# Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

*A Newsletter for MAC Jurisdiction N Providers*

May 2015


## In this issue



# First Coast's Web tools give denied claims the boot

Kristin Gunn is an experienced veteran in managing Medicare billing having done so for more than 27 years. With that extensive experience, Gunn says "SPOT is the greatest thing ever."

SPOT, secure provider online tool, is First Coast Service Options' free online portal for medical providers to handle multiple aspects of Medicare billing. The tool allows providers to check Medicare beneficiary eligibility and claim status. Providers also can reopen claims where clerical errors can be corrected as well as submit supporting documentation for claim redeterminations.

After 27 years of working for larger medical billing companies, Gunn started her own business in January 2015, the South Florida Revenue Cycle Specialists, LLC. She currently manages the billing for two physician practices. She says SPOT will put her in a good position to grow her business.

"The SPOT is the way to go. No more filling out forms and then having to fax or mail them in. I have used SPOT to get several claims re-opened. I cannot believe how easy it is. By using SPOT we also received those payments quicker than if we had faxed or mailed the request," Gunn said.

Recently she used SPOT to quickly handle an overpayment request involving a Medicare beneficiary who was reported deceased. "SPOT made it so easy to resolve the issue.

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> **"The SPOT is the way to go. No more filling out forms and then having to fax or mail them in. I have used SPOT to get several claims re-opened."**
>
> *-Kristin Gunn*,
> South Florida Revenue Cycle Specialists, LLC

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

# Contents



### Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.


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

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

Fax comments about this publication to:

**Medicare Publications**
**904-361-0723**

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

# 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 applicable contact section located at the end of this publication for the address in which to send written appeals requests.

## Ambulance

# Medicare Claims Processing Manual - Chapter 15, Section 40, Ambulance - Medical Conditions List

### Provider types affected

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

### What you need to know

Change request (CR) 9142 informs you that the Centers for Medicare & Medicaid Services (CMS) has moved the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Medical Conditions List and transportation indicators list in Chapter 15, Section 40 of the *Medicare Claims Processing Manual*. Make sure your billing staffs are aware of this change.


### Background

CMS issued the ICD-9-CM medical conditions list as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. In addition to the ICD-9-CM medical conditions list, CMS provided information on the appropriate use of transportation indicators.

CMS has decided to move this information from the *Medicare Claims Processing Manual*. The *Ambulance Services Center* is available at *http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html*.

There are no policy changes as a result of moving this information to the CMS website.

### Additional information

The official instruction, CR 9142, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3240CP.pdf*.

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

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Effective Date: July 27, 2015
Related CR Transmittal #: R3240CP
Implementation Date: July 27, 2015

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## Anesthesia

# Incorrect denial of anesthesia code 00810

### Issue

As a result of revisions to change request (CR) 8874, the Center for Medicare & Medicaid Services has directed Part B Medicare administrative contractors to update its claim processing systems so that:

- *00810* anesthesia services billed with modifier 33 (Preventive services) will have the deductible and coinsurance waived, even when a screening colonoscopy service (G0105 or G0121) is not in history
- *00810* anesthesia services billed with modifier PT will have the deductible waived

### Resolution

Contractors have been directed to adjust 00810 anesthesia claims for dates of service since January 1, 2015, that were:

- denied because a G0105 or G0121 screening colonoscopy service was not present in history at the time that a claim for a *00810* service billed with modifier 33
- billed with a modifier PT and denied

### Status/date resolved

Open. Adjustment of claims that have been denied should be completed no later than June 14.

### Provider action

No action is required by the provider.

### Current processing issues

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

Drugs and Biologicals

# July 2015 update to drug/biological code changes

## Provider types affected

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

## Provider action needed

This article is based on change request (CR) 9167 and informs Medicare providers about the updating of specific drug and biological HCPCS codes that occur quarterly. It alerts providers that the July file includes new HCPCS codes.

CR 9167 also updates Chapter 17, Section 20.1.2 (Average Sales Price (ASP) Payment Methodology) in the *Claims Processing Manual* to address the use of a compounded drug not otherwise classified (NOC) code on claims for compounded drugs. Make sure that your billing staffs are aware of these changes.

## Summary of new HCPCS codes in CR 9167

CR 9167 adds the following HCPCS codes with the effective dates noted.

**Table 1 – New HCPCS codes in CR 9167**

| For dates of service on or after: | Code | Long description | Short description | TOS |
|---|---|---|---|---|
| 3/6/15 | Q5101 | Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram | Inj filgrastim g-csf biosim | 1, P |
| 7/1/15 | Q9976 | Injection, Ferric | Inj Ferric | 1,L |
| 7/1/15 | Q9978 | Netupitant 300 mg and Palonosetron 0.5 mg, oral | Netupitant Palonosetron oral | 1 |
| July 1, 2015 | Q9977 | Compounded Drug, Not Otherwise Classified | Compounded Drug NOC | 1, P |

**Note**: The Medicare physician fee schedule status indicator for all four codes above is E.

CR 9167 also updates Section 20.1.2 Average Sales Price (ASP) Payment Methodology in Chapter 17 of the *Medicare Claims Processing Manual* to show that, beginning in July 2015, claims for compounded drugs should be submitted using a compounded drug, NOC HCPCS code.

## Additional information

The official instruction, CR 9167 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3254CP.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.

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Evaluation & Management

# Chronic care management services frequently asked questions

## Provider types affected

This *MLN Matters*® special edition is intended for physicians and non-physician practitioners such as certified nurse midwives (CNMs), clinical nurse specialists (CNSs), nurse practitioners (NPs), and physician assistants (PAs) who bill the Medicare fee-for-service program (original Medicare) for the new chronic care management (CCM) services provided to Medicare beneficiaries.

## Provider action needed

This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) revised the *Medicare Learning Network*® fact sheet on CCM services (ICN 909188, released in March 2015) to clarify Medicare's requirement for 24/7 access by individuals furnishing CCM services to the electronic care plan rather than the entire medical record. Also, CMS released a set of frequently asked questions (FAQs) and answers to address requests received from practitioners and providers for additional guidance in specific areas such as claims submission, intersection with transitional care management services, and the provision of CCM services in facility settings. Those FAQs appear later in this article.

## Key points

The revised fact sheet is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*. The CCM Services fact sheet is a resource that succinctly identifies the newly payable CCM service, identifies eligible providers and patients, and details the Medicare physician fee schedule (PFS) billing requirements.

## Background

CMS recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending. Beginning January 1, 2015 Medicare pays separately under the physician fee schedule (PFS) under American Medical Association *Current Procedural Terminology* (*CPT*®) *99490*, for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions.

## Frequently asked questions about billing Medicare for chronic care management services

This document answers frequently asked questions about billing CCM services to the PFS and hospital outpatient prospective payment system (OPPS) under *CPT*® *99490*.

### Physician fee schedule

1. ***CPT*® *99490* requires at least 20 minutes of time per calendar month by "clinical staff" in order to bill the code. Who qualifies as "clinical staff"? If the billing physician (or other appropriate practitioner) furnishes services directly, does their time count towards the required minimum 20 minutes of time?**

   In most cases, we believe clinical staff will provide CCM services incident to the services of the billing physician (or other appropriate practitioner who can be a physician assistant, nurse practitioner, clinical nurse specialist or certified nurse midwife). Practitioners should consult the *CPT*® definition of the term "clinical staff." In addition, time spent by clinical staff may only be counted if Medicare's "incident to" rules are met such as supervision, applicable State law, licensure and scope of practice. If the billing physician (or other appropriate billing practitioner) provides CCM services directly, that time counts towards the 20 minute minimum time. Of course, other staff may help facilitate CCM services, but only time spent by clinical staff may be counted towards the 20 minute minimum time.

2. **Can CCM services be subcontracted out to a case management company? What if the clinical staff employed by the case-management company are located outside of the United States?**

   A billing physician (or other appropriate practitioner) may arrange to have CCM services provided by clinical staff external to the practice (for example, in a case management company) if all of the "incident to" and other rules for billing CCM to the PFS are met. Because there is a regulatory prohibition against payment for non-emergency Medicare services furnished outside of the United States (42 CFR 411.9), CCM services cannot be billed if they are provided to patients or by individuals located outside of the United States.

3. **Does the billing practice have to furnish every scope of service element in a given service period, even those that may not apply to an individual patient?**

   It is our expectation that all of the scope of service elements will be routinely provided in a given service period, unless a particular service is not medically indicated or necessary (for example, the beneficiary has no hospital admissions that month so there is no management of a transition after hospital discharge).

4. **What date of service should be used on the physician claim and when should the claim be submitted?**

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The service period for *CPT® 99490* is one calendar month, and CMS expects the billing practitioner to continue furnishing services during a given month as applicable after the 20 minute time threshold to bill the service is met (see #3 above). However practitioners may bill the PFS at the conclusion of the service period or after completion of at least 20 minutes of qualifying services for the service period. When the 20 minute threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month.

**5. What place of service (POS) should be reported on the physician claim?**

Practitioners must report the POS for the billing location (i.e., where the billing practitioner would furnish a face-to-face office visit with the patient). Accordingly, practitioners who furnish CCM in the hospital outpatient setting, including provider-based locations, must report the appropriate POS for the hospital outpatient setting). Payment for CCM furnished and billed by a practitioner in a facility setting will trigger PFS payment at the facility rate.

***6. CPT® 99490* is payable to hospital outpatient departments (provider-based locations) under the hospital OPPS. Can physicians practicing in these departments or in locations that are hospital-owned (but not provider-based) also bill this code to the PFS? What if the patient is a hospital or SNF inpatient or is otherwise in a Medicare "facility" or "institution?"**

If the patient resides in a community setting and the CCM service is provided by or "incident to" services of the billing physician (or other appropriate billing practitioner) working in or employed by a hospital, *CPT® 99490* can be billed to the PFS and payment is made at the facility rate (if all other billing requirements are met). We discuss this further under the section below addressing billing for CCM furnished in the hospital outpatient department setting.

