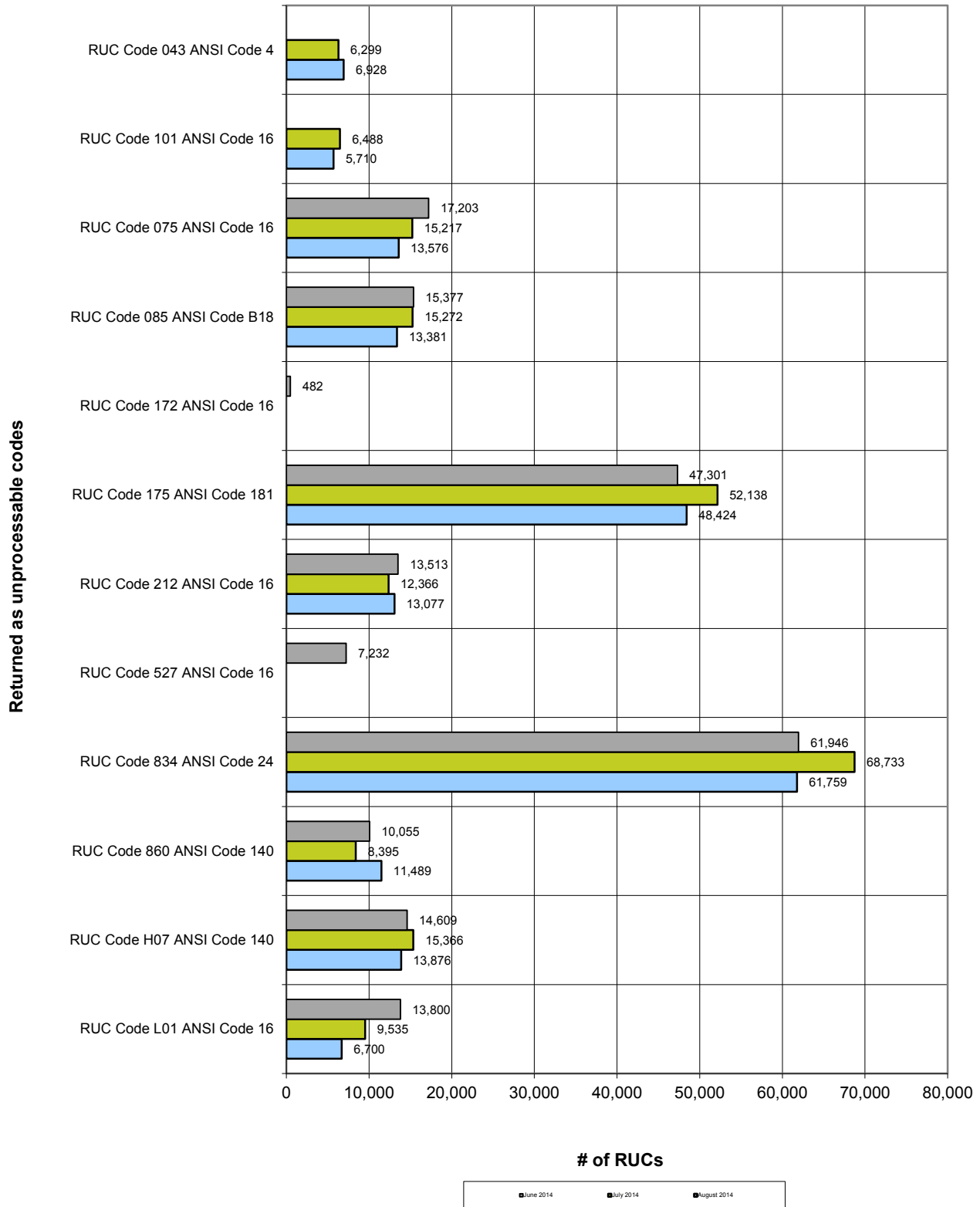
For assistance with denied claims and how to correct them, the following frequently asked questions are

available the First Coast Medicare provider website:

