Medicare B CONNECTION

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers October 2014

In this issue

Faxed reopening requests will not be accepted after November 30

Expedite your Part B clerical reopening requests with the 'SPOT' or IVR

In the past, providers had only two available methods to submit clerical reopening requests to First Coast Service Options: Mail or fax. However, these submission methods were neither time nor cost efficient.

Today, members of First Coast's provider community have the opportunity to submit clerical reopening requests through more **efficient** channels: the Secure Provider Online Tool (SPOT) and the interactive voice response system (IVR).

The SPOT and the IVR allow providers to submit clerical reopening requests directly into a secure database, which helps lessen processing time.

Since the availability of these more expedient submission channels has eliminated the need for providers to fax clerical reopening requests, First Coast will no longer offer that option *starting December 1*.

Option 1: Correct your claim online with 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 in their eligible Part B claims quickly, easily, and securely – **online**.

To begin, search for the claim you wish to correct by its **ICN** or by its date(s) of service in the **Claim Status** window. The SPOT will automatically determine if any line items are eligible and prepopulate the online request form accordingly.

You may select the request type for any eligible line item 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. Once you have completed and reviewed your corrections, submit your request. You will receive a

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

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

About the 'Medicare B Connection'

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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

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

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

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

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

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 (wavier of liability statement on file).

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

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

Clinical laboratory new waived tests

***Note**: This article was revised September 19, 2014, to reflect the revised change request (CR) 8805 issued September 17. The article was revised to correct the description in bullet point 7 under Background. Also the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the August 2014 Medicare B Connection, Pages 19-20.*

Provider types affected

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

Provider action needed

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

The *Current Procedural Terminology* (*CPT*®) codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 8805 informs the MACs about the latest new *CPT*® codes that are subject to CLIA edits. Make sure your billing staffs are aware of these latest CLIA-related changes, and that you remain current with certification requirements.

Background

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The *CPT*® codes for the following new tests must have the modifier QW (CLIA-waived test) to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR *8805* (i.e., *CPT*® codes: *81002, 81025, 82270, 82272, 82962, 83026*, *84830, 85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.

The *CPT*® code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- G0434QW, September 6, 2013, BTNX Inc. Rapid Response Multi-Drug Urine Test Cup;
- G0434QW, September 6, 2013, BTNX Inc. Rapid Response Multi-Drug Urine Test Panel;
- G0434QW, October 4, 2013, uVera Diagnostics, Inc. CR2 Multi-Drug Urine Test Cup;
- G0434QW, October 4, 2013, uVera Diagnostics, Inc. CR3 Multi-Drug Urine Test Cup;
- G0434QW, October 4, 2013, uVera Diagnostics, Inc. SMARTOX U3 Multi-Drug Urine Test Cup;

- G0434QW, October 24, 2013, American Institute of Toxicology, Inc., AIT Laboratories Drug of Abuse Cup;
- *80061*QW, *82962*, *82465*QW, *83718*QW, *84478*QW, November 12, 2013, Jant Pharmacal Corp, LipidPlus Professional Lipid Profile and Glucose Measuring System (LipidPlus Lipid Profile test strips);
- G0434QW, December 4, 2013, Nobel Medical Inc. INSTA-SCREEN Multi-Drug Urine Test Cup;
- G0434QW, December 5, 2013, Micro Distributing II, LTD One Step Multi-Drug Urine Test Panel;
- G0434QW, February 11, 2014, Alfa Scientific Designs, Inc. Confidential Drug Test – Multi Drugs of Abuse Urine Test (OTC);
- *87880*QW, February 18, 2014, BD Veritor System for Rapid Detection of Group A Strep (direct from throat swab);
- *85018*QW, February 18, 2014, Clarity HbCheck Hemoglobin Testing System;
- *87077*QW, February 18, 2014, Jant Accutest Rapid Urease test (H. pylori detection);
- G0434QW, March 13, 2014, UCP Biosciences, Inc. UCP Multi-Drug Test Key Cups;
- *83986*QW, March 18, 2014, RightBio Metrics, RightSpot Infant pH Indicator;
- *83986*QW, March 18, 2014, RightBio Metrics, RightSpot pH Detector;
- *83986*QW, March 18, 2014, RightBio Metrics, RightSpot pH Indicator;
- *85018*QW, March 21,2014, AimStrip Hb Hemoglobin (Hb) Testing System;
- G0434QW, April 11, 2014, PTox Drug Screen Cup {Cassette Dip Card format};
- *86308*QW, April 22, 2014, Polymedco Polystat Mono {whole blood};
- *82274*QW, G0328QW, April 22, 2014, Rapid Response(TM) FIT-Fecal Immunochemical Test;
- *84443*QW, May 16, 2014, Germaine Laboratories, Inc. AimStep Thyroid Screen {whole blood};
- *82055*QW, May 21, 2014, Express Diagnostics

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International, Incorporated Saliva Alcohol Test;

- *83037*QW, May 22, 2014, BIO-RAD in2it (II) System Analyzer Prescription Home Use; and
- *87880*QW, May 23, 2014, Accustrip Strep A {Specimen type (Throat Swab)}.

You should be aware that your MAC will not search their files, to either retract payment or retroactively pay claims; however, they should adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 8805, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3070CP.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: MM8805 *Revised*
Related Change Request (CR) #: CR 8805
Related CR Release Date: September 17, 2014
Effective Date: : October 1, 2014
Related CR Transmittal #: R3070CP
Implementation Date: October 6, 2014

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2015 update to the AIC requirements for ALJ and federal district court appeals

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

- **ALJ hearing request**: The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2014, is $140. This amount will rise to $150 for ALJ hearing requests filed on or after January 1, 2015.
- **Federal district court review**: The amount that must remain in controversy for federal district court review requests filed on or before December 31, 2014, is $1,430. This amount increased to $1,460 for appeals to Federal District Court filed on or after January 1, 2015.

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confirmation email that will outline the changes you made.

If you would like to take advantage of First Coast's online submission method for clerical reopening requests, you must *register for your SPOT account*.

Option 2: Correct your claim on the telephone with the IVR

If you *don't have online access*, you may submit your Part B clerical reopening request through First Coast's IVR system. Although the IVR offers the same primary request types as the SPOT, the IVR offers the additional option of making history corrections to your claim.

To access your claim through the IVR, you must enter the billing provider's information (i.e., NPI, PTAN, and TIN), the beneficiary's information (i.e., name, date of birth, Medicare number), and the ICN of the claim you wish to correct.

After you have selected the request type and have entered corrections for applicable fields, you will be asked to confirm your choices and submit the request. If the request is approved, you will receive a letter and new remittance advice notice.

If you would like to take advantage of First Coast's **telephone submission** method for clerical reopening requests, please refer to *Telephone reopening requests via the IVR*.

Remember, whether you prefer to correct your claims online or on the telephone, you won't have to wait until December 1. You can *fix your claims* faster on the SPOT and IVR – **today**.