As we discussed in the 2014 PFS final rule, the resources required to provide care management services to patients in facility settings significantly overlap with care management activities by facility staff that are included in the associated facility payment. Therefore, *CPT® 99490* cannot be billed to the PFS for patients who reside in a facility (that receives payment from Medicare for care of that beneficiary, see 78 FR 74423) regardless of the location of the billing practitioner, because the payment made to the facility under other payment systems includes care management and coordination. For example, *CPT® 99490* cannot be billed to the PFS for services provided to SNF inpatients or hospital inpatients, because the facility is being paid for extensive care planning and care coordination services. However if the patient is not an inpatient the entire month, time that is spent furnishing CCM services to the patient

while they are not inpatient can be counted towards the minimum 20 minutes of service time that is required to bill for that month.

Billing practitioners in hospital-owned outpatient practices that are not provider-based departments are working in a non-facility setting, and may therefore bill *CPT® 99490* and be paid under the PFS at the non-facility rate. However, *CPT® 99490* can only be billed for CCM services furnished to a patient who is not a hospital or SNF inpatient and does not reside in a facility that receives payment from Medicare for that beneficiary.

**7. Is a new patient consent form required each calendar month or annually?**

No, as provided in the 2014 PFS final rule (78 FR 74424), a new consent is only required if the patient changes billing practitioners, in which case a new consent must be obtained and documented by the new billing practitioner prior to furnishing the service.

**8. Is Medicare now paying separately under the PFS for remote patient monitoring services described by *CPT® 99091* or similar *CPT® codes*?**

*CPT® 99091* continues to be bundled with other services for payment under the PFS. As per *CPT®* guidance, *CPT®* codes *99090*, *99091*, and other codes cannot be billed during the same service period as *CPT® 99490*. However as discussed in the 2015 PFS final rule (79 FR 67727), analysis of patient-generated health data and other activities described by *CPT® 99091* or similar codes may be within the scope of CCM services, in which case these activities would count towards the minimum 20 minutes of qualifying care per month that are required to bill *CPT® 99490*. But in order to bill *CPT® 99490*, such activity cannot be the only work that is done—all other requirements for billing *CPT® 99490* must be met in order to bill the code, and time counted towards billing *CPT® 99490* cannot also be counted towards billing other codes.

**9. If a physician arranges to furnish CCM services to his/her patients "incident to" using a case management entity outside the billing practice, does the billing physician need to ever see the patient face-to-face?**

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Yes, as provided in the 2014 final rule (78 FR 74425), CCM must be initiated by the billing practitioner during a comprehensive evaluation & management (E/M) visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the CCM service and can be separately billed to the PFS, but is required before CCM services can be provided directly or under other arrangements. The billing practitioner must discuss CCM with the patient at this visit. While informed patient consent does not have to be obtained during this visit, it is an opportunity to obtain the required consent. The face-to-face visit included in transitional care management (TCM) services (*CPT® 99495* and *99496*) qualifies as a comprehensive visit for CCM initiation. *CPT®* codes that do not involve a face-to-face visit by the billing practitioner or are not payable by Medicare (such as *CPT® 99211*, anticoagulant management, online services, telephone and other E/M services) do not meet the requirement for the visit that must occur before CCM services are furnished. If the practitioner furnishes a comprehensive E/M, AWV, or IPPE and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.

**10. Do face-to-face activities count as billable time?**

*CPT® 99490* describes activities that are not typically or ordinarily furnished face-to-face, such as telephone communication, review of medical records and test results, and consultation and exchange of health information with other providers. If these activities are occasionally provided by clinical staff face-to-face with the patient but would ordinarily be furnished non-face-to-face, the time may be counted towards the 20 minute minimum to bill *CPT® 99490*. However, see #11 below regarding care coordination services furnished on the same day as an E/M visit.

**11. Medicare and *CPT®* allow billing of E/M visits during the same service period as *CPT® 99490*. If an E/M visit or other E/M service is furnished the same day as CCM services, how do I allocate the total time between *CPT® 99490* and the other E/M code(s)?**

Under longstanding Medicare guidance, only one E/M service can be billed per day unless the conditions are met for use of modifier 25. Time cannot be counted twice, whether it is face-to-face or non-face-to-face time, and Medicare and *CPT®* specify certain codes that cannot be billed for the same service period as *CPT® 99490* (see 12 and 13). Face-to-face time that would otherwise be considered part of the E/M service that was furnished cannot be counted towards *CPT® 99490*. Time spent by clinical staff providing non-face-to-face services within the scope of the CCM service can be counted towards *CPT® 99490*. If both an E/M and the CCM code are billed on the same day, modifier 25 must be reported on the CCM claim.

**12. Medicare and *CPT®* specify that CCM and TCM cannot be billed during the same month. Does this mean that if the 30-day TCM service period ends during a given calendar month and 20 minutes of qualifying CCM services are subsequently provided on the remaining days of that calendar month, *CPT® 99490* cannot be billed that month to the PFS?**

*CPT® 99490* could be billed to the PFS during the same calendar month as TCM, if the TCM service period ends before the end of a given calendar month and at least 20 minutes of qualifying CCM services are subsequently provided during that month. However we expect that the majority of the time, CCM and TCM will not be billed during the same calendar month.

**13. Are there any other services that cannot be billed under the PFS during the same calendar month as *CPT® 99490*?**

Yes, Medicare does not allow *CPT® 99490* to be billed during the same service period as home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182) or certain ESRD services (*CPT® 90951-90970*) because care management is an integral part of all of these services. Also see *CPT®* coding guidance for a list of additional codes that cannot be billed during the same month as *CPT® 99490*. There may be additional restrictions on billing for practitioners participating in a CMS model or demonstration program; if you participate in one of these separate initiatives, please consult the CMS staff responsible for these initiatives with any questions on potentially duplicative billing.

**14. Can I bill *CPT® 99490* if the beneficiary dies during the service period?**

*CPT® 99490* can be billed if the beneficiary dies during the service period, as long as at least 20 minutes of qualifying services were furnished during that calendar month and all other billing requirements are met.

**15. Will practitioners be able to use an acceptably certified electronic health record (EHR) technology for which certification expires mid-year in order to bill for CCM? For example, can they use technology certified to the 2011 edition to fulfill the scope of services required to bill *CPT® 99490* in 2015 once this technology no longer bears a "2011 Edition certified" mark?**

Yes. Under the CCM scope of services, practitioners must use technology certified to the edition(s) of certification criteria that is acceptable for the EHR incentive programs as of December 31st of the year preceding each CCM payment year. In certain years, this may mean that practitioners can fulfill the scope of services requirement using multiple Editions of certification criteria. For instance, for payment in 2015, practitioners may use technology certified to either the 2011 or 2014 Edition of certification criteria to meet the EHR scope of service requirements, as both editions

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could be used to meet the requirements of the EHR incentive programs as of December 31, 2014. This remains true for a given PFS payment year even after ONC-Authorized Certification Bodies (ONC-ACBs) have removed the certifications issued to technology certified to a given acceptable edition (e.g., the 2011 Edition for CCM payment in 2015) as a result of the relevant criteria being removed from the *Code of Federal Regulations*. Thus, practitioners using an acceptable EHR technology that loses its certification mid-year may still use that technology to fulfill the certified EHR criteria for billing *CPT® 99490* during the applicable payment year.

**16. Does the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) affect the billing rules for CCM services?**

No, Section 103 of the MACRA codifies payment broadly for chronic care management services under the PFS, authorizing PFS payment after January 1, 2015, for CCM services furnished by physicians and the non-physician practitioners that Medicare generally recognizes to furnish and bill for E/M services (physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives). It does not impact the current billing and payment rules for *CPT® 99490*. It provides that provision of an AWV or IPPE in advance shall not be a condition of payment for CCM services, which is consistent with our current policy. It also provides that payment shall not be duplicative of other Medicare payments, consistent with the rules we have implemented to date regarding duplicative payment for *CPT® 99490*.

**17. Where can I find more guidance on CCM billing requirements?**

A fact sheet on CCM is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*. The scope of service elements and other requirements for billing CCM to the PFS are also laid out in the 2014 and 2015 PFS final rules (CMS-1600-FC, CMS-1612-FC and CMS-1612-F2, available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*). Most of the requirements were finalized in the 2014 PFS final rule, effective 2015. The 2015 final rule with comment period and correction notice address supervision and other "incident to" rules, electronic health record and other electronic technology requirements, valuation, and intersection with CMS' care coordination models and demonstrations. Regarding the intersection with CMS' care coordination models and demonstrations, please consult the CMS staff responsible for those projects. You may also direct questions to your Medicare administrative contractor.

## Hospital outpatient prospective payment system (OPPS)

**18. Are hospital outpatient departments (HOPDs) eligible to bill *CPT® 99490* under the OPPS?**

Yes, *CPT® 99490* is payable under the OPPS when certain requirements are met (see details in question #19 on billing requirements). As *CPT® 99490* is defined as a physician-directed service, the OPPS provides payment to the HOPD when the hospital's clinical staff furnishes the service at the direction of the physician (or other appropriate practitioner). Payment under the OPPS represents only payment for the facility portion of the service. Payment for the physician's (or other appropriate practitioner's) time directing CCM services in the HOPD setting is made under the PFS at the facility rate.

