Medicare B CONNECTION

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers June 2015

In this issue

Family practice physicians readied for ICD-10 using First Coast Web Tools

Barring any last minute delays, medical providers across the United States will begin using ICD-10 codes for all claims October 1, 2015. For some office and practice managers, the experience of preparing for this large change might be coded as F43.02, "reaction to severe stress."

But for Najwa Liscombe and her team of medical coders at the Department of Community Health and Family Medicine at the College of Medicine, University of Florida, no code is needed. They are ready.

"Our IT people have us well-prepared for ICD-10. We've already loaded ICD-10 codes and we have it cross-mapped to ICD-9 codes so we can train our residents on what they will see when the change to ICD-10 happens," Liscombe said.

Liscombe is a coding and reimbursement analyst. The Department educates medical students in family medicine.

For the soon-to-be physicians, Liscombe plays an important role getting them ready for the next era in medical coding. What she teaches could be the difference in whether doctors get paid for providing medical care. And, according to Liscombe, *First Coast Service Options' Web tools* play a critical role in training doctors for the future.

"I want every resident to know how to document appropriately and code to the documentation. But most importantly, I want them to understand medical necessity," Liscombe said. "The E/M worksheet is an excellent audit tool for all providers to use in their coding. If I were to hire additional staff, the *E/M worksheet* would be an important part of their orientation."

Liscombe added: "I work with the residents to review their charts. We walk through a chart together. I'll ask them what their documentation shows. Did they code it appropriately based on the documentation? And then, we will look and see if anything is missing."

She has a number of home-grown tools like the ICD-10 cross-map at her disposal to help train UF residents. "As we transition to ICD-10, I will show the resident this is how the coding works in ICD-9 and this is how it will look in ICD-10," Liscombe said. "Our residents code for themselves. After they complete a chart, I will go over it with them using a chart review tool and the (First Coast) evaluation and management worksheet. I will use it to see what evaluation

See **TOOLS**, Page 34

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.

Quarterly update to the correct coding initiative edits

Provider types affected

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

Provider action needed

Change request (CR) 9111 informs MACs about the release of the latest package of national correct coding initiative (NCCI) edits, version 21.3, which will be effective October 1, 2015. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the national correct coding initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology Manual*, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of CCI edits, version 21.3, effective October 1, 2015, will be available to MACs via the CMS data center (CDC). A test file will be available on or about August 2, 2015, and a final file will be available on or about August 17, 2015. Version 21.3 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/Column 2 correct coding edits and mutually-exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE.

It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits. CMS no longer publishes a MEC file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file on each website. The edits previously contained in the MEC file are **not** being deleted but are being moved to the column one/column two correct coding edit file.

Additional information

The official instruction, CR 9111, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3275CP.pdf*.

Refer to the CMS NCCI Web page for additional information at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.htm*.

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: MM9111
Related Change Request (CR) #: CR 9111
Related CR Release Date: May 29, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3275CP
Implementation Date: October 5, 2015

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

Ambulatory Surgical Center

July 2015 update of the ASC payment system

Provider types affected

This *MLN Matters*® article is intended for physicians and ambulatory surgical centers (ASCs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9207 informs MACs about changes to and billing instructions for various payment policies implemented in the July 2015 ASC payment system update and includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure your billing staffs are aware of these changes.

Key points of CR 9207

1. New device pass-through category and device offset from payment

Additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the outpatient prospective payment system (OPPS). Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires the creation of additional categories for transitional pass-through payment of new medical devices not described by current or expired categories of devices. This policy was implemented in the 2008 revised ASC payment system.

The Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS device pass-through category as of July 1, 2015, for the OPPS and the ASC payment systems. HCPCS C2613 (Lung biopsy plug with delivery system) is assigned ASC payment indicator (PI)= J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). The following table displays the new code, its short descriptor, long descriptor, payment indicator, and the device offset from payment (discussed below).

New device pass-through code, effective July 1, 2015

HCPCS	Short descriptor	Long descriptor	ASC PI	Device offset from payment
C2613	Lung bx plug w/del sys	Lung biopsy plug with delivery system	J7	$24.83

a. Device offset from payment:

Beginning on and after the effective date of July 1, 2015, CMS will take a device offset when the C2613 device is

billed with *CPT*® *32405* (*Biopsy, lung or mediastinum, percutaneous needle*). The ASC code pair file will be used to establish the reduced ASC payment amount for *CPT*® *32405* (2.36 percent reduction) when billed with HCPCS C2613.

b. Application of offset to *CPT*® *37224* and *37226* when billed with C2623:

In the April 2015 update to the ASC payment system (CR 9100), CMS determined that an offset would apply to *CPT*® *37224* (*Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty*), and *37226* (*Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed*); when billed with the C2623 device, because these codes already contained costs associated with the device that C2623 described. (For more information, please refer to the related *Medicare Learning Network Matters*® (*MLN*®) article which you is at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9100.pdf*.)

After further review however, CMS has determined that the costs associated with C2623 are not packaged into *CPT*® *37224* and *37226*; and therefore, the aforementioned offset is not applied to them. This determination to not apply the device offset from payment will be retroactive to April 1, 2015. Suppliers who believe that they may have received an incorrect payment for *CPT*® *37224* and *37226* impacted by these corrections, may request their MAC to adjust the previously processed claims.