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

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

Part B top return as unprocessable claims for June-August 2014



New LCD

CYP2C19, CYP2D6, CYP2C9, and VKORC1 genetic testing new LCD

LCD ID number: L35366 (Florida/Puerto Rico/ U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) via the coverage and analysis department has facilitated a national contractor medical director collaboration workgroup known as, “The local coverage determination (LCD) writers.” The workgroup includes medical directors from all of the A/B Medicare administrative contractors (MACs). One of the goals of all MACs is collaboration with other contractors and consensus LCDs is one outcome of this collaboration. In most cases, the contractor medical directors worked with the relevant specialty physicians in developing certain consensus draft LCDs. When a consensus draft LCD is adopted by a contractor, there is no major change to the LCD development process, which includes a 45-day comment period, the finalization of the draft based on comments received from physicians representing their society and/or any stakeholder in the community, and a 45-day notice period. The finalized LCD remains the local contractor’s discretion and responsibility.

This LCD limits CYP2C19 [*Current Procedural Terminology (CPT®) 81225*] and CYP2D6 (*CPT® 81226*) genetic testing to defined indications. All other testing for CYP2C19 and CYP2D6 is non-covered until definitive clinical utility is established to justify coverage. The LCD also non-covers CYP2C9 (*CPT® 81227*) and VKORC1 (*CPT® 81355*) genetic testing for all medications as not reasonable and necessary under §1862(a)(1)(A). The available literature does not support that CYP2C9 and VKORC1 testing for drug responsiveness, improves health outcomes in Medicare beneficiaries.

This policy is not addressing coverage with evidence development (CED) under section 1862(a)(1)(E). CYP2C9 and VKORC1 when performed for CED for warfarin responsiveness [Healthcare Common Procedure Coding System (HCPCS) code G9143] will be covered when provided in accordance to the coverage limitations of the national coverage determination (NCD) for Pharmacogenomic Testing for Warfarin Response. For



CED coverage please make reference to NCD 90.1 and the coding article related to this LCD

This new LCD has been developed to outline indications and limitations of coverage and/or medical necessity, *CPT®* codes, and ICD-9-CM diagnosis codes for CYP2C19, CYP2D6, CYP2C9, and VKORC1.

Effective date

This new LCD is effective for services rendered **on or after November 03, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please [click here](#).

Revisions to LCDs

Colorectal Cancer Screening – revision to the Part B LCD

LCD ID number: L29100 (Florida)

LCD ID number: L29115 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for colorectal cancer screening has been revised to add diagnosis codes V76.41 (Special screening for malignant neoplasms, rectum) and V76.51 (Special screening for malignant neoplasms, colon) under the “ICD-9 Codes that Support Medical Necessity” section of the LCD for HCPCS codes G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) and G0120 (Colorectal cancer screening; alternative to G0105, screening colonoscopy,

barium enema).

Effective date

This LCD revision is effective for claims processed **on or after August 28, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please [click here](#).

Docetaxel (Taxotere®) – revision to the Part B LCD

LCD ID number: L29155 (Florida)

LCD ID number: L29417 (Puerto Rico/U.S. Virgin Islands)

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

Effective date

The LCD revision is effective for services rendered **on or after October 7, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please [click here](#).

Low density lipoprotein (LDL) apheresis– revision to the Part B LCD

LCD ID number: L32998 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for low density lipoprotein (LDL) apheresis became effective on February 4, 2013. At that time, data analysis by the Program Safeguards Communication Group (PSCG) identified that the utilization of CPT® code 36516 (therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion) had steadily increased since 2008. Medicare Part B data analysis obtained for the second half of 2013 indicated a significant increase in carrier-to-nation ratio at nearly 800 percent above the national average. Due to the risk for a high dollar claim payment error, this LCD has been revised to address the

limited indications for this service and establish frequency parameters in the utilization guidelines section for LDL apheresis.

Effective date

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

Noncovered services – revision to the Part B LCD

LCD ID number: L29288 (Florida)

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

Based on change request (CR) 8757 [Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)], the local coverage determination (LCD) for noncovered services was revised to remove *Current Procedural Terminology (CPT®)* code 0275T from the “CPT/HCPCS Codes-Procedures” section of the LCD. As stated in CR 8757, effective for services performed on or after January 09, 2014, the Centers for Medicare & Medicaid Services (CMS) has determined that PILD will be covered by Medicare when provided in a clinical study under Section 1862(a)(1)(E) through coverage with evidence development (CED) for beneficiaries with LSS who are enrolled in an approved clinical study that meets the criteria outlined in national coverage determination (NCD) 150.13 (Percutaneous-image-guided lumbar decompression for lumbar spinal stenosis).