**19. What are the requirements to bill CCM under the OPPS?**

*CPT® 99490* is a physician-directed service that is only payable under the OPPS when the hospital's clinical staff furnishes the service at the direction of the physician (or other appropriate practitioner). The billing physician or practitioner directing the CCM services must meet the requirements to bill CCM services under the PFS, when the CCM service is furnished in the physician office or the hospital outpatient department. A fact sheet on CCM including requirements to bill CCM services to the PFS is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*. Specifically, a hospital outpatient department may bill and be paid for CCM services furnished to eligible hospital outpatients under the OPPS if the hospital's clinical staff furnishes at least 20 minutes of care management services under the direction of the physician (or other appropriate practitioner) during the calendar month and the billing physician or practitioner directing the CCM services satisfies the billing requirements for *CPT® 99490* under the PFS including the following requirements:

- **Patient eligibility**: Patient has multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

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- **Patient agreement**: Patient consent to receive CCM services has been obtained by the practitioner and documented in the medical record.
- CCM scope of service elements including structured data reporting, care plan, access to care, and care management of the patient are furnished by the hospital. The full listing of required CCM Scope of Service Elements is located in the 2014 and 2015 PFS final rules (CMS-1600-FC, CMS-1612-FC and CMS-1612-F2, available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*).
- Hospital furnished the CCM services using a version of certified EHR that is acceptable under the EHR incentive programs as of December 31st of the calendar year preceding each Medicare PFS payment year (**referred to as "CCM certified technology"**). The hospital must also meet the requirements to use electronic technology in providing CCM services, such as 24/7 access to the care plan, and electronic sharing of the care plan and clinical summaries (other than by fax), specified in the 2014 and 2015 PFS final rules.

**20. How does CMS define a "hospital outpatient" for whom a hospital may bill CCM services (*CPT® 99490*)?**

Per section 20.2 of publication 100-04 of the *Medicare Claims Processing Manual*, a hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital. Since *CPT® 99490* will ordinarily be performed non face-to-face (see # 10 above), the patient will typically not be a registered outpatient when receiving the service. In order to bill for the service, the hospital's clinical staff must provide at least 20 minutes of CCM services under the direction of the billing physician or practitioner. Because the beneficiary has a direct relationship with the billing physician or practitioner directing the CCM service, we would expect a beneficiary to be informed that the hospital would be performing care management services under their physician or other practitioner's direction.

**21. When CCM services are furnished by a physician in a hospital outpatient department, can the physician and the hospital both bill Medicare for the CCM service?**

Yes, when certain conditions are met. Specifically, when CCM services are furnished by a physician in a hospital outpatient department to an eligible patient, the physician may bill Medicare for *CPT® 99490* under the PFS reporting place of service (POS) 22 (outpatient hospital), which will indicate that PFS payment should be made at the facility rate, and the hospital may bill for *CPT® 99490* under the OPPS.

**22. Can more than one hospital bill and be paid for furnishing CCM services if the patient has been a registered hospital outpatient at more than one hospital over a 12-month span? If only one hospital can bill and receive payment for CCM services, which hospital is allowed to bill?**

*CPT® 99490* is only payable under the OPPS when the hospital's clinical staff furnishes the CCM service at the direction of a qualified physician (or other appropriate practitioner). As only one physician or practitioner is allowed to bill under the PFS for *CPT® 99490* during a calendar month service period, accordingly, only one hospital is allowed to bill and be paid for *CPT® 99490* for a particular beneficiary during a calendar month service period. We would expect the hospital billing for *CPT® 99490* under physician direction to have access to the patient's consent to receive CCM services documented in the patient's medical record. The patient may choose a different practitioner to furnish CCM at the conclusion of the service period, at which time the practitioner assuming the provision of CCM services will be required to have the patient consent of CCM services documented in the patient's medical record. New patient consent is only required if the patient chooses a new practitioner to furnish CCM services, in which case a new consent must be documented in the patient's medical record prior to furnishing the service.

**23. Is *CPT® 99490* payable to provider-based hospital outpatient departments under the hospital OPPS? May a hospital-owned practice that is not provider-based bill the OPPS for CCM services?**

A provider-based outpatient department of a hospital is part of the hospital and therefore may bill for CCM services furnished to eligible patients, provided that it meets all applicable requirements. A hospital-owned practice that is not provider-based to a hospital is not part of the hospital and, therefore, not eligible to bill for services under the OPPS; but the physician (or other qualifying practitioner) practicing in the hospital-owned practice may bill under the PFS for CCM services furnished to eligible patients, provided all PFS billing requirements are met.

**24. What is the supervision level for CCM services furnished in the hospital setting?**

*CPT® 99490* is assigned a general supervision level under the OPPS when furnished in the hospital setting. General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

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# Payment errors for chronic care management

As of January 1, 2015, the Centers for Medicare and Medicaid Services (CMS) has created a new *Current Procedural Terminology*® (*CPT*®) code for chronic care management (CCM): *99490*. First Coast's data analysis reveals that providers are improperly billing this service. In response to these findings, First Coast will be implementing edits within the claim processing system to avoid improper payment for CCM services that do not meet CCM service guidelines.

This article reviews specific points that providers should consider regarding CCM guidelines, along with a link to a *Medicare Learning Network*® (*MLN*®) article that outlines the CCM guidelines in more detail.

## Provider eligibility

- Only one provider may be paid for the CCM service for a given calendar month. CCM may be billed most frequently by primary care physicians, although specialty physicians who meet all of the billing requirements may bill the service
  - CCM is not within the scope of certain practitioners
- Only clinical staff may provide CCM
  - General supervision requirements apply to CCM services

## Patient eligibility

- Patients with two or more chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline are eligible for the CCM service
- A provider must have seen a patient for either an annual wellness visit (AWV), an initial preventive physical examination (IPPE) or a comprehensive level of evaluation and management (E/M) visit prior to providing CCM
  - Based on this examination, a provider may identify the need for CCM, and must document the patient's acceptance and awareness of this arrangement along with additional specific points regarding CCM
  - CCM must ensure 24-hour-a-day, seven-day-a-week access to care management services, providing the patient with a means to make timely contact with health care practitioners in the practice who have access to the patient's health record to address his or her urgent chronic care needs

## CCM billing and documentation guidelines

- *CPT*® *99490* cannot be billed during the same calendar month as:
  - *CPT*® *99495-99496* (transitional care management) or *90951-90970* (certain end-stage renal disease services)
  - Healthcare Common Procedure Coding System (HCPCS) codes G0181/G0182 (home health care supervision/hospice care supervision)
- CCM requires at least 20 minutes of clinical staff time directed by the practitioner to qualify for billing the service
  - This time may accumulate throughout the month, and once the 20 minute requirement has been fulfilled, the related claim may be billed (i.e., at any time during the month)
- CMS requires the use of certified electronic health record (EHR) technology to satisfy certain CCM scope of service elements

For additional information on the CCM points listed above, please see the *MLN*® article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*.

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### Additional information

To review the provisions included in the 2015 PFS proposed rule go to: *http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-07-03-1.html* and scroll down to read the section titled: Primary Care and Complex Chronic Care Management.

To review the revisions to payment policies under the PFS, clinical laboratory fee schedule and other revisions to Part B for 2014 (CMS-1600-FC) go to page 186: *CMS-1600-FC (PDF version)*.

Page 10 of the CCM services fact sheet outlines a comprehensive list of resources with Web addresses for additional information on CCM services.

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Implementation Date: N/A

Laboratory/Pathology

# Edit correction on anti-markup and reference laboratory claims

## Provider types affected

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

## Provider action needed

Change request (CR) 9150 instructs the maintainer of Medicare's multi-carrier system (MCS) to correct edit 043H that was incorrectly coded under CR 8806 (Transmittal 3103, issued November 13, 2014). This CR also delays implementation of CR 8806 until October 1, 2015. Make sure that your billing staffs are aware of this correction.

## Background

CR 8806 implemented a new policy that physicians and other suppliers would no longer be permitted to submit their own national provider identifier (NPI) in Item 32a of the CMS-1500 claim form for anti-markup and reference laboratory claims when the performing physician or supplier is located in another jurisdiction. CR 8806 instructed MACs to return reference laboratory and anti-markup claims as unprocessable when the billing and service location NPIs match. The MCS created edit 043H to satisfy this requirement.

It has come to the attention of the Centers for Medicare & Medicaid Services (CMS) that edit 043H is erroneously comparing the rendering physician NPI in Item 24J of the CMS-1500 to the service location NPI, rather than comparing the billing NPI to the service location NPI. CR 9150 instructs the MCS to correct edit 043H to compare the billing NPI to the service location NPI. CR 9150 also delays implementation of CR 8806 until October 1, 2015. Effective for claims with a receipt date on or after October 1, 2015, MACs will return reference laboratory and anti-markup claims as unprocessable when the billing and service location NPIs match.

## Additional information

The official instruction, CR 9150 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3255CP.pdf*.

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

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Implementation Date: October 5, 2015

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### Respond to ADR requests on the SPOT

The SPOT allows users to respond promptly to prepay claim additional development response (ADR) requests … *online*. ADRs and any required documentation may be submitted from SPOT to First Coast's e-documentation system.

Surgery

# Transcatheter mitral valve repair national coverage determination

***Note**: This article was revised April 26, 2015, due to the release of an updated change request (CR). That CR removed the text concerning billing TMVR for MR with modifier 62 (and from the "Coding requirements/claim processing requirements" section). The CR release date, transmittal number, and link to the transmittal was also changed. This information was previously published in the January 2015 Medicare B Connection, Page 33.*

## Provider types affected

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

## Provider action needed

Effective for claims with dates of service furnished on or after August 7, 2014, the Centers for Medicare & Medicaid Services (CMS) will reimburse claims for TMVR for mitral regurgitation (MR) when furnished under coverage with evidence development (CED).

## Background

TMVR is a new technology for use in treating MR. MR occurs when the leaflets of the mitral valve do not close properly and blood flows from the left ventricle back into the left atrium, causing the heart to work harder to pump. This, in turn, causes enlargement of the left ventricle and can lead to potential heart failure.