2. Category III *CPT*® codes

The American Medical Association (AMA) releases category III *CPT*® codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2015 update, CMS is implementing in the OPPS two category III *CPT*® codes that the AMA released in

See **JULY**, next page

JULY

From previous page

January 2015 for implementation on July 1, 2015. Both category III *CPT*® codes are separately payable under the ASC payment system. The following table displays the *CPT*® and their long and short descriptors, and payment indicators. Payment rates for these services are in the July 2015 ASC update addenda that are available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

Category III *CPT*® codes implemented as of July 1, 2015

2015 *CPT*® code	Long descriptor	Short descriptor	July 2015 ASC PI
0392T	*Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band)*	Lap es sph augment dev place	G2
0393T	*Removal of esophageal sphincter augmentation device*	Es sph augmnt device removal	G2

3. LINX reflux management system

In January 2014, CMS established HCPCS C9737 to describe the laparoscopic implantation of a magnetic esophageal ring for the treatment of gastroesophageal reflux disease (GERD), which is the procedure associated with the LINX reflux management dystem. For the July 2015 update, the *CPT*® editorial panel established *CPT*® *0392T* (*Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (e.g., magnetic band)*) to describe the LINX reflux management system.

With the establishment of this *CPT*® CMS is deleting HCPCS code C9737 effective June 30, 2015. Therefore, effective July 1, 2015, ASCs must report *CPT*® *0392T* to report the implantation of a magnetic esophageal ring associated with the LINX reflux management system procedure.

4. Drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP), effective July 1, 2015

For 2015, payment for non pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. Additionally, in 2015, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items.

Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective July 1, 2015, are available in the July 2015 ASC Addendum BB at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

b. Drugs and biologicals based on ASP methodology with restated payment rates

Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible the first date of the quarter at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html*. Suppliers who believe that they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request their MAC to adjust the previously processed claims.

c. Drugs and biologicals with OPPS pass-through status, effective July 1, 2015

For July 2015, three new HCPCS codes are created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. The following table displays these new codes, their long and short descriptors and payment indicators.

Drugs and biologicals with OPPS pass-through status, effective July 1, 2015

HCPCS code	Long descriptor	Short descriptor	ASC PI
C9453	Injection, nivolumab, 1 mg	Injection, nivolumab	K2
C9454	Injection, pasireotide long acting, 1 mg	Inj, pasireotide long acting	K2
C9455	Injection, siltuximab, 10 mg	Injection, siltuximab	K2

d. Revised descriptor for HCPCS code C9349

Effective July 1, 2015, the descriptor for HCPCS code C9349 has changed. The following table displays the code and its previous and revised descriptors.

See **JULY**, next page

JULY

From previous page

Revised 2015 descriptor (desc) for HCPCS code C9349

Previous short desc	Previous long desc	Revised short desc	Revised long desc
FortaDerm, FortaDerm Antimic	*FortaDerm , and FortaDerm Antimicrobial, any type, per square centimeter*	PuraPly, PuraPly Antimic	*PuraPly, and PuraPly*

e. Revised ASC payment Indicators for HCPCS codes *90620* and *90621*

Effective July 1, 2015, the payment indicators for HCPCS codes *90620* (Menb pr w/omv vaccine im) and *90621* (Menb rlp vaccine im) will change to PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.). The following table displays these codes, their long and short descriptors, and the new payment indicators.

Drug and biological with revised status indicator

HCPCS code	Long descriptor	Short descriptor	
90620	*Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use*	Menb rp w/ omv vaccine im	K2
90621	*Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use*	Menb rlp vaccine im	K2

f. Other changes to 2015 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

Effective July 1, 2015, HCPCS code Q9978 will replace HCPCS code C9448. The status indicator will remain K2, “Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.” The following table displays this code change and effective date.

Other changes to 2015 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

HCPCS code	Short desc	Long desc	ASC PI	Add/ Term date
C9448	Oral netupitant	Netupitant 300mg and palonosetron 0.5 mg, oral	K2	4/1/15/ 6/30/15
Q9978	Netupitant	Netupitant 300 mg and	K2	7/1/15

5. Coverage determinations

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

Additional information

The official instruction, CR 9207, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3279CP.pdf*.

If you have questions please contact your MAC at their toll-free number. The 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: MM9207
Related Change Request (CR) #: CR 9207
Related CR Release Date: June 5, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3279CP
Implementation Date: July 6, 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.

Cardiac Services

Coverage of Microvolt T-wave Alternans (MTWA)

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for Microvolt T-wave Alternans (MTWA) diagnostic testing services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 9162 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) states that effective January 13, 2015, your local MAC will determine, at their discretion, Medicare coverage of MTWA using a modified moving average (MMA) method of analysis and methods of analysis other than spectral analysis (SA) for the evaluation of patients at risk for sudden cardiac death (SCD) from ventricular arrhythmias. No national coverage determination (NCD) is appropriate at this time for MTWA testing using the MMA method for the evaluation of patients at risk for SCD. As a result, national non-coverage of the MMA method was removed.