Ambulance

Ambulance inflation factor for 2015 and productivity adjustment

***Note**: This article was revised October 9, 2014, to reflect the revised change request (CR) 8895 issued October 7. The CR was revised to update the multifactor productivity adjustment which then adjusts the inflation factor. In addition, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the September 2014 Medicare B Connection, Page 8.*

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

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 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 0.60 percent and the CPI-U for 2015 is 2.10 percent. Under 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 CY 2015 is 1.50 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/R3090CP.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 *Revised*
Related Change Request (CR) #: CR 8895
Related CR Release Date: October 7, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3090CP
Implementation Date: January 5, 2015

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Ambulatory Surgery Center

October 2014 update of the ASC payment system

***Note**: This article was revised September 30, 2014, to reflect the revised change request (CR) 8880 issued September 26. In the article, the descriptor for HCPCS code C9135 has been revised in the first table under "Billing for drugs, biologicals, and radiopharmaceuticals" to end with per i.u., instead of per 10 i.u. In addition, the CR release date, transmittal number and the Web address for accessing the CR were revised. all other information remains the same. This information was previously published in the August 2014 Medicare B Connection, Pages 7-8.*

Provider types affected

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

Provider action needed

CR 8880 describes changes to and billing instructions for various payment policies implemented in the October 2014 ASC payment system update. CR 8880 also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staffs are aware of these changes.

Key points of CR 8880

New services

There are no new services assigned for separate payment under the ambulatory surgical center (ASC) payment system, effective October 1, 2014.

Billing for drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP), effective October 1, 2014

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

b. New HCPCS codes for drugs and biologicals separately payable under the ASC payment system, effective October 1, 2014

Four drugs and biologicals have been granted ASC payment status, effective October 01, 2014. These items, along with their descriptors and ASC payment indicators (PIs) are as follows:

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

Code	Short descriptor	Long descriptor	ASC PI
C9023	Inj testosterone undecanoate	Injection, testosterone undecanoate, 1 mg	K2
C9025	Injection, ramucirumab	Injection, ramucirumab, 5 mg	K2
C9026	Injection, vedolizumab	Injection, vedolizumab, 1 mg	K2
C9135	Factor ix (Alprolix)	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.	K2

Note: These HCPCS codes are new codes effective October 1, 2014.

c. Revised ASC payment indicator for HCPCS codes J9160 and J9300

Effective October 1, 2014, the payment indicator for HCPCS codes J9160 (Injection, denileukin diftitox, 300 micrograms) and J9300 (Injection, gemtuzumab ozogamicin, 5 mg) will change from K2 to Y5 because the product associated with HCPCS code J9160 is no longer marketed. Effective October 1, 2014, the payment indicator for HCPCS code J9300 (Injection, gemtuzumab ozogamicin, 5 mg) will change from K2 to Y5 because the product associated with HCPCS code J9300 is no longer marketed.

d. Updated payment rate for HCPCS code J9171, effective January 1, 2014, through March 31, 2014

The payment rate for one HCPCS code was incorrect in the January 2014 ASC drug file. The corrected payment rate is listed in the following table, and has been installed in the revised January 2014 ASC drug file, effective for services furnished on January 1, 2014, through March 31, 2014. Suppliers who think they may have received an incorrect payment for dates of service January 1, 2014, through March 31, 2014, may request their MAC to adjust the previously processed claims.

Updated payment rate for HCPCS code J9171

Effective January 1, 2014, through March 31, 2014

Code	Short descriptor	Corrected payment rate	ASC PI
J9171	Docetaxel injection	4.63	K2

e. Updated payment rates for certain HCPCS codes, effective April 1, 2014, through June 30, 2014

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The payment rate for three HCPCS codes was incorrect in the April 2014 ASC drug file. The corrected payment rate is listed in the following table, and has been installed in the revised April 2014 ASC drug file, effective for services furnished on April 1, 2014, through June 30, 2014. Suppliers who think they may have received an incorrect payment for dates of service April 1, 2014, through June 30, 2014, may request their MAC to adjust the previously processed claims.

Updated payment rates for certain HCPCS codes Effective April 1, 2014, through June 30, 2014

Code	Short descriptor	Corrected payment rate	ASC PI
J7335	Capsaicin 8% patch	25.49	K2
J8700	Temozolomide	6.94	K2
J9171	Docetaxel injection	4.35	K2

f. Updated payment rates for certain HCPCS codes, effective July 1, 2014, through September 30, 2014

The payment rate for two HCPCS codes was incorrect in the July 2014 ASC drug file. The corrected payment rates are listed in the following table, and have been installed in the revised July 2014 ASC drug file, effective for services furnished on July 1, 2014, through September 30, 2014. Suppliers who think they may have received an incorrect payment for dates of service July 1, 2014, through September 30, 2014, may request their MAC to adjust the previously processed claims.

Updated payment rates for certain HCPCS codes Effective July 1, 2014, through September 30, 2014

Code	Short descriptor	Corrected payment rate	ASC PI
J9047	Injection, carfilzomib, 1 mg	29.67	K2
J9315	Romidepsin injection	270.24	K2

Additional information

The official instruction, CR 8880, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3078CP.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: MM8880 *Revised*
Related Change Request (CR) #: CR 8880
Related CR Release Date: September 26, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3078CP
Implementation Date: October 6, 2014

Cardiac Services

Benson-Henry Institute Cardiac Wellness Program added to ICR benefit

Provider types affected

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

Provider action needed

Change request (CR) 8894 alerts providers that the Benson-Henry Institute Cardiac Wellness Program meets the program requirements set forth by Congress and is a Medicare-covered benefit as of May 6, 2014. Make sure your billing staffs are aware of these changes.

Background

In CR 8894, the Centers for Medicare & Medicaid Services (CMS) explains that on September 3, 2013, it initiated a national coverage analysis (NCA) to consider the expansion of Medicare-coverage of intensive cardiac rehabilitation (ICR) services to include the Benson-Henry Institute Cardiac Wellness Program. As a result, effective for dates of service on and after May 6, 2014, CMS determines that the evidence is sufficient to expand the ICR benefit to include the Benson-Henry Institute Cardiac Wellness Program, national coverage determination (NCD) NCD 20.31.3. The program meets the ICR program requirements set forth by Congress in Section 1861 (eee)(4)(A) of the Social Security Act and in the regulations at 42 C.F.R. Section 410.49(c). This program has been included on the list of approved ICR programs available at *http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html*.

The current ICR policy and program criteria remain unchanged as follows: ICR refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner. An ICR program must show, in peer-reviewed

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published research, that it accomplished one or more of the following for its patients:

1. Positively affected the progression of coronary heart disease;
2. Reduced the need for coronary bypass surgery; or
3. Reduced the need for percutaneous coronary interventions.

The ICR program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

1. Low density lipoprotein;
2. Triglycerides;
3. Body mass index;
4. Systolic blood pressure;
5. Diastolic blood pressure; and
6. The need for cholesterol, blood pressure, and diabetes medications.

For claims with dates of service on or after May 6, 2014, MACs will adjust claims brought to their attention but will not search their files for claims processed prior to implementation of CR 8894.

Note: Providers should refer to CR 6850 for detailed claim processing, coverage, coding, and payment information regarding ICR. No additional claim processing instructions are required to implement CR 8894. You may review the *MLN Matters*® article related to CR 6850 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6850.pdf*.

Remember that MACs will only pay for ICR services when submitted on types of bill (TOB) 13x and 85x. When these services are submitted on other TOBs, note that the services will be denied with a new claim adjustment reason code 171 – Payment is denied when performed by this type of provider in this type of facility.