Abbott's MitraClip, the only U.S. Food and Drug Administration (FDA)-approved TMVR device, involves clipping together a portion of the mitral valve leaflets. This is performed under general anesthesia, with delivery of the device typically through a percutaneous transvenous approach, via echocardiographic and fluoroscopic guidance. The procedure is performed in a cardiac catheterization laboratory or hybrid operating room/cardiac catheterization laboratory with advanced quality imaging. TMVR is covered for uses not listed as an FDA-approved indication when performed in approved clinical studies which meet certain study question requirements. The TMVR procedure must be performed by an interventional cardiologist or cardiac surgeon, or they may jointly participate in the intraoperative technical aspects, as appropriate.

On August 7, 2014, CMS issued a final decision memorandum covering TMVR for MR under CED for the treatment of MR when furnished for an FDA-approved indication with an FDA-approved device as follows:

- Treatment of significant, symptomatic, degenerative MR when furnished according to an FDA-approved indication, and all CMS coverage criteria are met; and
- TMVR for MR uses not expressly listed as FDA-approved indications but only within the context of an FDA-approved, randomized clinical trial that meets all CMS coverage criteria.

CED requires that each patient be entered into a qualified national registry. In addition, prior to receiving TMVR, face-to-face examinations of the patient are required by a cardiac surgeon and a cardiologist experienced in mitral valve surgery to evaluate the patient's suitability for TMVR and determination of prohibitive risk, with documentation of their rationale.

The NCD lists the criteria that must be met prior to beginning a TMVR program and after a TMVR program is established. No NCD existed for TMVR for MR prior to August 7, 2014, and TMVR is non-covered outside CED or for non-MR indications. The Web address for accessing the NCD transmittal is available in the *Additional information* section at the end of this article.

CR 9002 revises the *Medicare Claims Processing Manual*, Chapter 32, Section 340 (Transcatheter Mitral Valve Repair (TMVR)), and the *National Coverage Determinations (NCD) Manual*, Chapter 20, Section 20.33 (Transcatheter Mitral Valve Repair (TMVR) which are included in CR 9002.

**Based on the NCD, TMVR must be furnished in a hospital with the appropriate infrastructure that includes but is not limited to:**

- On-site active valvular heart disease surgical program with >2 hospital-based cardiothoracic surgeons experienced in valvular surgery;
- Cardiac catheterization lab or hybrid operating room/catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering catheterization laboratory-quality imaging;
- Non-invasive imaging expertise including transthoracic/transesophageal/3D echocardiography, vascular studies, and cardiac CT studies;
- Sufficient space, in a sterile environment, to accommodate necessary equipment for cases with and without complications;
- Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures;
- Adequate outpatient clinical care facilities; and
- Appropriate volume requirements per the applicable qualifications below.

**There are institutional and operator requirements for performing TMVR. The hospital must have the following:**

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- A surgical program that performs ≥25 total mitral valve surgical procedures for severe MR per year of which at least 10 must be mitral valve repairs;
- An interventional cardiology program that performs ≥1000 catheterizations per year, including ≥400 percutaneous coronary interventions (PCIs) per year, with acceptable outcomes for conventional procedures compared to National Cardiovascular Data Registry (NCDR) benchmarks;
- The heart team must include:
  1. An interventional cardiologist(s) who:
     - Performs ≥50 structural procedures per year including atrial septal defects ASD), patent foramen ovale (PFO) and trans-septal punctures; and,
     - Must receive prior suitable training on the devices to be used; and
     - Must be board-certified in interventional cardiology or board-certified/eligible in pediatric cardiology or similar boards from outside the United States.
  2. Additional members of the heart team, including cardiac echocardiographers, other cardiac imaging specialists, heart valve and heart failure specialists, electrophysiologists, cardiac anesthesiologists, intensivists, nurses, nurse practitioners, physician assistants, data/research coordinators, and a dedicated administrator.
- All cases must be submitted to a single national database;
- Ongoing continuing medical education (or the nursing/ technologist equivalent) of 10 hours per year of relevant material; and
- The cardiothoracic surgeon(s) must be board-certified in thoracic surgery or similar foreign equivalent.
- The heart team's interventional cardiologist or a cardiothoracic surgeon must perform the TMVR. Interventional cardiologist(s) and cardiothoracic surgeon(s) may jointly participate in the intra-operative technical aspects of TMVR as appropriate.

The heart team and hospital must be participating in a prospective, national, audited registry that: 1) consecutively enrolls TMVR patients; 2) accepts all manufactured devices; 3) follows the patient for at least one year; and, 4) complies with relevant regulations relating to protecting human research subjects, including *45 Code of Federal Regulations* (CFR) Part 46 and 21 CFR Parts 50 & 56. For complete details on the outcomes that must be tracked by the registry and the data that must be provided to the registry, see the CR 9002 NCD transmittal. The Web address for that transmittal is in the *Additional information* section at the end of this article.

## Coding requirements/claim processing requirements

### Coding requirements for TMVR for MR claims furnished on or sfter August 7, 2014

The *Current Procedural Terminology* (*CPT*®) codes for TMVR for MR claims are:

- *0343T*: *Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; initial prosthesis.* (**Note**: *0343T* will be replaced by *CPT® 33418* effective January 1, 2015.)
- *0344T*: *Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure).* (**Note**: *0344T* will be replaced by *CPT® 33419* effective January 1, 2015.)
- *0345T*: *Transcatheter mitral valve repair percutaneous approach via the coronary sinus*
- *33418*: *Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis.* (**Note**: *CPT® 33418* is effective January 1, 2015.)
- *33419*: *Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session. (List separately in addition to code for primary procedure.)* (**Note**: *CPT® 33419* is effective January 1, 2015.)

### ICD-9/ICD-10 codes for TMVR for MR claims

The ICD-9 (and upon ICD-10 implementation)/ ICD-10 codes are:

- ICD-9 procedure code - 35.97 - Percutaneous mitral valve repair with implant - and ICD-10 procedure code is 02UG3JZ – Supplement mitral valve with synthetic substitute, percutaneous approach and
- ICD-9 diagnosis code for TMVR for MR claims is - 424.0 – mitral valve disorder and ICD-10 diagnosis codes are

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I34.0 – nonrheumatic mitral (valve)insufficiency or I34.8 – other nonrheumatic mitral valve disorders.

### Professional claims place of service (POS) codes for TMVR for MR claims

Effective for claims with dates of service on and after August 7, 2014, place of service (POS) code 21 is valid for use for TMVR for MR services. All other POS codes will be denied. MACs will supply the following messages when MACs denying TMVR for MR claims for invalid POS:

- **Claim adjustment reason code (CARC) 58**: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **Group code CO (contractual obligation)** assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed advance beneficiary notice (ABN) is on file.)


### Professional claim modifiers for TMVR for MR claims

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with *CPT*® codes *0343T, 0344T*, and *0345T* in a clinical trial when billed with modifier Q0. (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® *0343T* and *0344T*, respectively.) TMVR for MR claim lines in a clinical trial billed without modifier Q0 will be returned as unprocessable. MACs will supply the following messages when returning TMVR for MR claim lines in a clinical trial billed without modifier Q0 as unprocessable:

- **CARC 4**: "The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N517**: "Resubmit a new claim with the requested information."
- **Group code**: CO

### Professional clinical trial diagnostic coding for TMVR for MR claims

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with *CPT*® codes *0343T, 0344T*, and *0345T* in a clinical trial when billed with ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6). (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.) TMVR for MR claim lines in a clinical trial billed without ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6) will be denied.

MACs will supply the following messages when denying TMVR for MR claim lines in a clinical trial billed without secondary ICD-9 diagnosis code V70.7(ICD-10=Z00.6) as unprocessable:

- **CARC 50**: "These are non-covered services because this is not deemed a "medical necessity" by the payer."
- **RARC N386**: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- **Group code**: CO

### Mandatory national clinical trial (NCT) number for TMVR for MR claims

Effective for claims with dates of service on or after August 7, 2014, contractors shall pay TMVR for MR claim lines billed with *CPT*® codes *0343T*, *0344T*, and *0345T* in a clinical trial only when billed with an eight-digit national clinical trial (NCT) number. (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.) MACs shall accept the numeric, 8-digit NCT number preceded by the two alpha characters of "CT" when placed in Field 19 of paper Form CMS-1500, or when entered WITHOUT the "CT" prefix in the electronic 837P in Loop 2300 REF02 (REF01=P4). NOTE: The "CT" prefix is required on a paper claim, but it is not required on an electronic claim. TMVR for MR claim lines in a clinical trial billed without an 8-digit NCT number shall be returned as unprocessable. MACs will supply the following messages when returning TMVR for MR claim lines as unprocessable when billed without an eight-digit NCT number:

- **CARC 16**: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)"
- **RARC MA50**: "Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services."
- **Group code**: CO

### Claims processing requirements for TMVR for MR on inpatient hospital claims

Inpatient hospitals shall bill for TMVR for MR on a 11x type of bill (TOB) effective for discharges on or after August 7,

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2014. In addition to the ICD-9/10 procedure and diagnosis codes mentioned above, inpatient hospital discharges for TMVR for MR shall be covered when billed with the following clinical trial coding:

- Secondary ICD-9 diagnosis code V70.7/ICD-10 diagnosis code Z00.6;
- Condition code 30; and
- An 8-digit NCT Number assigned by the National Library of Medicine (NLM) and displayed at *https://clinicaltrials.gov/*.

Inpatient hospital discharges for TMVR for MR will be rejected when billed without the ICD-9/ICD-10 diagnosis and procedure codes and clinical trial coding mentioned above. Claims that do not include these required codes shall be rejected with the following messages:

- **CARC 50**: "These are non-covered services because this is not deemed a "medical necessity" by the payer."
- **RARC N386**: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- **Group code**: Contractual obligation (CO)

### Additional Information

The official instruction, CR 9002, issued to your MAC regarding this change consists of two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3241CP.pdf*. The second updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R178NCD.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.