“CPT®/HCPCS-codes” section of the LCD.

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

Any interested stakeholder can request a reconsideration of an LCD after the notice period has ended and this revision becomes effective. Please refer to the attached article at the bottom of the noncovered services LCD which includes a list of the articles and related information that were addressed by the Medical Policy department in making the noncoverage determination. If the stakeholder has new information based on the evaluation of the list, LCD reconsideration can be initiated. It is the responsibility of the interested stakeholder to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the website.

Effective date

This LCD revision is effective for claims processed **on or after October 06, 2014**, for services rendered **on or after January 09, 2014**.

In addition, the following CPT®/HCPCS codes were evaluated and determined not to meet the Medicare reasonable and necessary threshold for coverage. Therefore, 81504, C9739, C9740, and 53899 (*Unlisted procedure, urinary system*), 55899 (*Unlisted procedure, male genital system*), and L8699 (Prosthetic implant, not otherwise specified), when code L8699 is used for the transprostatic urethral lift implant, have been added to the

Effective date

This LCD revision is effective for services rendered **on or after November 03, 2014**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please [click here](#).

Omalizumab (Xolair®) – revision to the Part B LCD

LCD ID number: L29240 (Florida)

LCD ID number: L29456 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination for omalizumab (Xolair®) has been revised based on a reconsideration request to add the Food and Drug Administration (FDA) approved new indication: chronic idiopathic urticaria in adults and adolescents (12 years of age and above) who remain symptomatic despite H1 antihistamine treatment. A revision was made to add the FDA approved indication for omalizumab (Xolair®) to the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD. The “ICD-9 Codes that Support Medical Necessity” section was revised to add diagnosis codes 708.1 and 708.8 and descriptors to correspond with the approved indication. The “Utilization Guidelines” section of the LCD was also updated to include this indication. In addition, First Coast Service Options, Inc. (First Coast) took this opportunity to

revise the guidelines for moderate and severe persistent asthma based on the National Asthma Education and Prevention Program Expert Panel Report 3. The “Sources of Information and Basis for Decision” has been updated to add the references for this revision.

Effective date

This LCD revision is effective for claims processed **on or after August 28, 2014**, for services rendered **on or after March 21, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs, please [click here](#).

Upcoming provider outreach and educational events

How to register for SPOT (Secure Provider Online Tool)

When: Tuesday, October 14

Time: 1:00-2:00 p.m. **Type of event:** Webcast

<http://medicare.fcso.com/Events/273452.asp>

Medicare Speaks 2014: Keeping you informed of changes and updates

When: Wednesday, October 22

Time: 1:00 -3:00 p.m. **Type of event:** Face-to-face **Location:** U.S. Virgin Islands

<http://medicare.fcso.com/Events/273451.asp>

Medicare Speaks 2014 Panama City

When: Wednesday-Thursdays, November 5-6

Time: 8:00 a.m.-4:30 p.m. **Type of event:** Face-to-face

http://medicare.fcso.com/Medicare_Speaks/272432.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™ Provider eNews for August 28, 2014

MLN Connects™ Provider eNews for August 28, 2014
[View this edition as a PDF](#)

In this edition:

MLN Connects™ National Provider Calls

- PQRS: How To Avoid 2016 Negative Payment Adjustments For CMS Medicare Quality Reporting Programs – Register Now
- Overview of the 2013 Quality And Resource Use Reports – Registration Opening Soon
- New MLN Connects™ National Provider Call Video Slideshow, Audio Recording, And Transcript

Announcements

- NIST EHR Randomizer Tool: Provider User Guide Available
- Review New FAQs for the EHR Incentive Programs

Claims, pricers, and codes

- Update to Preventive Services Paid Based on the RHC or FQHC All-inclusive Rate
- Adjustment of Some Home Health Claims
- FY 2014 HH PPS PC Pricer Updated

MLN Educational Products

- “International Classification of Diseases, 10th Revision (ICD-10) Testing – Acknowledgement Testing with Providers” MLN Matters® Article – Released

MLN Connects™ Provider eNews for September 4, 2014

MLN Connects™ Provider eNews for September 4, 2014
[View this edition as a PDF](#)

In this edition:

MLN Connects™ National Provider Calls

- CMS Offers Settlement to Acute Care Hospitals and CAHs for Resolving Patient Status Denials - Register Now
- PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs - Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript
- Providers and Suppliers - Browse the MLN Connects™ Call Program Collection of Resources

Announcements

- Get Ready for DMEPOS Competitive Bidding - Get Accredited
- Healthy Aging® Month - Discuss Preventive Services

- “ICD-10-CM/PCS Billing and Payment Frequently Asked Questions” Fact Sheet – Revised
- “ICD-10-CM/PCS Myths and Facts” Fact Sheet - Revised
- “ICD-10-CM Classification Enhancements” Fact Sheet – Revised
- “General Equivalence Mappings Frequently Asked Questions” Booklet – Revised
- “New Physician Specialty Code for Interventional Cardiology” MLN Matters® Article – Released
- “Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes – Companion Information to MM8581: Automation of the Request for Reopening Claims Process” MLN Matters® Article – Released
- “Fingerprint-based Background Check Begins August 6, 2014” MLN Matters® Article – Released
- “Comprehensive Error Rate Testing (CERT): Skilled Nursing Facility (SNF) Certifications and Recertifications” MLN Matters® Article – Released
- “MLN Suite of Products & Resources for Rural Health Providers” Educational Tool – Revised
- New MLN Educational Web Guides Fast Fact
- MLN Products Available in Electronic Publication Format

with your Patients

- New CMS Rule Allows Flexibility in Certified EHR Technology for 2014
- Open Payments System Outages

MLN Educational Products

- “Quick Reference Information: Coverage and Billing Requirements for Medicare Ambulance Transports” Educational Tool - Released
- “Intravenous Immune Globulin (IVIG) Demonstration - Implementation” MLN Matters® Article - Revised
- “Medicare Enrollment and Claim Submission Guidelines” Booklet - Revised
- “Medicare Vision Services” Fact Sheet - Revised
- “Medicare Enrollment Guidelines for Ordering/Referring Providers” Fact Sheet - Revised
- New MLN Provider Compliance Fast Fact
- MLN Products Available in Electronic Publication Format

MLN Connects™ Provider eNews for September 11, 2014

MLN Connects™ Provider eNews for September 11, 2014
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In this edition:

MLN Connects™ National Provider Calls

- PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs – Last Chance to Register

Announcements

- Hospitals Appeals Settlement FAQs
- National Cholesterol Education Month – Medicare Preventive Services for Cardiovascular Disease
- New Release of PEPPER for Short-term Acute Care Hospitals
- EHR Incentive Programs: Learn More about Patient Electronic Access Requirements
- EHR Incentive Programs: Exclusions and Hardship Exceptions for Broadband Access Claims, Pricers, and Codes
- Incarcerated Beneficiary Update
- Updated Information on Preventive Services Paid Based on the RHC or FQHC All – Inclusive Rate

- October 2014 Average Sales Price Files Now Available

MLN Educational Products

- “HIPAA Privacy and Security Basics for Providers” Fact Sheet – Released
- “The CMS Physician Quality Reporting System (PQRS) Program: What Medicare Eligible Professionals Need to Know in 2014” Web– Based Training Course – Released
- “The CMS Value– Based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2014” Web– Based Training Course – Released
- “The Medicare and Medicaid EHR Incentive Programs: What Medicare and Medicaid Providers Need to Know in 2014” Web–Based Training Course – Released
- “Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)” MLN Matters® Article – Revised
- “Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes – Companion Information to MM8581: Automation of the Request for Reopening Claims Process” MLN Matters® Article – Revised
- New MLN Topic of the Month

MLN Connects™ Provider eNews for September 18, 2014

MLN Connects™ Provider eNews for September 18, 2014
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In this edition:

MLN Connects™ National Provider Calls

- Hospital Appeals Settlement Update – Registration Opening Soon
- Transitioning to ICD-10 – Registration Now Open
- New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

- ICD-10 Coordination and Maintenance Committee Meeting

Announcements

- New Affordable Care Act Tools and Payment Models Deliver \$372 Million in Savings, Improve Care
- HHS Provides Additional Flexibility for Certification of Electronic Health Record Technology

- Medicare EHR Incentive Program: October 3 Last Day for 1st-year EPs to Begin 2014 Reporting Period