Background

CMS was asked to reconsider the NCD on MTWA diagnostic testing to extend coverage to the MMA method of analysis. CMS currently covers MTWA nationally only when it is performed using the SA method for the evaluation of patients at risk for SCD from ventricular arrhythmias, and patients who may be candidates for Medicare coverage of the placement of an implantable cardiac defibrillator (ICD).

Key points of CR 9162

- MACs will accept the inclusion of the -KX modifier on the claim line(s) along with *Current Procedural Technology CPT*® code *93025* (MTWA for assessment of ventricular arrhythmias, short descriptor: microvolt t-wave assess) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the MTWA was performed using a method of analysis other than SA for the evaluation of patients at risk for SCD from ventricular arrhythmias and that all other NCD criteria were met.
- Claims for MTWA using the SA method of analysis do not require the KX modifier and will continue to be processed as they are currently. See CR 4351 for instructions for processing MTWA claims using the SA method of analysis at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R894CP.pdf* or see MM4351 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4351.pdf*.
- Effective for claims with dates of service on and after January 13, 2015, MACs will determine coverage at their discretion of MTWA diagnostic testing for the evaluation of patients at risk for SCD using analysis methods other than SA.
- Effective for dates of service on and after January 13, 2015, MACs will process claims for MTWA diagnostic testing for the evaluation of patients at risk for SCD when methods of analysis other than SA are used.
- If MACs determine that a claim for MTWA with methods of analysis other than SA are billed without the KX modifier, MACs will deny the claim using the following messages:
  - **Claim adjustment reason code (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."
  - **Remittance advice remarks code (RARC) N657**: This should be billed with the appropriate code for these services.
  - **Group code of CO** (contractual obligation) assigning financial liability to the provider.
- The following diagnosis code list/translation was approved by CMS. There are duplicate codes because the ICD-9 and ICD-10 tables can be read as a side-by-side translation for ICD-10 purposes and not all translations are 1-to-1 translations. It may or may not be a complete list of covered indications/diagnosis codes that are covered but should serve as a finite starting point. Individual MACs within their respective jurisdictions have the discretion to make coverage determinations they deem reasonable and necessary under section 1862(a)1)(A) of the Social Security Act. Therefore, MACs may have additional covered diagnosis codes in their individual policies where MAC discretion is appropriate.

See **MTWA**, next page

MTWA

From previous page

ICD-9 codes

Code	Descriptor
410.11	Acute myocardial infarction of other anterior wall, initial episode of care
410.11	Acute myocardial infarction of other anterior wall, initial episode of care
410.01	Acute myocardial infarction of anterolateral wall, initial episode of care
410.11	Acute myocardial infarction of other anterior wall, initial episode of care
410.31	Acute myocardial infarction of inferoposterior wall, initial episode of care
410.21	Acute myocardial infarction of inferolateral wall, initial episode of care
410.41	Acute myocardial infarction of other inferior wall, initial episode of care
410.81	Acute myocardial infarction of other specified sites, initial episode of care
410.51	Acute myocardial infarction of other lateral wall, initial episode of care
410.61	True posterior wall infarction, initial episode of care
410.81	Acute myocardial infarction of other specified sites, initial episode of care
410.91	Acute myocardial infarction of unspecified site, initial episode of care
410.71	Subendocardial infarction, initial episode of care
410.01	Acute myocardial infarction of anterolateral wall, initial episode of care
410.11	Acute myocardial infarction of other anterior wall, initial episode of care
410.21	Acute myocardial infarction of inferolateral wall, initial episode of care
410.31	Acute myocardial infarction of inferoposterior wall, initial episode of care
410.41	Acute myocardial infarction of other inferior wall, initial episode of care
410.71	Subendocardial infarction, initial episode of care
410.51	Acute myocardial infarction of other lateral wall, initial episode of care
410.61	True posterior wall infarction, initial episode of care
410.81	Acute myocardial infarction of other specified sites, initial episode of care
410.91	Acute myocardial infarction of unspecified site, initial episode of care
411.89	Other acute and subacute forms of ischemic heart disease, other
411.89	Other acute and subacute forms of ischemic heart disease, other
427.1	Paroxysmal ventricular tachycardia
427.1	Paroxysmal ventricular tachycardia
427.41	Ventricular fibrillation
427.42	Ventricular flutter
780.2	Syncope and collapse
V45.89	Other postprocedural status

ICD- 10 codes (upon implementation of ICD-10)

Code	Descriptor
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery
I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
I21.29	ST elevation (STEMI) myocardial infarction involving other sites
I21.29	ST elevation (STEMI) myocardial infarction involving other sites
I21.29	ST elevation (STEMI) myocardial infarction involving other sites
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall

See **MTWA**, next page

MTWA

From previous page

Code	Descriptor
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
I22.2	Subsequent non-ST elevation (NSTEMI) myocardial infarction
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites
I22.9	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site
I24.8	Other forms of acute ischemic heart disease
I24.9	Acute ischemic heart disease, unspecified
I47.0	Re-entry ventricular arrhythmia
I47.2	Ventricular tachycardia
I49.01	Ventricular fibrillation
I49.02	Ventricular flutter
R55	Syncope and collapse
Z98.89	Other specified postprocedural states

- Your MAC shall not search for and adjust any claims for MTWA for the evaluation of patients at risk for SCD when methods of analysis other than SA are used, with dates of service January 13, 2015, through the implementation date of CR 9162. However, they may adjust claims meeting their coverage criteria when brought to their attention by the provider within the timely filing period if appropriate.