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## General Coverage

# Patient eligibility requirements for home health services

***Note**: This article was revised April 22, 2015, to reflect an updated change request (CR). That CR revised the effective date from May 11, 2015, to January 1, 2015. The CR release date, transmittal numbers and links to the transmittals also changed. All other information remains the same. This information was previously published in the April 2015 Medicare B Connection, Page 20.*

### Provider types affected

This *MLN Matters*® article is intended for physicians, non-physician practitioners (NPPs), and home health agencies (HHAs) that submit claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs for services provided to Medicare beneficiaries.

### Provider action needed

CR 9119 manualizes policies discussed in the 2015 home health prospective payment system (HH PPS) final rule published November 6, 2014. CR 9119 instructs MACs to be aware of the revisions to the requirements for physician certification and recertification of patient eligibility for Medicare home health services.

MACs are also instructed to be aware of the revised timeframe for therapy functional reassessments. Make sure that your billing staffs are aware of these changes.

### Background

The Centers for Medicare & Medicaid Services (CMS) finalized clarifications and revisions to policies regarding physician certification and recertification of patient eligibility for Medicare home health services in the 2015 HH PPS final rule which was published November 6, 2014 (see *http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf*). In the final rule, CMS also finalized revisions to the timeframe required for therapy functional reassessments.

#### Face-to-face encounter requirements

The Affordable Care Act requires that the certifying physician or allowed NPP must have a face-to-face encounter with the beneficiary before they certify the beneficiary's eligibility for the home health benefit.

CMS is implementing the following three changes to the face-to-face encounter requirements for episodes beginning on or after January 1, 2015. These changes will reduce administrative burden and provide HHAs with additional flexibilities in developing individual agency procedures for obtaining documentation supporting patient eligibility for Medicare home health care.

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- CMS is eliminating the narrative requirement. The certifying physician is still required to certify (attest) that a face-to-face patient encounter occurred and document the date of the encounter as part of the certification of eligibility. For medical review purposes, Medicare requires documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) to be used as the basis for certification of patient eligibility.
- If a HHA claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services.
- CMS is clarifying that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care assessment is completed to initiate care.

### Therapy reassessments

CMS has eliminated the 13th and 19th visit therapy reassessment requirements. Forepisodes beginning on or after January 1, 2015; at least every 30 calendar days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient. This policy change will lessen HHAs' burden of counting visits.

This change will reduce the risk of non-covered visits so that therapists can focus more on providing quality care for their patients, while still promoting therapist involvement and quality treatment for all beneficiaries regardless of the level of therapy provided.

## Additional information

The official instruction, CR 9119, consists of two

transmittals. The first updates the *Medicare General Information, Enrollment and Entitlement Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R92GI.pdf*. The second transmittal updates the *Medicare Benefit Policy Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R208BP.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: MM9119 *Revised*
Related Change Request (CR) #: CR 9119
Related CR Release Date: April 22, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R92GI and R208BP
Implementation Date: May 11, 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.*

# Update for remittance advice remark and claims adjustment reason code and MREP and PC Print

## Provider types affected

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

## Provider action needed

This article is based on change request (CR) 9125, which updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if they use that software.

## Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or policy information, which generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and shared system maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 9125, MACs will implement on the date specified on the WPC website. The WPC website is available at *http://www.wpc-edi.com/Reference*.

CR 9125 lists only the changes that have been approved since the last code update CR (CR 9004 issued January 9, 2015, with a related *MLN Matters*® article available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9004.pdf*), and does not provide a complete list of codes for these two code sets. The complete list for both CARC and RARC from the WPC website is updated three times a year – around March 1, July 1, and November 1. The WPC website, which has four listings available for both CARC and RARC, is available at *http://www.wpc-edi.com/Reference*.

In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version should be implemented.

**Note**: This recurring code update CR lists only the changes approved since the last recurring code update CR once. If any modification or deactivation becomes effective at a future date, MACs must make sure that they update on the effective date or the quarterly release date that matches the effective date as posted on the WPC website.

### Changes in CARC list since CR 9004

The following tables are changes in the CARC database since the last code update in CR 9004.

### New codes – CARC

| Code | Modified narrative | Effective date |
|---|---|---|
| 269 | Anesthesia not covered for this service/procedure. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | 03/01/2015 |

### Modified codes – CARC

| Code | Modified narrative | Effective date |
|---|---|---|
| 45 | Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability) This change effective 11/1/2015: Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement. **Note**: this must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability) | 03/01/2015 |

See **RARC**, next page

# RARC

From previous page

| Code | Modified narrative | Effective date |
|---|---|---|
| 55 | Procedure/treatment/drug is deemed experimental/ investigational by the payer. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | 03/01/2015 |
| 133 | The disposition of this service line is pending further review. (Use only with Group Code OA). **Note**: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837). | 03/01/2015 |
| 267 | Claim/service spans multiple months. Rebill as separate claim/service. This change effective 9/1/2015: Claim/ service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) | 04/01/2015 |

## Deactivated codes – CARC

| Code | Current narrative | Effective date |
|---|---|---|
| A7 | Presumptive Payment Adjustment | 07/01/2015 |

## Changes in RARC list since CR 9004

The following tables are changes in the RARC database since the last code update in CR 9004.

## New codes – RARC

| Code | Modified narrative | Effective date |
|---|---|---|
| N736 | Incomplete/invalid Sleep Study Report. | 03/01/2015 |
| N737 | Missing Sleep Study Report. | 03/01/2015 |
| N738 | Incomplete/invalid Vein Study Report. | 03/01/2015 |
| N739 | Missing Vein Study Report. | 03/01/2015 |
| N740 | The member's Consumer Spending Account does not contain sufficient funds to over the member's liability for this claim/service. | 03/01/2015 |


| Code | Modified narrative | Effective date |
|---|---|---|
| N741 | This is a site neutral payment. | 03/01/2015 |
| N742 | Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at *http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html* on the CMS website. | 03/01/2015 |
| N743 | Adjusted because the services may be related to an employment accident. | 03/01/2015 |
| N744 | Adjusted because the services may be related to an auto accident. | 03/01/2015 |
| N745 | Missing Ambulance Report. | 03/01/2015 |
| N746 | Incomplete/invalid Ambulance Report. | 03/01/2015 |
| N747 | This is a misdirected claim/ service. Submit the claim to the payer/plan where the patient resides. | 03/01/2015 |
| N748 | Adjusted because the related hospital charges have not been received. | 03/01/2015 |
| N749 | Missing Blood Gas Report. | 03/01/2015 |
| N750 | Incomplete/ invalid Blood Gas Report. | 03/01/2015 |
| N751 | Adjusted because the drug is covered under a Medicare Part D plan. | 03/01/2015 |
| N752 | Missing/incomplete/ invalid HIPPS Treatment Authorization Code (TAC). | 03/01/2015 |

See **RARC**, next page

# RARC

From previous page

### Modified codes – RARC

| Code | Modified narrative | Effective date |
|---|---|---|
| N10 | Adjustment based on the findings of a review organization/professional consult/manual adjudication/ medical advisor/dental advisor/peer review. | 3/01/2015 |

### Deactivated codes – RARC

| Code | Current narrative | Effective date |
|---|---|---|
| N483 | Missing Periodontal Charts | 05/01/2015 |
| N484 | Incomplete/invalid Periodontal Charts. | 05/01/2015 |
| N29 | Missing documentation/ orders/notes/summary/ report/chart | 03/01/2016 |
| N225 | Incomplete/invalid documentation/orders/notes/ summary/report/chart | 03/01/2016 |

The full CARC and RARC lists must be downloaded from the WPC website available at *http://wpc-edi.com/Reference*.

## Additional Information

The official instruction, CR 9125 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3242CP.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: MM9125
Related Change Request (CR) #: CR 9125
Related CR Release Date: April 27, 2015
Effective Date: July 1, 2015
Related CR Transmittal #:R3242CP
Implementation Date: July 6, 2015

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## Quarterly provider update

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

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

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

# Section 504: Implement national Medicare summary notices (MSNs) in alternate formats

## Provider types affected

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

## What you need to know

Change request (CR) 9153 alerts providers that the Centers for Medicare & Medicaid Services (CMS) has designated the MACs as responsible for printing requests for large print Medicare summary notices (MSNs) that are sent to beneficiaries in aternate formats, and to have a third party contractor responsible for requests for braille, CD-ROM, and audio alternate formats. MACs are required to produce large print MSNs for beneficiaries in their respective jurisdictions who prefer large print MSNs.

## Background

CMS has an obligation to provide the MSN in alternate formats for beneficiaries who elect one of the formats as a preference. CMS has been working on the alternate format project for several years. Most recently, CMS has directed MACs to provide MSNs to a subset of beneficiaries through a manual process. CR 9153 implements the MAC requirements to produce large print MSNs for beneficiaries with that preference in their respective jurisdictions.

Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794 forbids Executive Agencies and recipients of Federal financial assistance from excluding individuals with disabilities or denying them an equal opportunity to receive program benefits and services.

## Additional information

The official instruction, CR 9153, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1499OTN.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: MM9153
Related Change Request (CR) #: CR 9153
Related CR Release Date: May 8, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R1499OTN
Implementation Date: October 5, 2015

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## TOOLS

From front page

We checked the physician's records to see if we billed an incorrect patient number among other things. Then I checked the eligibility tab on SPOT, checked the date of death and compared the date of service. I made a screen print from SPOT and sent it through the secure mail. "You hit 'send'. Boom. There it goes. No visits to the post office."