Additional information

The official instruction, CR 8894, consists of two

transmittals. The first updates the NCD manual and is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R175NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3084CP.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.

The Decision Memorandum for Intensive Cardiac Rehabilitation (ICR) Program – Benson-Henry Institute Cardiac Wellness Program (CAG-00434N) is available at *http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=271*.

To review the CMS booklet titled *Cardiovascular Disease Services* visit *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Cardiovascular-Disease-Services-Booklet-ICN907784.pdf*.

MLN Matters® Number: MM8894
Related Change Request (CR) #: CR 8894
Related CR Release Date: October 3, 2014
Effective Date: May 6, 2014
Related CR Transmittal #: R175NCD and R3084CP
Implementation November 4, 2014

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Consolidated Billing

2015 annual code update of SNF consolidated billing

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 who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

Stop – impact to you

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in change request (CR) 8943 could impact your payments.

Caution – what you need to know

CR 8943 provides the 2015 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (SNF CB) and explains how the updates affect edits in Medicare claim processing systems.

By the first week in December 2014, the new code files for B MAC processing, and the new Excel and PDF files for A MAC processing will be available at *http://www.cms.gov/SNFConsolidatedBilling*; and become effective on January 1, 2015.

Go – what you need to do

It is important and necessary to read the *General Explanation of the Major Categories* PDF file located at the bottom of each year's MAC update in order to understand the major categories, including additional exclusions not driven by HCPCS codes.

Medicare's claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay. These edits allow separate payment for only those services that are excluded from consolidated billing.

Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Sections 20.6 and 110.4.1. You may view this manual at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf*.

Additional information

The official instruction, CR 8943, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3088CP.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: MM8943
Related Change Request (CR) #: CR 8943
Related CR Release Date: October 3, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3088CP
Implementation Date: January 5, 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.

Drugs and Biologicals

January 2015 quarterly average sales price Medicare Part B drug pricing files

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

Change request (CR) 8912 instructs Medicare administrative contractors (MACs) to download and implement the January 2015 and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised October 2014, July 2014, April 2014, and January 2014, average sales price (ASP) drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 5, 2015, with dates of service January 1, 2015, through March 31, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted that manufacturers submit to CMS. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are in Chapter 4, Section 50, of the *Medicare Claims Processing Manual* which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

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

Files	Effective dates of service
January 2015 ASP and ASP NOC	January 1 through March 31, 2015
October 2014 ASP and ASP NOC	October 1 through December 31, 2014
July 2014 ASP and ASP NOC	July 1 through September 30, 2014

Files	Effective dates of service
April 2014 ASP and ASP NOC	April 1 through June 30, 2014
January 2014 ASP and ASP NOC	January 1 through March 31, 2014

Additional information

The official instruction, CR 8912, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3072CP.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: MM8912
Related Change Request (CR) #: CR 8912
Related CR Release Date: September 19, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3072CP
Implementation Date: January 5, 2015

Evaluation & Management

Prepayment review for CPT® codes 99223 and 99233

First Coast Service Options Inc. (First Coast) recently conducted data analysis due to the high comprehensive error rate testing (CERT) error rates for evaluation and management services pertaining to *Current Procedural Terminology*® (*CPT*®) codes *99223* (initial hospital visit) and *99233* (subsequent hospital visit). The CERT November 2014 forecasting report indicates a projected error rate of 39.8 percent for *CPT*® code *99223* and a projected error rate of 34.4 percent for *CPT*® code *99233*. The data indicates that the specialty of internal medicine is the primary contributor to the CERT error rate: internal medicine error rates are currently trending at 36.6 percent for *CPT*® code *99233* and 33.3 percent for *CPT*® code *99223*.

Documentation requirements

The American Medical Association (AMA) *CPT*® manual defines code *99223* as follows:

***Initial hospital care, per day**, for the evaluation and management of a patient, which requires these 3 key components:*

- *A comprehensive history;*
- *A comprehensive examination; and*
- *Medical decision making of high complexity*

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring an admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital unit.

The AMA *CPT*® manual defines code *99233* as follows:

***Subsequent hospital care**, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:*

- *A detailed interval history ;*
- *A detailed examination;*
- *Medical decision making of high complexity*

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs.

Usually, the patient is unstable or has developed a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital unit.

First Coast and the Centers for Medicare & Medicaid Service (CMS) offer multiple resources addressing the documentation guidelines for E/M service levels at:

- First Coast's *Evaluation and Management (E/M) services page*, offering links to tools, FAQs, online learning, and additional resources.
- CMS *Internet-only manual (IOM) guidelines* addressing multiple types and settings pertaining to E/M services.

First Coast actions

In response to the high percentage of error rates and the continual risks of improper payments associated with hospital care visits billed by internal medicine specialists, First Coast will be implementing a prepayment medical review audit for *CPT*® codes *99223* and *99233* billed by internal medicine specialty. The new audit will be based on a predetermined percentage of claims in an effort to reduce the error rates for these hospital services. The audit will be implemented effective October 21, 2014.

ICD-10-CM official guidelines for coding and reporting available

The *2015 ICD-10-CM Official Guidelines for Coding and Reporting* is now available on the *2015 ICD-10-CM and GEMs* Web page and also on the *Centers for Disease Control and Prevention* website.

- Narrative changes appear in bold text
- Items underlined have been moved within the guidelines since the fiscal year 2014 version
- Italics are used to indicate revisions to heading changes

Health Professional Shortage Area

2015 annual update for the health professional shortage area bonus payments

Provider types affected

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

Provider action needed

Change request (CR) 8942 alerts you that the annual HPSA bonus payment file for 2015 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your MAC and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2015, through December 31, 2015. You should review physician bonuses Web page at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses* each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

Background

Section 413(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. CMS automated HPSA ZIP code file shall be populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file shall be made available to MACs in early December of each year. MACs shall implement the HPSA ZIP code file and, for claims with dates of service January 1 to December 31 of the following year, shall make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file. Only areas designated as HPSAs prior to the end of the calendar will be eligible for a bonus payment in the following year.

Additional information

The official instruction, CR 8942, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3087CP.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: MM8942
Related Change Request (CR) #: CR 8942
Related CR Release Date: October 3, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3087CP
Implementation Date: January 5, 2015

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Laboratory/Pathology

Manual update to clarify claim processing for laboratory services

Provider types affected

This *MLN Matters*® article is intended for Medicare practitioners providing laboratory services to Medicare beneficiaries and billing Medicare administrative contractors (MACs) or durable medical equipment Medicare (DME) MACs for those services.

Provider action needed

Change request (CR) 8883 updates the *Medicare Claims Processing Manual* to clarify that the location where the independent laboratory performed the test determines the appropriate billing jurisdiction for specimen collection fees and travel allowance. The changes are intended to clarify the existing policies and no system or processing changes are anticipated. Make sure your billing staffs are aware of these policies.