Additional information

The official instruction, CR 9162, was issued to your MAC in two transmittals. The first updates the *Medicare National Coverage Determinations Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R182NCD.pdf*.

The second updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3265CP.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: MM9162
Related Change Request (CR) #: CR 9162
Related CR Release Date: May 22, 2015
Effective Date: January 13, 2015
Related CR Transmittal #: R182NCD and R3265CP
Implementation Date: June 23, 2015

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.

Transcatheter aortic valve replacement hospital program volume requirements

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) established Medicare coverage criteria for individual hospitals that want to perform transcatheter aortic valve replacement (TAVR). Before a TAVR procedure is eligible for Medicare coverage individual hospitals must meet the volume requirements specified in the TAVR national coverage determination (NCD). Hospitals that do not meet these volume requirements are not eligible for waivers or exceptions. This special edition article is being provided by CMS to remind providers of the hospital volume requirements for TAVR programs.

Background

TAVR, also known as transcatheter aortic valve implantation (TAVI), is a technology for use in treating aortic stenosis. A bioprosthetic valve is inserted intravascularly using a catheter and implanted in the orifice of the native aortic valve.

The procedure is performed in a cardiac catheterization lab or a hybrid operating room/cardiac catheterization lab with advanced quality imaging and with the ability to safely accommodate complicated cases that may require conversion to an open surgical procedure. The interventional cardiologist and cardiothoracic surgeon jointly participate in the intra-operative technical aspects of TAVR.

Effective May 1, 2012, Medicare covers TAVR procedures under coverage with evidence development (CED) for the treatment of symptomatic aortic stenosis when:

- Furnished according to a Food and Drug Administration (FDA) approved indication; and
- Certain conditions are met including requirements for individual hospitals in which TAVR procedures are performed.

Hospital volume requirements

CMS established specific volume requirements pertaining to various procedures that hospitals, with and without TAVR experience, must meet in order for a hospital to perform TAVR procedures in compliance with the NCD for TAVR (NCD 20.32) and be eligible for Medicare coverage, the individual hospital must meet these volume requirements.

The hospital TAVR program volume requirements are specific to each individual hospital site where TAVR procedures are performed, and they are as follows:

1. To begin a TAVR program, the hospital (without TAVR experience) must have:
   a. = 50 total aortic valve replacements (AVRs) in the previous year prior to TAVR, including = 10 high-risk patients; and
   b. = 2 physicians with cardiac surgery privileges; and
   c. = 1000 catheterizations per year, including = 400 percutaneous coronary interventions (PCIs) per year.
2. To continue a TAVR program, the hospital (with TAVR experience) must maintain:
   a. = 20 AVRs per year or = 40 AVRs every 2 years; and
   b. = 2 physicians with cardiac surgery privileges; and
   c. = 1000 catheterizations per year, including = 400 percutaneous coronary interventions (PCIs) per year.

It is important to note that there are also requirements for heart team members and these volume requirements may include procedures performed at different facilities, but the hospital volume requirements are specific to the site where TAVR procedures are performed. Hospitals that do not meet these volume requirements are not eligible for waivers or exceptions.

In addition, hospital systems comprised of multiple individual sites (that may or may not be in close proximity to each other) may not combine procedural experiences at multiple sites to meet these volume requirements.

Additional information

You can review the complete national coverage determination (NCD) for TAVR which details all requirements that must be met for Medicare coverage at *http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=355*.

The Medicare approved TAVR registry and Medicare approved clinical trials which were reviewed and determined to meet the requirements of Medicare coverage are available at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/TAVR.html*.

You can review the *MLN Matters*® article MM8168 titled National Coverage Determination (NCD): Transcatheter Aortic Valve Replacement (TAVR) Coding Update/ Policy Clarification at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8168.pdf*.

You can find the Medicare *National Coverage Determinations Manual* (Publication 100-03; Chapter 1, Part 1, Section 20.32 (Transcatheter Aortic Valve Replacement (TAVR)) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf*.

See **TAVR**, next page

Consolidated Billing

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

Provider types affected

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

Provider action needed

This article, based on change request (CR) 9192, provides the quarterly update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of HH services. CR 9192 announces the addition of HCPCS codes *97607* and *97608*, negative pressure wound therapies, to the HH consolidated billing therapy code list, effective for services on or after October 1, 2015.

These codes replace codes G0456 and G0457, negative pressure wound therapies, which are deleted from the HH consolidated billing therapy code list. In addition, code A7048 replaces code A7043 on the HH consolidated billing non-routine supply code list, effective for services on or after October 1, 2015. Be sure your staffs are aware of this update.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the HH prospective payment system (HH PPS).

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

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key points

Effective for claims with dates of service on or after October 1, 2015, the following HCPCS code is added to the HH consolidated billing non-routine supply code list and will replace code A7043, which is deleted from the same list effective October 1, 2015:

- A7048: Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each.