Gunn uses three SPOT tools primarily. She says she is particularly fond of the claim status window. "The claim status check is my favorite thing on SPOT. I go in with the ICN number. I can do a reopening if I need to make a change to a modifier or other field. I don't have to dial the phone to reopen the claim." With SPOT, Part B providers may change a date of service, diagnosis code, procedure code, modifier, or units billed through a clerical reopening of a claim.

Before starting her own business, Gunn worked for a large medical billing company that used other software products to handle Medicare claims. When one billing company merged with her employer, she decided to become her own boss. "I knew about SPOT, but had not used it until I started on my own business."

Gunn says she has signed up for several of the *online learning classes* to gain continuing education credits. She also plans to use First Coast's learning center to brush up on many of the features available through SPOT

### Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "*Where do I find*" page.

# Clarification of ordering and certifying documentation maintenance requirements

## Provider action needed

This *MLN Matters*® article is based on change request (CR) 9112 which clarifies the term "access to documentation" in Chapter 15, Section 15.18 of the *Program Integrity Manual (PIM)*. Make sure that your billing staffs are aware of this change.

## Background

Under *42 CFR § 424.516(f)(1)*, a provider or supplier that furnishes covered ordered DMEPOS items, clinical laboratory services, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for seven years from the date of service, and
- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the national provider identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for DMEPOS items and clinical laboratory, imaging, and home health services.

## Key points in CR 9112

### Maintaining and providing access to documentation

CMS or a Medicare contractor may request access to documentation as described in 42 CFR § 424.516(f). The term "access to documentation" means that the documentation is actually provided or made available in the manner requested by CMS or a Medicare contractor.

All providers and suppliers who either furnish, order, or certify DMEPOS items, clinical laboratory services, imaging services, or covered ordered/certified home health services are subject to this requirement and are individually responsible for maintaining these records and providing them upon request.

CMS recognizes that providers and suppliers often rely upon an employer or another entity to maintain these records on their behalf. However, it remains the responsibility of the individual or entity upon whom/which the request has been made to provide documentation.

All individuals and entities subject to this documentation requirement are responsible for ensuring that documents are provided upon request and may ultimately be subject to the revocation basis associated with not complying with the documentation request.

### Examples

To illustrate, if a Medicare contractor requests copies of all orders for wheelchairs from an ordering physician for all beneficiaries with dates of service from November 1, 2014, through November 10, 2014, the ordering physician must provide the copies, in full, according to the specific request. If copies cannot be provided because the physician or eligible professional did not personally maintain the records or can only be partially provided, then the requirement to maintain this documentation and provide access to it will not have been met and the provider, supplier, physician, or eligible professional may be subject to the revocation basis set forth in 42 CFR § 424.535(a)(10).

**Table 1: Examples of sufficient and deficient access**

| Sufficient access | Deficient access |
|---|---|
| All documentation requested | Providing none of the requested documentation |
| Documentation specific to the order(s) or certification(s), as requested | Providing only a portion of the requested documentation |
| Documentation for the dates of service or billing periods requested | Providing similar documentation that does not contain the order or certification requested |
| | Providing other documents **not** requested by CMS or a Medicare contractor and/or not specifically directing attention to the requested documentation |

## Additional information

The official instruction, CR 9112 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R587PI.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: MM9112
Related CR Release Date: April 17, 2015
Related Transmittal #: R587PI
Change Request (CR) #: CR 9112
Implementation Date: July 20, 2015
Effective Date: July 20, 2015

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# Physicians and non-physician practitioners reported on Part A critical access hospital claims

## Provider types affected

This *MLN Matters*® article is intended for critical access hospitals (CAHs), method II providers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

## Provider action needed

This is a reminder that CAHs, method II claims submitted to Medicare must contain an attending or rendering physician or non-physician practitioner who has a valid national provider identifier (NPI), is of an eligible specialty, and is enrolled in Medicare in an approved status. Failure to list a physician or non-physician practitioner, in the attending or referring fields that meet the above requirements will result in the rejection of the CAH Methods II claim.

## Background

All Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities (except small health plans), including enrolled Medicare providers and suppliers that are covered entities, are required to obtain an NPI and to use their NPI to identify themselves as "health care providers" in the HIPAA standard transactions that they conduct with Medicare and other covered entities.

Every provider or supplier that submits an enrollment application must furnish its NPI(s) in the applicable section(s) of the Form CMS-855. The Centers for Medicare & Medicaid Services (CMS) has implemented edits that verify that the NPI reported for physicians or non-physician practitioners in the attending or rendering physician fields on CAH method II claims for payment has a valid NPI and that the provider for that NPI is enrolled in Medicare in an approved status, otherwise the claim will be rejected. If the physician or non-physician practitioner is not enrolled in Medicare, he/she will need to establish an enrollment record in Provider Enrollment, Chain, and Ownership System (PECOS) with a valid NPI. He/she may submit their enrollment application electronically using PECOS located at *https://pecos.cms.hhs.gov/pecos/login.do* or by completing the paper CMS-855I or CMS- 855O application, which is available at *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html*. Note that an application fee is not required as part of the physician's or non-physician practitioner's application submission.

Only physicians and certain types of non-physician practitioners are eligible as attending or rendering providers on CAH method II claims. Those providers are as follows:

- Doctor of medicine or osteopathy;
- Dental surgery;
- Podiatric medicine;
- Optometry;
- Chiropractic medicine;
- Physician assistant;
- Certified clinical nurse specialist;
- Nurse practitioner;
- Clinical psychologist;
- Certified nurse midwife;
- Licensed clinical social worker;
- Certified registered nurse anesthetist; and
- Registered dietitian/nutritional professional.

If the attending or rendering provider is listed on the claim, the edits will compare the first four letters of the provider's last name and validate that the physician or non-physician practitioner is enrolled in Medicare with a valid NPI. If the provider's enrollment status cannot be validated the claim will be rejected with the following claim adjustment reason codes:

- N253: Missing/incomplete/invalid attending provider primary identifier, and
- N290: Missing/incomplete/invalid rendering provider primary identifier.

## Additional information

To assist providers, CMS provides an attending and rendering file that identifies those physicians and non-physician practitioners who are of a specialty type that is eligible to be listed as an attending or rendering provider on CAH method II claims and is enrolled in Medicare in an approved status.

When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the attending and rendering file available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html*. Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the attending/rendering fields.

*MLN Matters*® Number: SE1505
Related CR Release Date: N/A
Related Transmittal #: N/AI
Change Request (CR) #: CR N/A
Implementation Date: N/A
Effective Date: N/A

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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.

**"SPOT is amazing because you have given us a tool which the entry level employee can use easily and has a major positive impact on our business"**


*– Linda Zane, President, Physical Therapy Association of Florida*

## Retired LCDs

# Multiple Part B local coverage determinations being retired

**LCD ID number: L29052, L29096, L29193, L29295 (Florida)**
**LCD ID number: L29070, L29111, L29348, L29331 (Puerto Rico/U.S. Virgin Islands)**

Based on data analysis and a review of the local coverage determinations (LCDs), it was determined that the following LCDs are no longer required and, therefore, were retired.

- Accelerated partial breast irradiation (APBI)
- Ceredase/cerezyme
- Ibritumomab tiuxetan (Zevalin®) therapy
- Transmyocardial revascularization

### Effective date

The retirement of the accelerated partial breast Irradiation (APBI), ceredase/cerezyme, and iIbritumomab tiuxetan (Zevalin®) therapy LCDs is effective for services rendered **on or after May 14, 2015**.

The retirement of the transmyocardial revascularization LCD is effective for services rendered **on or after May 16, 2015**. 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 "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

**Note**: To review active, future and retired LCDs, *click here*.

# Pamidronate (Aredia®, APD) – Part B LCD retired

**LCD ID number: L29250 (Florida)**
**LCD ID number: L29461 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for pamidronate (Aredia®) has been retired. Pamidronate (Aredia®) has been incorporated into the bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications LCD.

### Effective date

This LCD retirement is effective for services rendered **on or after May 13, 2015**. 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 "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

**Note**: To review active, future and retired LCDs, *click here*.

### *Medicare Learning Network®*

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

## New LCDs

# Amniotic membrane-sutureless placement on the ocular surface – new LCD

### LCD ID number: L35935 (Florida/Puerto Rico/ U.S. Virgin Islands)

Data analysis identified an increase in utilization of placement of amniotic membrane on the ocular surface; without sutures, *Current Procedural Terminology*® (*CPT*®) *65778*. The Medicare Part B Extraction Summary System (BESS) statistical medical data obtained for dates of service January 1, 2014, through June 30, 2014, indicated a carrier to nation ratio for Florida at *2.79 for procedure code *65778* (150 percent above the national average). (**Note**: data for Puerto Rico and the U.S. Virgin Islands was below the national average for the applicable code). Reimbursement for *CPT*® *65778* from Medicare physician and nonphysician practitioner fee schedule (MPFS) for non-facility participating (NON-FAC PAR) in Florida location 99 (rest of Florida) is $1338.50.

Due to the risk for a high dollar claim payment error and lack of quality evidence for many proposed indications in available published literature, the LCD has been created to address indications for this service.

This LCD outlines indications and limitations of coverage and/or medical necessity, *CPT*®, ICD-9-CM diagnosis codes, documentation guidelines, and utilization guidelines for amniotic membrane- sutureless placement on the ocular surface. In addition, coding guidelines were created and attached to the LCD to provide instructions on coding and billing.

### Effective date

This new LCD is effective for services rendered **on or after June 29, 2015**. 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 “Attachments” in the “Section Navigation” drop-down menu at the top of the LCD page.

**Note**: To review active, future and retired LCDs, please *click here*.

# Cardiology-non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET – new LCD

### LCD ID number: L35933 (Florida/Puerto Rico/ U.S. Virgin Islands)

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage and/or medical necessity, *CPT*® codes, ICD-9-CM diagnosis codes, documentation guidelines, and utilization guidelines for noninvasive testing for obstructive coronary artery disease in the outpatient setting.