Key points

The manual updates, which are attached to CR 8883, are as follows:

- The location where the independent laboratory performed the test determines the appropriate billing jurisdiction. If the sample originates in a different jurisdiction from where the sample is being tested, the claim must be filed in the jurisdiction where the test was performed.
- Claims filing jurisdiction for the specimen collection fee and travel allowance is also determined by the location where the test was performed. When billed by an independent laboratory, the specimen collection fee and travel allowance must be billed in conjunction with a covered laboratory test.
- The specimen collection fee is paid based on the location of the independent laboratory where the test is performed and is billed in conjunction with a covered laboratory test.

Additional information

The official instruction, CR 8883, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3071CP.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: MM8883
Related Change Request (CR) #: CR 8883
Related CR Release Date: September 19, 2014
Effective Date: December 22, 2014
Related CR Transmittal #: R3071CP
Implementation Date: December 22, 2014

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Radiology

FDG PET for solid tumor claims

Issue

Claims for fluorodeoxyglucose (FDG) positron emission tomography (PET) for solid tumors submitted October 6 through November 10 will be held to ensure Medicare systems can accurately calculate payments. Specifically, these are claims containing Healthcare Common procedure Coding System (HCPCS) A9552 for all oncologic conditions. See *MLN Matters® article MM8739* for additional information.

Resolution

These claims will be processed beginning November 11 after the system has been fully tested.

Status/date resolved

Open. These claims will be processed beginning November 11 after the system has been fully tested.

Provider action

No action is required by providers

Current processing issues

Here is a link to a table of *current processing issues* for both Part A and Part B.

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.

Online Medicare refreshers

The *Medicare Learning Network®* (MLN) Products Web-Based Training (WBT) courses are designed for self-paced training via the Internet.

These WBT courses provide information on a broad range of Medicare topics for health care professionals and their staff. Many of these courses offer continuing education credits.

Click here to explore the wide away of training opportunities.

Enthusiasm for Web tools puts surgery center at cutting edge

If you were to talk with Allison Wakeland about the First Coast Service Options' *Web self-service tools*, she sounds much like a home shopping network emcee. She talks up the benefits with each Web tool with such enthusiasm, you want to reach for your Visa® card and buy one right away.

Fortunately, for health care providers who service Medicare beneficiaries, these tools are free. And NeuroSpinal Associates, a physician group in Bradenton, FL, and the affiliated RiverWalk Surgical Center, bank on Wakeland's enthusiasm in using them.

Wakeland leads the Medicare billing efforts for the group of surgeons and pitches in to assist with filing facility claims as necessary. In making sure claims are filed timely and correctly, Wakeland has become a super-user of the *First Coast Web tools*.

She bookmarks her most-used pages and cites a business use for each of the 15 tools available on the site. "I'm in the *fee schedule* and *LCD lookup* tools each day. The site stays up on my screen all day because I use them so much," Wakeland says.

"The LCD lookup is really helpful with medical documentation. The LCDs help us educate doctors on what they need to document. It provides a great deal of detail. I will show the doctor the LCD and review with them what they need to document in the way of diagnosis codes," she added.

> **"I feel the site gets better each day. And it's all free. I get so much out of using it."**
>
> ***-Allison Wakeland, NeuroSpinal Associates***

Allison Wakeland uses the self-service tools on First Coast's website throughout her work day at NeuroSpinal Associates and the RiverWalk Surgical Center. (Photo Courtesy: NeuroSpinal Associates)

The ambulatory surgery center and affiliated physician office process more than 300 claims a month. Seventy percent of their patients are Medicare beneficiaries, with nearly a third of those patients enrolled in Medicare Advantage plans. Because of these numbers, NeuroSpinal Associates and RiverWalk need Wakeland to stay on top of the changes in Medicare billing.

"It might take 30 days or more to find out we filed a claim with the wrong payer. This delay can add up quickly," Wakeland says. "The patients don't always know they're covered by an advantage plan. Often, they tell us they're enrolled in Medicare." Wakeland says checking a patient's secondary payer status and Medicare eligibility *through First Coast's Secure Provider Online Tool (SPOT)* has greatly improved office operations.

Several of the *First Coast Web self-service tools* include integrated features that allow providers to see important information through multiple channels. For example, when Wakeland reviews the *fee schedule* for a particular procedure, she can click over to the associated LCD document if one exists.

The fee schedule lookup tool offers a drop down window for providers to review if filing the claim requires any modifiers. "We check to make sure modifiers are applicable to the *CPT*® code the doctor is billing," she says.

The *modifier verification* and the *evaluation and management interactive worksheet* play important role in the office's compliance efforts as well. "With the evaluation and management worksheet supporting their billing, Wakeland says the billing team uses it to verify codes dictated by the physicians. "I will have the worksheet up on my screen as I run through what the physician has dictated," Wakeland said.

In addition to the practice of filing clean claims, Wakeland says the tools play a critical role with quality improvement in their offices. She uses *provider data summary (PDS) reports* to evaluate claim returns. Besides spotting trends in claims processing, Wakeland says the PDS reports are helpful in identifying where her office staff might need additional training. "If we see a list of codes getting missed on a regular basis, I can call up the spreadsheet to see who is entering those codes and come back and train behind it," she said.

Click here **and tell us about your success story with First Coast's Web tools.**

Wakeland also takes advantage of the *online and in-person training opportunities* offered by First Coast. She attended the *Medicare Speaks* seminar in Orlando and listens in on most webinars. "Once I get my certification in medical billing, I intend to take full advantage of the CEU credits available through First Coast University."

When asked what she would say to her peers in other medical practices, she says, "I feel the site gets better each day. And it's all free. I get so much out of using it."

Transitioning MAC workloads to the new banking contractor(s)

Provider types affected

This *MLN Matters*® article is intended to alert all providers that your Medicare administrative contractor (MAC) may be transitioning their banking to another bank.

What you need to know

This article is informational in nature and is intended to inform you that Medicare has re-competed its banking contracts and has awarded two five-year contracts to US Bank (an incumbent bank) and to Citibank (which replaces the prior contract with JP Morgan Chase). The Centers for Medicare & Medicaid Services (CMS) awarded these contracts July 10, 2014. Change request (CR) 8847 was issued to manage the transition of the MAC workloads from JP Morgan Chase to Citibank.

Background

In 2010, CMS changed its Medicare banking policies by discontinuing the use of time accounts to pay for banking service charges and awarded five-year commercial services contracts through full and open competition to two banks (US Bank and JP Morgan Chase); these two banks disburse MAC authorized payments and demonstration project payments for CMS. The two current commercial banking contracts are terminating in fiscal year 2015. CMS has awarded five-year contracts through full and open competition to US Bank (incumbent bank) and Citibank (new bank). Each selected bank shall provide both MAC payment services and Demonstration payment services and shall be designated financial agents of the U.S. Treasury.

CMS is transitioning MAC workloads from JP Morgan Chase to Citibank. The MAC workloads with US Bank will remain with US Bank. The transition began August 2014 and will end in January 2015.

Additional information

The official instruction for CR 8847 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R240FM.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: MM8847
Related Change Request (CR) #: CR 8847
Related CR Release Date: September 19, 2014
Effective Date: September 19, 2014
Related CR Transmittal #: R240FM
Implementation Date: September 30, 2014

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Electronic funds transfer upgrades to the Internet-based PECOS system

Over the last year, the Centers for Medicare & Medicaid Services (CMS) listened to your feedback about *Internet-based provider enrollment, chain, and ownership system (PECOS)* and made improvements to increase access to more information. PECOS is easier to use than ever with electronic funds transfer (EFT) upgrades that are now available.