Effective for claims with dates of service on or after October 1, 2015, the following HCPCS codes are added to the HH consolidated billing therapy code list and will replace HCPCS codes G0456 and G0457, which are deleted from this list, effective on October 1, 2015:

- *97607: Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters*
- *97608: Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system,*

See **CONSOLIDATED**, next page

TAVR

From previous page

MLN Matters® Number: SE1515
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A Related
CR Transmittal #: N/A
Implementation Date: N/A

Drugs and Biologicals

July 2015 update to ASP drug pricing files

Provider types affected

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

Provider action needed

Change request (CR) 9159 which instructs MACs to download and implement the July 2015 average sales price (ASP) drug pricing files and, if released by CMS, the April 2015, January 2015, October 2014, and July 2014 ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 6, 2015, with dates of service July 1, 2015, through September 30, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER).

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

Files (ASP&NOC)	Effective dates of service
July 2015	July 1-September 30, 2015
April 2015	April 1-June 30, 2015
January 2015	January 1-March 31, 2015
October 2014	October 1-December 31, 2014
July 2014	July 1-September 30, 2014

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.

Additional information

The official instruction, CR 9159, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3258CP.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: MM9159
Related Change Request (CR) #: CR 9159
Related CR Release Date: May 15, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3258CP
Implementation Date: July 6, 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.

CONSOLIDATED

From previous page

topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

Additional information

The official instruction, CR 9192, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3269CP.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: MM9192
Related Change Request (CR) #: CR 9192
Related CR Release Date: May 29, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3269CP
Implementation Date: October 5, 2015

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association.

Durable Medical Equipment

July quarterly update for 2015 DMEPOS fee schedule

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider action needed

This article is based on change request (CR) 9177 which advises providers of the July 2015 update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staff is aware of these updates.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf*.

Section 1834 (a), (h), and (i) of the Social Security Act requires payment on a fee schedule basis for DME, prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

Key points

Specific coding and pricing issues

1. As part of this update, fees are established for Healthcare Common Procedure Coding System (HCPCS) code A4602, which was added to the HCPCS file effective January 1, 2015. This item has been paid on a local fee schedule basis prior to this update. **Claims for code A4602 that have already been processed and have dates of service on or after January 1, 2015, may not be adjusted to reflect newly established fees.**
2. Section 203 of the Achieving a Better Life Experience (ABLE) Act of 2014 amended Section 1834(a)(1) of the Social Security Act to exclude Medicare coverage for vacuum erection systems.
3. As of July 1, 2015, HCPCS codes describing vacuum erection systems are statutorily excluded from Medicare coverage and are not payable when billed to Medicare. The fee schedules for the following vacuum erection system HCPCS codes will be removed from the DMEPOS fee schedule file effective July 1, 2015:
   a. L7900 Male vacuum erection system; and
   b. L7902 Tension ring, for vacuum erection device, any type, replacement only, each

   Effective for claims with dates of service on or after July 1, 2015, claims submitted with HCPCS codes L7900 and L7902 will be denied using the following codes:
   - Group code -PR – "patient responsibility."
   - **Claim adjustment reason codes (CARC) 96** – Non-covered charge(s). 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.) **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
   - Remittance advice remark code (RARC) N425 – "Statutorily excluded service(s)".

   Also, note that MACs will follow existing procedures for denying statutorily non-covered items, when these codes are billed with the "GY" modifier.
4. As part of the January 2015 update, fee schedules for HCPCS code A7048 (Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each) were added to the DMEPOS fee schedule file. In response to questions received on these fee schedule amounts, CMS is providing the following clarification:
   a. HCPCS code A7048 describes all supplies, including the appropriately sized collection container, that are needed for a collection unit change when draining an implanted catheter.
   b. A7048 is used for each single, complete collection and represents a supply allowance rather than a specifically defined kit.
   c. Items included in this code are not limited to pre-packaged kits that are bundled by manufacturers or distributors.
   d. The A7048 supplies include, but are not limited to, drainage tubing, gauze, dressings and any number of collection units of various sizes needed to capture the drainage for each complete drainage collection.

See **DMEPOS**, next page

Laboratory/Pathology

CMS adds seven new clinical lab tests to waived list

Provider types affected

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

Provider action needed

Change request (CR) 9164 informs MACs of new Clinical Laboratory Improvement Amendments of 1998 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) notifies the MACs of the new tests so that they can accurately process claims. There are seven (7) newly added waived complexity tests, displayed in the *Background* section below.

CLIA requires that, for each test it performs, a laboratory facility must be appropriately certified. The *Current Procedural Terminology*® (*CPT*®) codes that CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. If you do not have a valid, current CLIA certificate and submit a claim to your MAC for a *CPT*® code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be affected. Make sure that your billing staffs are aware of these changes.

Background

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Medicare and Medicaid programs only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The *CPT*® codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of CR 9164 titled, "Tests Granted Waived Status under CLIA" (that is, *CPT*® codes: *81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.

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

CPT® code	Effective date	Description
*83036*QW	September 23, 2014	Alere Technologies AS, Alere Afinion AS101 Analyzer
G0434QW	November 13, 2014	Native Diagnostics International DrugSmart Dip Multi-Panel Drug Screen Dip Card with OPI 2000 Tests
G0434QW	December 1, 2014	Chemton Biotech, Inc. Chemtrue Multi-Panel DOA Dip Card Tests

See **WAIVED**, next page

DMEPOS

From previous page

e. Since included in A7048, supplies that are used in a collection change should not be separately billed using miscellaneous codes.