The diagnosis and management of patients with suspected and documented coronary artery disease in the office setting is supported by several validated tests including treadmill stress test, stress echocardiography, myocardial perfusion imaging (MPI) through both single photon emission computed tomography (SPECT) and positron emission tomography (PET). Historically, in the course of the contractor’s standard policy development process that includes routine data analysis for Jurisdiction N, several LCDs were implemented addressing office based diagnostic testing. Physicians have requested reconsideration of several of these LCDs that share similar indications for many clinical situations. This new LCD updates and consolidates several existing policies and serves to align indications and utilization guidelines in the office setting for patients in a non-emergency situation. The following existing policies will be retired with implementation of this policy.

- Cardiovascular stress testing
- Stress echocardiography
- Cardiovascular nuclear imaging studies(Part B)/ Myocardial perfusion imaging (Part A)
- Myocardial imaging, positron emission tomography (PET) scan

### Effective date

This new LCD is effective for services rendered **on or after June 29, 2015**. 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 “Attachments” in the “Section Navigation” drop-down menu at the top of the LCD page.

**Note**: To review active, future and retired LCDs, please *click here*.

# Humanitarian Use Device (HUD) and Humanitarian Device Exemption (HDE) process – new LCD

### LCD ID number: L35931 (Florida/Puerto Rico/ U.S. Virgin Islands)

Humanitarian-use device (HUD), as defined by the Food and Drug Administration (FDA), is a device intended to benefit patients by treating or diagnosing a disease or condition that affects or is manifested in fewer than 4,000 individuals per year in the United States. When the manufacturer submits a humanitarian device exemption (HDE) application to the FDA, it must provide sufficient information for the FDA to determine that the device does not pose an unreasonable or significant risk of illness or injury to the patient and that the probable benefits to health outweigh the risk of injury or illness from its use. The manufacturer is not required to provide the results of scientifically valid clinical investigations demonstrating that the device is effective for its intended purpose prior to marketing (see FDA regulations [21 CFR 814.124]). This FDA regulation was developed to provide an incentive for the development of devices for use in the treatment or diagnosis of diseases affecting limited populations. Such devices may only be used in institutions where an institutional review board (IRB) has approved the use of the device to treat or diagnose the specific rare disease.

This policy clarifies that a device classified by the FDA as an HUD is not addressed by the Medicare administrative contractor (MAC) jurisdiction N (JN) investigational device exemption (IDE) study approval process. An HDE-designated device may only be considered for coverage at the claim level (pre or post-payment review). On audit, the medical record must support that the device meets the Medicare reasonable and necessary (R&N) threshold for coverage assuming all other applicable requirements of the program are met. The device is specifically not covered if noted as such by national or local coverage determination or used off-label per the FDA indications. Claims for a device generally (with some exceptions) incorporate physician services billed to multi-carrier system (MCS) and hospital facility services billed to fiscal intermediary standard system (FISS).

### Effective date

This LCD is effective **on or after June 29, 2015**. 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 “Attachments” in the “Section Navigation” drop-down menu at the top of the LCD page.

**Note**: To review active, future and retired LCDs, please *click here*.

## Revisions to LCDs

# Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the Part B LCD

### LCD ID number: L32100 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was revised to add a new FDA approved indication for Xgeva®. Additionally, pamidronate (Aredia®) has been added to this LCD. The following sections of the LCD were revised: “Indications and Limitations of Coverage and/or Medical Necessity”, “ICD-9 Codes That Support Medical Necessity”, “Documentation Requirements”, “Utilization Guidelines”, and “Sources of Information and Basis for Decision”.

### Effective date

The LCD revision related to Xgeva® is effective for claims processed on or after May 13, 2015, for services rendered on or after December 14, 2014. The LCD revision related to the addition of pamidronate (Aredia®) is effective for services rendered on or after May 13, 2015. 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 “Attachments” in the “Section Navigation” drop-down menu at the top of the LCD page.

**Note**: To review active, future and retired LCDs, *click here*.

# Colorectal Cancer Screening – revision to the Part B LCD

**LCD ID number: L29100 (Florida)**
**LCD ID number: L29115 (Puerto Rico/U.S. Virgin Islands)**

Based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8874, two modifiers may be used to identify anesthesia services rendered in conjunction with a screening service.

- **Modifier 33 – Preventive services**: when the primary purpose of the service is the delivery of an evidence based service in accordance with United States Preventive Task Force A or B rating in effect and other preventive services Appending the 33 modifier will waive patient's deductible and co-insurance.
- **Modifier PT – Colorectal cancer screening test**; converted to diagnostic test or other procedure. Appending the PT modifier will waive the patient's deductible. Co-insurance will still apply.

The local coverage determination (LCD) for colorectal cancer screening has been revised to reflect the addition of modifiers 33 and PT.

### Effective date

This LCD revision is effective for services rendered **on or after January 1, 2015**. 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 "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

**Note**: To review active, future and retired LCDs, *click here*.

# Noncovered services – revision to the Part B LCD

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

- The Medical Policy & Procedures Department evaluated the following services and determined that they are not considered medically reasonable and necessary at this time based on current available published evidence (e.g., peer-reviewed medical literature, and published studies). Therefore, the following procedure codes have been added to the Noncovered Services local coverage determination (LCD). The comment period for the addition of these services was from February 14, 2015, to March 30, 2015. After a LCD becomes effective/active, any stakeholder may request a revision to the LCD, by following the reconsideration process as outlined on our website.
- *C2624 - Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components*
- *C9737 – Laparoscopy, surgical, esophageal sphincter augmentation with device (eg, magnetic band)*
- *0378T – 0379T* - Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days
- *0380T - Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report*


- *0381T – 0382T* – External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- *0383T – 0384T* – External heart rate and 3-axis accelerometer data recording from 15 to 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- *0385T – 0386T* – External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events

See **NONCOVERED**, next page

## NONCOVERED

From previous page

- ** 0387T- Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular*
- ** 0388T - Transcatheter removal of permanent leadless pacemaker, ventricular*
- ** 0389T - Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system*
- ** 0390T - Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure or test with analysis, review and report, leadless pacemaker system*
- ** 0391T - Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system*
- *43289 - Unlisted laparoscopy procedure, esophagus (LINX® reflux management system)*
- *93799 - Unlisted cardiovascular service or procedure (CardioMEMS™)*

**Covered if beneficiary is enrolled in a MAC approved category B investigational device exemption (IDE) study.*

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the quality of the evidence per the *Program Integrity Manual*. When addressing the articles and related information in the public domain, the jurisdiction N (JN) Medicare administrative contractor (MAC) reached the determination that available evidence was of moderate to low quality, consisting of small case series, retrospective studies, and review articles reporting limited safety and efficacy data for these procedures. Due to the unavailability of high quality evidence, the JN MAC reiterates that there is insufficient scientific evidence to support these procedures, and therefore they are not considered reasonable and necessary under Section 1862(a)(1)(a) of the Social Security Act.

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

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

Also, any interested party could request CMS to consider developing a national coverage determination (NCD). Of note, if the evidence is not adequate for coverage under Section 1862(a)(1)(A), an item or service may be considered for coverage under the CMS coverage with evidence development (CED) policy in which "reasonable and necessary" is established under 1862(a)(1)(E) of the Act. Under the authority of Section 1862(a)(1)(E), the NCD process may result in coverage if the item or service is covered only when provided within a setting in which there is a pre-specified process for gathering additional data, and in which that process provides additional protections and safety measures for beneficiaries, such as those present in certain clinical trials.

### Effective date

This LCD revision is effective for services rendered **on or after June 29, 2015**. 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 "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

**Note**: To review active, future and retired LCDs, *click here*.


### Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

## Additional Information

# Venofer® (iron sucrose- J1756) and Ferrlecit® (sodium ferric gluconate complex in sucrose- J2916) injection – claims that may have been denied in error

**LCD ID number: L29095 (Florida)**
**LCD ID number: L29110 (Puerto Rico/U.S. Virgin Islands)**

Venofer® (iron sucrose- J1756) is covered for the Food and Drug Administration (FDA) approved indication as a first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis as well as for the treatment of iron deficiency anemia in non-dialysis dependent chronic kidney disease patients.

Ferrlecit® is covered for the FDA approved indication as a first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy.

Claims submitted for HCPCS codes J1756 and J2916 (Injection) from **February 24-May 4, 2015**, may have been denied incorrectly with the following denial message: "These are non-covered services because this is not deemed a 'medical necessity' by the payer".

This error was corrected **on May 4, 2015**.

### No action required by providers

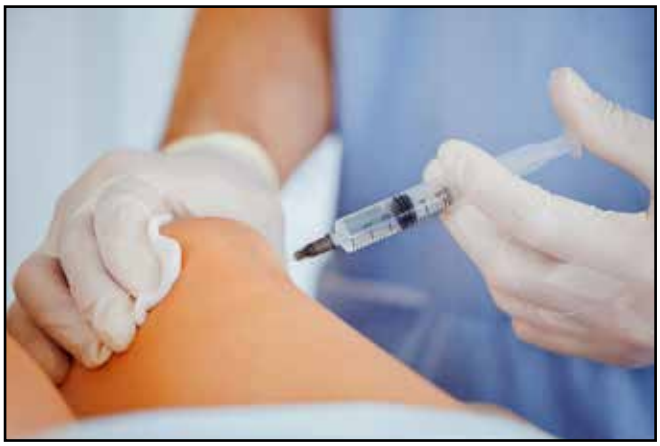
Providers whose claims were incorrectly denied due to this error do not need to take any action. First Coast Service Options Inc. will perform adjustments to correct the error on all the affected claims. We apologize for any inconvenience this may have caused.