If a provider/supplier wishes to submit a change to the EFT information, they should select “Perform a change of Information to current enrollment information.” **Note**: All EFT changes must be made through the change of information scenario.

Providers/suppliers are able to edit all EFT Information, except the routing transit number and/or depositor account number, once entered and saved. Once saved, if a provider/supplier needs to update the routing transit number and/or depositor account number, the providers/supplier must delete all information and re-enter new information. PECOS will now collect an EFT effective date and termination date to capture the timeframe when the financial information is valid. The effective date is the date on which funds will be directed to the account information entered. The termination date is the date on which funds will no longer be directed to the account information entered.

PECOS has also been updated to display the most current CMS-588 form which now collects the financial institution’s street address and financial institution’s ZIP code under “Financial Institution Information.”

CMS updates definition of spouse to include same-sex marriages for MSP

Provider types affected

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

Provider action needed

Stop – impact to you

Section 3 of the Defense of Marriage Act (DOMA) provided for purposes of federal law, the term "spouse" could not include individuals in a same-sex marriage. Because the MSP working-aged provisions only apply to subscribers and their spouses, the working-aged provisions did not apply on the basis of spousal status to individuals in a same-sex marriage.

The United States Supreme Court has invalidated this DOMA provision. Thus, the Centers for Medicare & Medicaid Services (CMS) is no longer prohibited from applying the MSP working-aged provision to individuals in a same-sex marriage.

Caution – what you need to know

Effective January 1, 2015, the rules below apply with respect to the term "spouse" under the MSP working-aged provisions. This is true for both opposite-sex and same-sex marriages.

- If an individual is entitled to Medicare as a spouse based upon the Social Security administration's rules, that individual is a "spouse" for purposes of the MSP working-aged provisions.
- If a marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory, or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction, both parties to the marriage are "spouses" for purposes of the MSP working-aged provisions.
- Where an employer, insurer, third-party administrator, group health plan (GHP), or other plan sponsor has a broader or more inclusive definition of spouse for purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the "spouse" in question. If such an individual is reported as a "spouse" through the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Section 111, Medicare will pay accordingly and pursue recovery, as applicable.

Go – what you need to do

Make sure your billing staffs are aware of these changes.

Background

Based on change request (CR) 8875, effective January 1, 2015, the definition of a spouse for purposes of the working-aged provisions means "a person who is entitled to Medicare as a spouse based upon the Social Security administration's rules or a person whose marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction."

The expanded rules for the definition of "spouse," including proper reporting pursuant to MMSEA Section 111, must be implemented with a start date for the coverage in question no later than January 1, 2015.

To the extent an employer, insurer, third-party administrator, GHP or other plan sponsor insurer has chosen to or chooses to utilize the new definitions referenced above or a broader definition of "spouse" for MSP purposes prior to January 1, 2015, it may do so. However, MACs may not apply the revised definition for Medicare purposes for coverage dates prior to January 1, 2015. Nor may MACs accept a definition of spouse broader than that quoted above. In the event, Medicare does pay for coverage prior to January 1, 2015, it will pursue recovery, as applicable.

Additional information

The official instruction, CR 8875, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R106MSP.pdf*.

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

MLN Matters® Number: MM8875
Related Change Request (CR) #: CR 8875
Related CR Release Date: October 10, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R106MSP
Implementation Date: January 1, 2015

October 2014 update for DMEPOS fee schedule

***Note**: This article was revised October 6, 2014, to reflect the revised change (CR) 8509 issued October 2. In the article, the effective and implementation dates have changed and the CR release date, transmittal number and the Web address for accessing the CR are changed. All other information is the same. This information was previously publication in the January 2014 Medicare B Connection, Page 37.*

Provider types affected

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

Provider action needed

Stop – impact to you

This change request (CR) 8509 revises the current CMS-1500 claim form instructions to reflect the revised CMS-1500 claim form, version 02/12.

Caution – what you need to know

Form version 02/12 will replace the current CMS-1500 claim form, 08/05, effective with claims received on and after April 1, 2014:

- Medicare will begin accepting claims on the revised form, 02/12, on January 6, 2014;
- Medicare will continue to accept claims on the old form, 08/05, through March 31, 2014;
- On April 1, 2014, Medicare will accept paper claims on only the revised CMS-1500 claim form, 02/12; and
- On and after April 1, 2014, Medicare will no longer accept claims on the old CMS-1500 claim form, 08/05.

Go – what you need to do

Make sure that your billing staff is aware of these instructions for the revised form version 02/12.

Background

The National Uniform Claim Committee (NUCC) recently revised the CMS-1500 claim form. On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised form, 02/12. The revised form has a number of changes. Those most notable for Medicare are new indicators to differentiate between ICD-9 and ICD-10 codes on a claim, and qualifiers to identify whether certain providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. In addition, the revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

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

- DN – Referring provider
- DK – Ordering provider
- DQ – Supervising Provider

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

The Administrative Simplification Compliance Act (ASCA) requires Medicare claims to be sent electronically unless certain exceptions are met. Those providers meeting these exceptions are permitted to submit their claims to Medicare on paper. Medicare requires that the paper format for professional and supplier paper claims be the CMS-1500 claim form. Medicare therefore supports the implementation of the CMS-1500 claim form and its revisions for use by its professional providers and suppliers meeting an ASCA exception. More information about ASCA exceptions can be found in Chapter 24 of the *Medicare Claims Processing Manual* which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf*.

Additional information

The official instruction, CR 8509 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3083CP.pdf*. CR 8509 contains the instructions for completing the revised CMS-1500 claim form (02/12), which will become part of Chapter 26 in the *Medicare Claims Processing Manual* (Pub. 100-04).

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*.