Additional information

The official instruction, CR 9177, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3277CP.pdf*.

You may want to review the related *MLN Matters*® article, SE1511 (Discontinued Coverage of Vacuum Erection Systems (VES) Prosthetic Devices in Accordance with the Achieving a Better Life Experience Act of 2014).

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: MM9177
Related Change Request (CR) #: CR 9177
Related CR Release Date: May 29, 2015
Effective Date: January 1, 2015 - for implementation of fee schedule amounts for codes in effect January 1, 2015; July 1, 2015 for all other changes
Related CR Transmittal #: R3277CP
Implementation Date: July 6, 2015

WAIVED

From previous page

CPT® code	Effective date	Description
G0434QW	December 1, 2014	Chemton Biotech, Inc. Chemtrue Multi-Panel DOA Dip Card with OPI 2000 Tests
*87880*QW	December 17, 2014	Quidel Sofia Strep A+FIA {from throat swab only}
G0434QW	December 29, 2014	Clarity Diagnostics Multi-Panel Drug Screen Dip Card Tests
G0434QW	December 29, 2014	Clarity Diagnostics Multi-Panel Drug Screen Dip Card with OPI 2000 Tests

The *CPT*® code *82055* (Alcohol (ethanol); any specimen except breath) was discontinued on December 31, 2014.

The *CPT*® code *G6040* (Alcohol (ethanol); any specimen except breath) was effective on January 1, 2015.

CPT® code *G6040QW* will be assigned to the following tests:

- Alere Toxicology Services, iScreen Saliva Alcohol Test Strip;
- Alfa Scientific Designs Inc. Oral-View Saliva Alcohol Test Strip;
- American Screening Corporation, Reveal Saliva Alcohol Test Strip;
- Acon Laboratories Inc. Mission Saliva Alcohol Test Strip;
- Chematics Inc. Alco-Screen Saliva Alcohol Test;
- Chematics Inc. Alco-Screen 02 Saliva Alcohol Test;
- CLIAwaived Inc. Rapid Saliva Alcohol Test;
- Express Diagnostics International, Incorporated Saliva Alcohol Test;
- Germaine Laboratories AimStrip Alcohol Saliva;
- Jant Pharmacal Corporation Accustrip Saliva Alcohol Test Strip;
- OraSure Technologies Q.E.D. A-150 Saliva Alcohol Test;

- OraSure Technologies Q.E.D. A-350 Saliva Alcohol Test;
- STC Diagnostics Q.E.D. A150 Saliva Alcohol Test;
- STC Diagnostics Q.E.D. A350 Saliva Alcohol Test; and
- Teco Diagnostics Saliva Alcohol Test.

Additional information

The official instruction, CR 9164, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3267CP.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: MM9164
Related Change Request (CR) #: CR 9164
Related CR Release Date: May 22, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3267CP
Implementation Date: July 6, 2015

Medicare Physician Fee Schedule

July update to the Medicare physician fee schedule database

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9152 which amends payment files that were previously issued to your MAC based upon the 2015 Medicare physician fee schedule database (MPFSDB) final rule.

Affected providers should be aware that MACs will only adjust claims brought to their attention. Please make sure your billing staff is aware of these changes.

Background

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

Payment files were previously issued to your MAC based on the 2015 MPFS final rule, which was published in the *Federal Register* and effective for services furnished between January 1 and December 31, 2015 (See *http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf*).

Quarterly update to MPFSDB July 2015 update

The Medicare Access and CHIP Reauthorization Act of 2015 allowed the zero percent update that would have ended on March 31, 2015, to continue through to June 30, 2015, and allows for a 0.5 percent from July 1 to December 31, 2015. It also extends the physician work geographic practice cost index (GPCI) floor of 1.0, and the therapy cap exceptions process, through December 2017.

CR 9152 provides files for MPFS changes that are effective for dates of service

January 1 through June 30, 2015, at the zero percent update, and files for changes effective for dates of service on or after July 1, 2015, at the 0.5 percent rate.

The attachment in CR 9152 lists new codes Q5101, Q9976, Q9977, Q9978, *0392T, 0393T, 90620, 90621*, and *90697* with the applicable "HCPCS effective date" for each code.

Tables 1-3 also list those codes.

In accordance with Chapter 23, Section 30.1 of the *Medicare Claims Processing Manual*, MACs will give providers 30-day notices before implementing the changes identified in CR 9152.

Your MAC will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, they will adjust claims brought to their attention.