Claims, Pricers, and Codes

- Mass Adjustments to IPF Claims with Teaching Adjustment Amounts Being Duplicated

MLN Educational Products

- “2014-2015 Influenza (Flu) Resources for Health Care Professionals” MLN Matters® Article – Released
- “Internet-based PECOS FAQs” Fact Sheet – Released
- “Safeguard Your Identity and Privacy Using PECOS” Fact Sheet – Released
- “Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs” Fact Sheet – Revised
- “Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs” Fact Sheet – Revised
- MLN Products Available In Electronic Publication Format

INFLUENZA

From front page

- **Quick reference information: Medicare Part B immunization billing chart** – http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf
- **Quick reference information: Preventive services chart** – http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf
- **MLN preventive services educational products Web page** – <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html>
- **Preventive services educational products PDF** – http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf

Other CMS resources

- **Seasonal influenza vaccines 2014 pricing** – <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2014ASPFiles.html>
- **Immunizations Web page** – <http://www.cms.gov/Medicare/Prevention/Immunizations/index.html>
- **Prevention general information** – <http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html>
- **CMS frequently asked questions** – <http://questions.cms.gov/faq.php>
- **Medicare Benefit Policy Manual – Chapter 15, Section 50.4.4.2 – Immunizations** <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>
- **Medicare Claims Processing Manual – Chapter 18, Preventive and Screening Services** – <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf>

Other resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2014 – 2015 flu season:

- **Advisory Committee on Immunization Practices** – <http://www.cdc.gov/vaccines/acip/index.html>

Other sites with helpful information include:

- **Centers for Disease Control and Prevention** – <http://www.cdc.gov/flu/>;
- **Flu.gov** – <http://www.flu.gov/>;
- **Food and Drug Administration** – <http://www.fda.gov/>;
- **Immunization Action Coalition** – <http://www.immunize.org/>;
- **Indian Health Services** – <http://www.ihs.gov/>;

- **National Alliance for Hispanic Health** – <http://www.hispanichealth.org/>;
- **National Foundation For Infectious Diseases** – <http://www.nfid.org/influenza/>;
- **National Library of Medicine and NIH Medline Plus** – <http://www.nlm.nih.gov/medlineplus/immunization.html> ;
- **National Network for Immunization Information** – <http://www.immunizationinfo.org/>;
- **National Vaccine Program** – <http://www.hhs.gov/nvpo/>;
- **Office of Disease Prevention and Health Promotion** – <http://odphp.osophs.dhhs.gov/>;
- **Partnership for Prevention** – <http://www.prevent.org/> and
- **World Health Organization** – <http://www.who.int/en>

Beneficiary information

For information to share with your Medicare patients, please visit <http://www.medicare.gov>

Medicare provides coverage for one seasonal influenza virus vaccine per influenza season for all Medicare beneficiaries. Medicare generally provides coverage of pneumococcal vaccination and its administration once in a lifetime for all Medicare beneficiaries; however, Medicare may cover additional pneumococcal vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status. Medicare provides coverage for these vaccines and their administration with no co-pay or deductible.

Remember to immunize yourself and your staff. Protect yourself from the flu.

Remember – The influenza vaccine plus its administration is a covered Part B benefit. The influenza vaccine is **not** a Part D covered drug. For more information on coverage and billing of the flu vaccine and its administration, please visit the [CMS Medicare Learning Network® Preventive Services Educational Products](#) and [CMS Immunizations Web pages](#).

While some health care professionals may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. [HealthMap Vaccine Finder](#) is a free, online service where users can search for locations offering flu vaccines.

MLN Matters® Number: SE1431
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Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation Date: NA

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Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

Email: FloridaB@fcso.com

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

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Customer service

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

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

Fax number (for general inquiries)

904-361-0696

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877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

Email: FloridaB@fcso.com

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

Websites

Provider

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Centers for Medicare & Medicaid Services

<http://www.cms.gov>

First Coast University

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

Beneficiaries

Centers for Medicare & Medicaid Services

<http://www.medicare.gov>

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

Email: FloridaB@fcso.com

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

Provider enrollment

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

Medical policy

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

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Jacksonville, FL 32231-4078

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Jacksonville, FL 32231-4071

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

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

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<http://www.cms.gov>

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

Beneficiaries

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

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

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