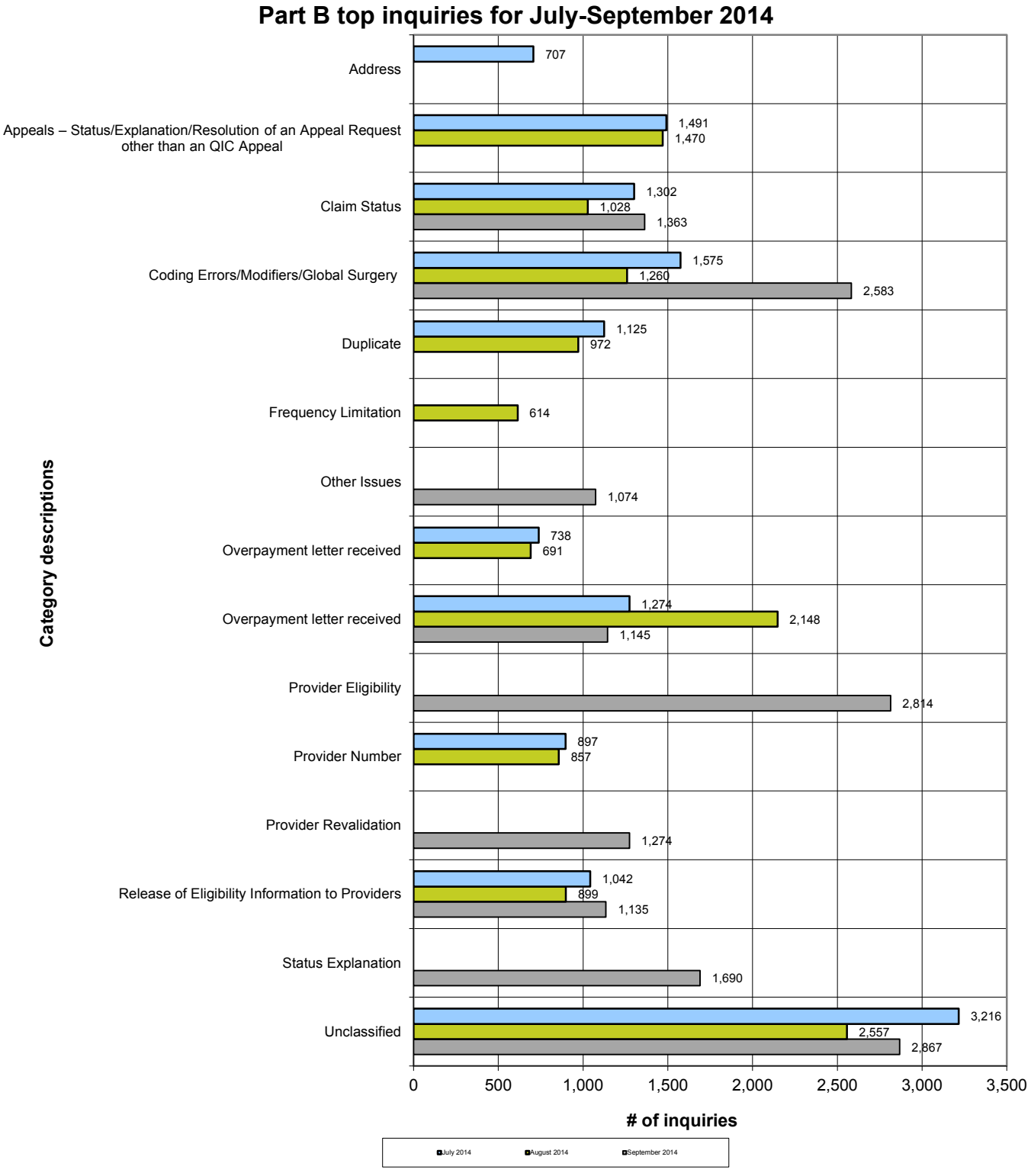
MLN Matters® Number: MM8509 *Revised*
Related Change Request (CR) #: CR 8509
Related CR Release Date: October 2, 2014
Effective Date: January 6, 2014, for CMS-1500; for ICD-10 - upon implementation of ICD-10
Related CR Transmittal #: R3083CP
Implementation Date: January 6, 2014, for CMS-1500; for ICD-10 - upon implementation of ICD-10

Claims and Inquiry Summary Data

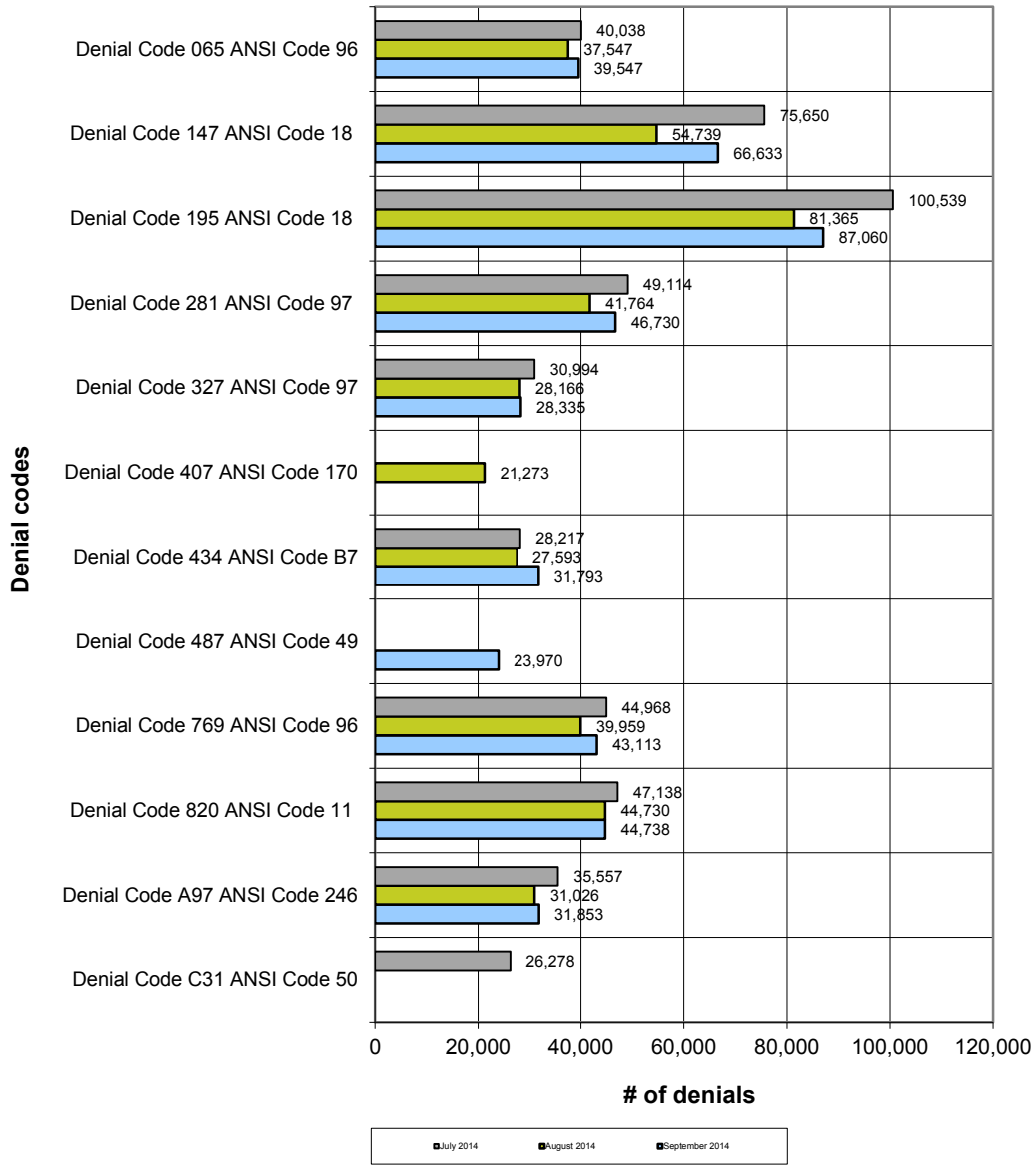
Top inquiries, rejects, and return unprocessable claims

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 July-September 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 denials for July-September 2014



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

Before contacting customer service, check claim status though 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.