New codes: Table 1

Code	Q5101	Q9976	Q9977
Effective date	3-6-2015	7-1-2015	7-1-2015
Type(s) of service	1, P	1, L	1, P
HCPCS coverage code	D	C	D
Long descriptor	*Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram*	*Injection, Ferric*	*Compounded Drug, Not Otherwise Classified*
Short descriptor	Inj filgrastim g-csf biosim	Inj Ferric	Compounded Drug NOC
MPFSDB record date	20150306	20150701	20150701
MPFS procedure status	E	E	E
Work RVU	0.00	0.00	0.00
Full non-facility PE RVU	0.00	0.00	0.00
Full facility PE RVU	0.00	0.00	0.00
Malpractice RVU	0.00	0.00	0.00
Site of service	0	0	0
PC/TC	9	9	9
Global surgery	XXX	XXX	XXX
Pre	0.00	0.00	0.00
Intra	0.00	0.00	0.00
Post	0.00	0.00	0.00
Multiple procedure indicator	9	9	9
Bilateral surgery indicator	9	9	9
Assistant surgery indicator	9	9	9
Co-surgery indicator	9	9	9

See **MPFSDB**, next page

MPFSDB

From previous page

Code	Q5101	Q9976	Q9977
Team surgery indicator	9	9	9
Physician supervision diagnostic indicator	09	09	09
Diagnostic family imaging indicator	99	99	99
Non-facility PE used for OPPS payment amount	0.00	0.00	0.00
Facility PE used for OPPS payment amount	0.00	0.00	0.00
MP used for OPPS payment amount	0.00	0.00	0.00

New codes: Table 2

Code	Q9978	*0392T*	*0393T*
Effective date	7-1-2015	7-1-2015	7-1-2015
Type(s) of service	1	2, 8	2, 8
HCPCS coverage code	D	C	C
Long descriptor	Netupitant 300 mg and	*Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band)*	*Removal of esophageal sphincter*
Short descriptor	Netupitant	Lap es sph augment dev place	Es sph augmnt device removal
MPFSDB record date	20150701	20150701	20150701

Code	Q9978	*0392T*	*0393T*
MPFS procedure status	E	C	C
Work RVU	0.00	0.00	0.00
Full non-facility PE RVU	0.00	0.00	0.00
Full facility PE RVU	0.00	0.00	0.00
	0.00	0.00	0.00
Site of service	0	0	0
PC/TC	9	0	0
Global surgery	XXX	YYY	YYY
Pre	0.00	0.00	0.00
Intra	0.00	0.00	0.00
Post	0.00	0.00	0.00
Multiple procedure indicator	9	0	0
Bilateral surgery indicator	9	0	0
Assistant surgery indicator	9	0	0
Co-surgery indicator	9	0	0
Team surgery indicator	9	0	0
Physician	09	09	09
Diagnostic family imaging indicator	99	99	99
Non-facility PE used for OPPS payment amount	0.00	0.00	0.00
Facility PE used for OPPS payment amount	0.00	0.00	0.00
MP used for OPPS payment amount	0.00	0.00	0.00

See **MPFSDB**, next page

MPFSDB

From previous page

New codes: Table 3

Code	*90620*	*90621*	*90697*
HCPCS effective date	2-1-2015	2-1-2015	1-1-2015
Type(s) of service	1	1	1
HCPCS coverage code	C	C	C
Long descri-ptor	*Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B, 2 dose schedule, for intramuscular use*	*Meningococcal recombinant lipoprotein vaccine, Serogroup B, 3 dose schedule, for intramuscular use*	*Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine,*
Short descri-ptor	Menb rp w/ omv vaccine im	Menb rlp vaccine im	Dtap-ipv-hib-hepb vaccine im
MPFSDB record date	20150201	20150201	20150101
MPFS	E	E	E
Work RVU	0.00	0.00	0.00
Full non-facility PE RVU	0.00	0.00	0.00
Full facility PE RVU	0.00	0.00	0.00
Malpra-ctice RVU	0.00	0.00	0.00
Site of service	0	0	0
PC/TC	9	9	9
Global surgery	XXX	XXX	XXX
Pre	0.00	0.00	0.00
Intra	0.00	0.00	0.00
Post	0.00	0.00	0.00
Multiple pocedure indicator	9	9	9
Bilateral surgery indicator	9	9	9
Assistant surgery indicator	9	9	9
Co-surgery indicator	9	9	9
Team surgery indicator	9	9	9
Physician	09	09	09

The following changes are effective for dates of service on and after January 1, 2015.

Code	Modifier	Action
34839		PC/TC indicator = 0
88366		Non-facility PE RVU = 5.27; facility PE RVU = 5.27
88366	TC	Non-facility PE RVU = 4.76; facility PE RVU = 4.76
93355		Multiple surgery indicator = 6

Additional information

You may want to review the following articles:

- MM9081 titled "Emergency Update to the Calendar Year (CY) 2015 Medicare Physician Fee Schedule Database (MPFSDB) at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9081.pdf*; and
- MM9104 titled "Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) April Calendar Year (CY) 2015 Update" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9104.pdf*.

The official instruction, CR 9152, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3259CP.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: MM9152
Related Change Request (CR) #: CR 9152
Effective Date: January 1, 2015 - Effective for dates of service on or after January 1, 2015, unless otherwise stated
Related CR Release Date: May 15, 2015
Related CR Transmittal #: R3259CP
Implementation Date: July 6, 2015

April Medicare physician fee schedule database update

***Note**: This article was revised June 15, 2015, to reflect the revised change request (CR) 9104 issued June 12. CR 9104 was revised to reflect the changes required by the Medicare Access and CHIP Reauthorization Act of 2015. The article has been revised accordingly. In addition, the CR release date, transmittal number, and the Web address for accessing CR 9104 are revised. This information was previously published in the March 2015 Medicare B Connection, Page 17.*

Provider types affected

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

Provider action needed

Change request (CR) 9104 informs MACs about the release of payment files based upon the 2015 Medicare physician fee schedule (MPFS) final rule. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to MACs based upon the 2015 MPFS final rule, published in the *Federal Register* December 19, 2014, to be effective for services furnished between January 1, 2015, and December 31, 2015.