# Viscosupplementation therapy for knee Part B LCD – imaging procedures routinely performed for needle placement not considered medically necessary

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

The local coverage determination (LCD) for viscosupplementation therapy for knee contains the following language related to the non-coverage of imaging procedures (e.g., *20611*, *77012, 77021, 76881, 76882* or *76942*).

Imaging procedures performed routinely for the purpose of visualization of the knee to provide guidance for needle placement will not be covered. Fluoroscopy may be medically necessary and allowed if documentation supports that the presentation of the patient's affected knee on the day of the procedure makes needle insertion problematic. No other imaging modality for the purpose of needle guidance and placement will be covered.



Therefore, these services will be denied.

**Take the time to 'chat' with the website team**

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast's new Live Chat service.

# Upcoming provider outreach and educational events

## Medicare Part B changes and regulations

**When:** Wednesday, June 17
**Time:** 11:30 a.m.-1:00 p.m. **Type of event:** Webcast

*http://medicare.fcso.com/Events/0276471.asp*

## Internet-based PECOS class

**When:** Thursday, June 25
**Time:** 1:00 p.m.-5:00 p.m. **Type of event:** Face-to-face

*http://medicare.fcso.com/Events/0293486.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 April 23, 2015

*MLN Connects® Provider eNews for April 23, 2015*

*View this edition as a PDF*

**In this edition:**

## MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs – Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript
- CMS Events
- Special Open Door Forum: Home Health Electronic and Paper Clinical Templates

## Announcements

- Proposed FY 2016 Skilled Nursing Facility Payment and Policy Changes
- Proposed FY 2016 Inpatient and Long-Term Care Hospital Payment and Policy Changes
- DMEPOS Competitive Bidding Round 1 2017 Announced
- National Minority Health Month
- CMS Releases Hospital Compare Star Ratings
- New Hospice Reports Available in CASPER
- CMS to Release Transthoracic Echocardiography Comparative Billing Report in May
- CMS to Award Special Innovation Projects for Partnership-Driven Quality Improvement Projects
- CMS is Accepting Suggestions for Potential PQRS Measures


## Claims, Pricers, and Codes

- Coordination of Benefits Issue Impacting Outpatient Hospital Claims
- Updated: Correcting the Display Issue for OPPS Claims Where Value Code "FD" Is Present

## Medicare Learning Network® Educational Products

- "Independent Diagnostic Testing Facilities" Podcast – *Released*
- "Vaccine and Vaccine Administration Payments under Medicare Part D" Fact Sheet – *Revised*
- "Home Health Prospective Payment System" Fact Sheet – *Revised*
- "Medicare Fraud and Abuse: Prevention, Detection, and Reporting" Web-Based Training Course – *Revised*
- New Medicare Learning Network® Educational Web Guides Fast Fact

### What is Medicare Fraud?

Fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. Learn more at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf*.

# MLN Connects® Provider eNews for April 30, 2015

*MLN Connects® Provider eNews for April 30, 2015*

*View this edition as a PDF*

### In this edition:

### MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs — Register Now
- 2014 Mid-Year QRURs – Save the Date
- New MLN Connects® National Provider Call Video Slideshow, Audio Recordings and Transcripts

### CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Patient Survey Star Ratings

### Announcements

- Proposed FY 2016 Inpatient Rehabilitation Facility Payment and Policy Changes
- Proposed FY 2016 Inpatient Psychiatric Facility Payment and Policy Changes
- Focusing on Women's Health
- Open Payments Physician and Teaching Hospital Review and Dispute Period Ends May 20
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- 2015 PV-PQRS GPRO Registration is Open
- Participation Continues to Rise in Medicare PQRS and eRx Incentive Program
- Antipsychotic Drug use in Nursing Homes: Trend Update
- Five Facts about ICD-10
- 2014 Mid-Year QRURs Available

### Claims, Pricers, and Codes

- April 2015 Outpatient Prospective Payment System Pricer File Update
- Coding for ICD-10-CM: Continue to Report *CPT*®/ HCPCS Modifiers for Laterality

### *Medicare Learning Network*® Educational Products

- "Physicians and Non-Physician Practitioners Reported on Part A Critical Access Hospital (CAH) Claims" *MLN Matters*® Article — *Released*
- "Accreditation for Ventilators" *MLN Matters*® Article — *Released*
- "The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Repairs and Replacements" Fact Sheet — *Revised*
- New *Medicare Learning Network*® Provider Compliance Fast Fact
- Subscribe to the *Medicare Learning Network*® Educational Products and *MLN Matters*® Electronic Mailing Lists


**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.*

See **ENEWS**, next page

# MLN Connects® Provider eNews for May 7, 2015

*MLN Connects® Provider eNews for May 7, 2015*

*View this edition as a PDF*

**In this edition:**

## MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs for Hospitals — Last Chance to Register
- 2014 Mid-Year QRURs — Registration Now Open
- National Partnership to Improve Dementia Care and QAPI — Registration Now Open
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

## CMS Events

- Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July — Forms Accepted May 11 through 22
- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Webinar for Comparative Billing Report on Transthoracic Echocardiography

## Announcements

- Proposed Updates to Hospice Wage Index and Payment Rates
- May is National Osteoporosis Month
- Medicare Coverage for Viral Hepatitis
- New CDC Measles Information and Resources
- HHS Announces $101 Million in Affordable Care Act Funding to 164 New Community Health Centers
- Amendment to Disproportionate Share Hospital Ruling
- Inpatient Hospital Probe and Educate Extension
- Quality Reporting Programs: Updated 2014 eCQMs for 2016 Reporting


- CMS Announces the Physician Quality Reporting Programs Strategic Vision
- ICD-10 Resources for Medicare Providers
- Five More Facts about ICD-10
- Medscape Article for CME Credit: Improving Quality of Care through Care Coordination
- EHR Proposed Rules Available for Comment: Stage 3 Comments Due by May 29
- FY 2016 Inpatient and LTCH PPS Proposed Rule: Comment Period Ends June 16
- CMS is Accepting Suggestions for Potential PQRS Measures

## *Medicare Learning Network*® Educational Products

- "The Medicare Home Health Benefit" Web-Based Training Course — *Released*
- "Resources for Medicare Beneficiaries" Fact Sheet — *Revised*
- "Medicare Part B Immunization Billing" Educational Tool — Reminder
- *Medicare Learning Network*® Products Available In Electronic Publication Format

## Correct your claims on the 'SPOT'

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

# MLN Connects® Provider eNews for May 14, 2015

*MLN Connects® Provider eNews for May 14, 2015*

*View this edition as a PDF*

**In this edition:**

### MLN Connects® National Provider Calls

- 2014 Mid-Year QRURs — Register Now
- Medicare Shared Savings Program ACO: Application Review — Registration Now Open
- National Partnership to Improve Dementia Care and QAPI — Register Now
- Hospice Quality and Hospice Item Set Manual v 1.02 — Save the Date
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Register Now

### MLN Connects® Videos

- New ICD-10 Videos: Impact on Inpatient Hospital Payment and Medicare Testing Plans

### CMS Events

- Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July — Forms Accepted May 11 through 22
- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Electronic and Paper Clinical Templates

### Announcements

- Depression is Not a Normal Part of Growing Older
- Therapy Caps Exceptions Process Extended through CY 2017
- Questions about Medicare?
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- Groups: 6 Weeks Left to Register for 2015 PQRS GPRO

### Medicare Learning Network® Educational Products

- "Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model" MLN Matters® Article — Released
- "Items and Services That Are Not Covered Under the Medicare Program" Booklet — Revised
- Medicare Learning Network® Product Available In Electronic Publication Format

## New CMS-855C and CMS-855POH forms

The Office of Management and Budget (OMB) has approved two new Centers for Medicare & Medicaid Services (CMS) 855 forms. The new forms are CMS-855C and CMS-855POH. Form CMS-855C is used by indirect payment plan (IPP) billers for Medicare registration and form CMS-855POH is used by physician-owned hospitals for reporting hospital ownership and investment interest.

For more information about these forms, please refer to the transmittal released by CMS:

- Change request (CR) 9120 – *Update of CMS-855A, Physician-Owned Hospital Reporting Via the CMS-855POH and Indirect Payment Procedure Registration Via the CMS-855C in Chapter 15 of Pub. 100-08*

When the forms are released by CMS, they may be obtained by accessing the *CMS Forms List page* or the *Provider Enrollment section* on the First Coast Medicare provider website.

## Get ready for ICD-10

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

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

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

*Online ICD-10 guide*

*ICD-10 basics for large medical practices*

# 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 2525
Jacksonville, FL 32231-0019

### 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 32231-0018

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
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 45268
Jacksonville, FL 32232-5268

### 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)

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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 45098
Jacksonville, FL 32232-5098

**Redeterminations**
Medicare Part B Redetermination
P.O. Box 45024
Jacksonville, FL 32232-5024

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

**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 45036
Jacksonville, FL 32232-5036

### Redeterminations

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

### Redetermination of overpayments

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

### 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 32232-5092,

### Special courier service

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

# Websites

### Provider

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

First Coast University
*http://www.fcsouniversity.com/*

### Beneficiaries

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

# Order form for Medicare Part B materials

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

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

| Item | Acct Number | Cost per item | Quantity | Total cost |
|---|---|---|---|---|
| **Part B subscription** – The Medicare Part B jurisdiction N publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2014 through September 2015. | 40300260 | $33 | | |
| **2015 fee schedule –** The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2015, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items.<br>**Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication. | 40300270 | $12 | | |
| Language preference: **English** [ ] **Español** [ ] | | | | |
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| ***Please write legibly*** | | | Subtotal | $ |
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**Mail this form with payment to:**
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**Medicare Publications**
**P.O. Box 406443**
**Atlanta, GA 30384-6443**

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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