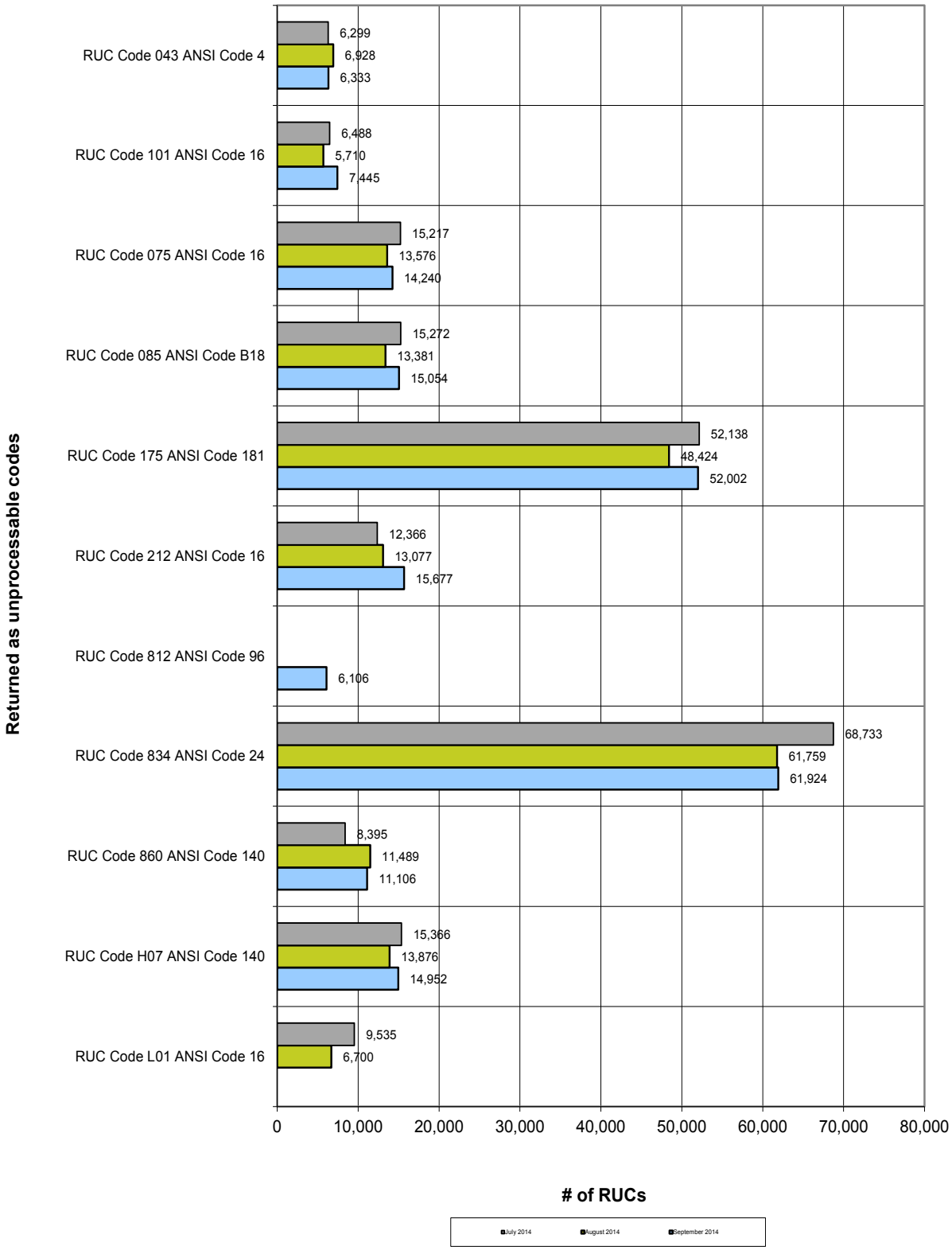
Ensure all information on a claim is correct before submitting to Medicare. **Example**: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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 July-September 2014



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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Find out first: Subscribe to First Coast eNews

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

Revised LCD

Hemophilia Clotting Factors – revision to the Part B LCD

LCD ID number: L29187 (Florida)
LCD ID number: L29345 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for hemophilia clotting factors was revised based on the Centers for Medicare & Medicaid Services (CMS) change request 8880 (October 2014 Update of the Ambulatory Surgical Center (ASC) Payment System). Healthcare Common Procedure Coding System (HCPCS) code C9135 (Factor ix [antihemophilic factor, recombinant], Alprolix, per 10 i.u.) was added to the "*CPT*®/HCPCS Codes" section of the LCD.

Additionally, based on the Food and Drug Administration's (FDA's) approval of Eloctate (antihemophilic factor VIII [recombinant], Fc Fusion Protein), HCPCS codes C9399 and J7199 were added to the "*CPT*®/HCPCS Codes" section of the LCD.

Effective date

The LCD revision to add HCPCS code C9135 is effective for services rendered **on or after October 1, 2014**. The LCD revision to add HCPCS codes C9399 and J7199 is effective for services rendered **on or after October 10, 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*.

Viscosupplementation therapy for knee – revision to the Part B LCD

LCD ID number: L29307 (Florida)
LCD ID number: L29408 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination for viscosupplementation therapy for knee has been revised based on an evaluation of the drug Monovisc™ which was approved by the Food and Drug Administration (FDA) for the treatment of pain in osteoarthritis of the knee in patients who have failed to respond adequately to conservative non-pharmacologic therapy and to simple analgesics. Monovisc™ is a sterile, non-pyrogenic, viscoelastic solution of hyaluronan contained in a single-use syringe which is equivalent to three injections of Orthovisc. A revision has been made to add HCPCS code C9399 -unclassified drugs or biologicals (Hyaluronan, Monovisc™, for intra-articular injection, single injection, 4 mL) and HCPCS code J3490-unclassified drugs (Hyaluronan, Monovisc™, for intra-articular injection, single injection, 4 mL) to the "*CPT*®/HCPCS Codes" section of the LCD. HCPCS codes C9399 and J3490 were added under the sub-heading of the "ICD-9 Codes that Support Medical Necessity" section of the LCD. Under the "Utilization Guidelines" section of the LCD, Monovisc™ was added as a medication with total dosage and description of duration of treatment. The "Sources of Information and Basis for Decision" has also been updated to add the references for this revision.

Effective date

This LCD revision is effective for claims processed **on or after September 30, 2014**, for services rendered **on or after February 25, 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*.

Additional Information

Self-administered drug (SAD) list – Part B: Tanzeum™ (albiglutide for injection) J3490/J3590/C9399

The Centers for Medicare & Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf#page=50*.

Effective for services rendered on or after December 1, 2014, the following drug has been added to the MAC J-N Part B SAD list.

- J3490/J3590/C9399 albiglutide for injection (Tanzeum™ for subcutaneous use) 30 mg

The evaluation of drugs for addition to the self-administered drug (SAD) list is an on-going process.

Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options Inc. (First Coast) SAD lists are available through the CMS Medicare coverage database at: *http://medicare.fcso.com/Self-administered_drugs/*.

Find out first: Subscribe to First Coast *eNews*

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

Upcoming provider outreach and educational events

Medicare Lunch & Learn: Modifier 25

When: Thursday, November 20
Time: 11:00 a.m.-12:30 p.m. **Type of event:** Webcast

http://medicare.fcso.com/Events/273919.asp

Medicare Lunch & Learn: Modifier 58

When: **Tuesday,** November 25
Time: **1**1:30 a.m. -12:0=30 p.m. **Type of event:** Webcast

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

SNF three-day hospital stay requirement for Model 2 of BPCI

When: **Wednesday,** December 3
Time: **11**:30 a.m.-1:00 p.m. **Type of event:** Webcast

http://medicare.fcso.com/Events/274234.asp

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

Two easy ways to register

Online – Visit our provider training website at *www.fcsouniversity.com*, 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

MLN Connects™ Provider eNews for September 25, 2014

MLN Connects™ Provider eNews for September 25, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings – Registration Opening Soon
- Hospital Appeals Settlement Update – Registration Now Open
- Transitioning to ICD-10 – Register Now
- New MLN Connects™ National Provider Call Video Slideshow

Announcements

- Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3
- National Partnership to Improve Dementia Care Exceeds Goal to Reduce Use of Antipsychotic Medications in Nursing Homes: CMS Announces New Goal
- Hospital Appeals Settlement: New FAQs Posted
- Groups: Remember to Register for 2014 PQRS GPRO Participation by September 30
- 2014 PQRS 2nd Quarter Interim Feedback Dashboard Reports Available
- 2013 PQRS and eRx Incentive Program Incentive Payments Available
- 2013 PQRS and eRx Incentive Program Feedback Reports Available
- 2012 eRx Incentive Program and 2012 PQRS Supplemental Incentive Payments Available
- Completion and Submission Timeframes for Hospice Item Set Records
- Important Skill Sets for Doctors and Nurses: CME Articles Available on Medscape
- New Resources and Webinars from National Health IT Week
- PQRS: New Quality Reporting Training Modules to Help Ensure Satisfactory 2014 Reporting
- 2014 CAHPS for PQRS Survey
- New PQRS FAQs Available
- New and Updated FAQs for the EHR Incentive Programs

Claims, Pricers, and Codes

- FDG PET for Solid Tumor Claims

MLN Educational Products

- "Medicare Billing Information for Rural Providers and Suppliers" Booklet – Revised
- "Rural Health Clinic" Fact Sheet – Revised
- "Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians" Fact Sheet – Revised
- "Critical Access Hospital" Fact Sheet – Revised
- Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

Availability of auxiliary aids and services

Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. § 794 prohibits discrimination on the basis of disability in federally assisted and federally conducted programs and activities.

For information about the availability of auxiliary aids and services, please visit *http://www.medicare.gov/about-us/nondiscrimination/nondiscrimination-notice.html*.

Medicare Learning Network®

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

MLN Connects™ Provider eNews for October 2, 2014

MLN Connects™ Provider eNews for October 2, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings – Last Chance to Register
- Hospital Appeals Settlement Update – Last Chance to Register
- Overview of the 2013 Quality and Resource Use Reports – Registration Opening Soon
- Transitioning to ICD-10 – Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript
- CMS Events
- Special Open Door Forum: Star Ratings on Dialysis Facility Compare

Announcements

- National Breast Cancer Awareness Month
- CMS Makes First Wave of Drug and Device Company Payments to Teaching Hospitals and Physicians Public
- Get Ready for DMEPOS Competitive Bidding – Common Ownership and Common Control
- PQRS GPRO Registration Extended Until October 3
- Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3

- Comply with MAC Request for Fingerprints within 30 Days
- CMS Announces Availability of 2013 Quality and Resource Use Reports
- EHR Incentive Program: CMS Attestation System Open
- ICD-10 Compliance Date Is October 1, 2015

Claims, Pricers, and Codes

- ICD-10-CM Official Guidelines for Coding and Reporting Available

MLN Educational Products

- "Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision" Fact Sheet – Revised
- "Medicare Appeals Process" Fact Sheet – Revised
- *Medicare Learning Network*® Products Available In Electronic Publication Format
- New *Medicare Learning Network*® Provider Compliance Fast Fact

Revised fact sheet on the appeals process

The *Medicare Appeals Process* fact sheet (ICN 006562) was revised and is now available in a downloadable format. This fact sheet is designed to provide education on the five levels of claim appeals in original Medicare (Medicare Part A and Part B). It includes details explaining how the Medicare appeals process applies to providers, participating physicians, and participating suppliers, in addition to including more information on available appeals-related resources.

MLN Connects™ Provider eNews for October 9, 2014

MLN Connects™ Provider eNews for October 9, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Overview of the 2013 Quality and Resource Use Reports — Registration Now Open
- CMS 2014 Certified EHR Technology Flexibility Rule — Registration Now Open
- Transitioning to ICD-10 — Register Now
- MLN Connects™ Videos
- Monthly Spotlight: Physician Quality Reporting System

Announcements

- CMS Announces Two Medicare Quality Improvement Initiatives
- New Outreach & Education Page at CMS.gov
- Work with Older Adult Patients? New Medscape Video for CME Credit
- Electronic Funds Transfer Upgrades to the Internet-based PECOS System
- Open Payments: Know the Numbers and Decode the Data
- CMS is Accepting Suggestions for Potential PQRS Measures
- PQRS: Physician Compare 2013 Group Practice Quality Measure Preview Period through November 7
- New FAQs for PQRS
- EHR Incentive Programs: Hardship Exception Applications to Avoid 2015 Payment Adjustment due November 30
- EHR Incentive Programs: Eligible Hospitals and Requirements for CEHRT to Participate in 2015
- EHR Incentive Programs: Learn How to Report 2014 eCQMs through the QualityNet Portal

MLN Educational Products

- "Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs" Fact Sheet – Revised
- *Medicare Learning Network*® Products Available in Electronic Publication Format

MLN Connects™ Provider eNews for October 16, 2014

MLN Connects™ Provider eNews for October 16, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Hospital Appeals Settlement Update 2 – Registration Opening Soon
- Overview of the 2013 Quality and Resource Use Reports – Last Chance to Register
- CMS 2014 Certified EHR Technology Flexibility Rule – Register Now
- Transitioning to ICD-10 – Register Now
- MLN Connects™ Videos
- New Videos on ICD-10: Medicare Testing Plans and Home Health Conversion
- Did You Miss the Hospital Appeals Settlement Video?

Announcements

- Proposed Rule on Conditions of Participation for HHAs – Comments due December 8
- Get Ready for DMEPOS Competitive Bidding
- Cutting-edge Colorectal Cancer Screening Now Covered

Claims, Pricers, and Codes

- Hold on Certain CAH Method II Claims for Anesthesiologist and CRNA Services
- Hold on FQHC Medicare Advantage PPS Claims

MLN Educational Products

- "Quick Reference Information: Coverage and Billing Requirements for Medicare Ambulance Transports" Educational Tool – Released
- "Reading a Professional Remittance Advice (RA)" Booklet – Released
- "Reading the Institutional Remittance Advice (RA)" Booklet – Released
- "Medicare Disproportionate Share Hospital" Fact Sheet – Revised
- "Medicare Secondary Payer Provisions" Web-Based Training Course – Revised
- "CMS Website Wheel" Educational Tool – Reminder
- "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet – Reminder
- *Medicare Learning Network*® Product Available in Electronic Publication Format

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

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

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**:** *askFloridaB@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

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

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**:** *askFloridaB@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 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

Special courier service

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

Websites

Provider

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http://medicare.fcso.com

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Centers for Medicare & Medicaid Services
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