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

The Medicare Access and CHIP Reauthorization Act of 2015 allowed the zero percent update that would have ended March 31, 2015, to continue through to June 30, 2015, and allows for a 0.5 percent update from July 1, 2015, to December 31, 2015. It also extends the physician work geographic practice cost index (GPCI) floor of 1.0, and the therapy cap exceptions process, through December 2017.

In the 2015 Medicare physician fee schedule final rule, the Centers for Medicare & Medicaid Services (CMS) announced a conversion factor (CF) of $28.2239 for services furnished on or after April 1, 2015, resulting in an average reduction of 21.2 percent from the 2014 rates (this CF was later corrected to $28.1872 in a correction notice). However, the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 allowed the zero percent update that would have ended March 31, 2015, to continue through to June 30, 2015. Therefore, the CF of 35.7547 in effect from January 1, 2015, through March 31, 2015, was extended to June 30, 2015.

Changes for certain *CPT*®/HCPCS codes included in the April update to the 2015 MPFSDB are as follows:

- J1826 - Procedure status = E
- J9010 - Procedure status = N
- *77063* - Type of service = 1
- *93355* - Multiple surgery indicator = 2 and type of service = 4
- *93644* -Type of service = 2

Code G0279 has a new short descriptor of "Tomosynthesis, mammo".

In addition, the following codes have a procedure status of "I": *80300, 80301, 80302, 80303, 80304, 80320, 80321, 80322, 80323, 80324, 80325, 80326, 80327, 80328, 80329, 80330, 80331, 80332, 80333, 80334, 80335, 80336, 80337, 80338, 80339, 80340, 80341, 80342, 80343, 80344, 80345, 80346, 80347, 80348, 80349, 80350, 80351, 80352, 80353, 80354, 80355, 80356, 80357, 80358, 80359, 80360, 80361, 80362, 80363, 80364, 80365, 80366, 80367, 80368, 80369, 80370, 80371, 80372, 80373, 80374, 80375, 80376*, and *80377*.

Effective for services on or after April 1, 2015, the following codes will have a procedure status of "X": *81500, 81503, 81506, 81508, 81509, 81510, 81511, 81512,* and *81599*.

Also, effective for services on or after April 1, 2015, new code Q9975 is added with a short descriptor of "Factor VIII FC Fusion Recomb" and a long descriptor of "Injection, Factor VIII, FC Fusion Protein (Recombinant), per iu". The procedure status code for Q9975 is "E" and it has a global surgery modifier of "XXX."

Finally, S8032 was transposed as S0832 in the January 2015 MPFS; S0832 has been replaced with S8032 in the April 2015 MPFS.

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

Additional information

The official instruction, CR 9104, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3283CP.pdf*.

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

MLN Matters® Number: MM9104 *Revised*
Related Change Request (CR) #: CR 9104
Related CR Release Date: June 12, 2015
Effective Date: January 1, 2015, based on dates of service unless otherwise stated in this article.
Related CR Transmittal #: R3283CP
Implementation Date: April 6, 2015

Medicare Secondary Payer

Billing and coding reminders related to Medicare secondary payer claims involving Veterans Affairs services

Provider types affected

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

Provider action needed

This article is intended to provide additional information and coding reminders for billing Medicare when the Department of Veterans Affairs (VA) is involved for a portion of the services. This article is based on change request (CR) 8198 (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1213OTN.pdf*) which informs MACs about clarification to procedures for institutional claims related to the Department of Veterans Affairs (VA). Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) sent the MACs a letter (technical direction letter #12002), titled "Clarification to Procedures Related to the Department of Veterans Affairs (VA)". This communication advised MACs to no longer accept VA information entered on claims as the basis for assuming that Medicare should pay secondary.

The coordination of benefits contractor (COBC) also disabled the creation of VA Medicare secondary payer (MSP) records when an action to create such records was requested via the electronic correspondence referral system (ECRS). The CMS took these actions based on the following language found in Section 1862(a) (3) of the Social Security Act (the Act): Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. VA claims, therefore, represents a Medicare program exclusion rather than an indication of MSP.

Billing instructions

For inpatient claims where the VA is the payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn't approve all the services, any Medicare covered services not considered by the VA may be billed to the Medicare program. VA approved services (that is, Medicare excluded services) may be submitted on a separate non-covered claim to Medicare.

Only Medicare covered services should be billed to the Medicare program. Medicare should not be billed as the secondary payer to VA using the value code "42". (See the *Medicare Claims Processing Manual*, Chapter 1, Section 60 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf* for billing instructions).

For outpatient claims where the VA is the Payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn't approve all the services, any Medicare covered services can be billed to Medicare. Medicare should not be billed as the secondary payer to VA using the value code "42".

(See the *Medicare Claims Processing Manual*, Chapter 1, Section 60 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf* for billing instructions).

Additional information

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: SE1517
Related Change Request (CR) #: CR 8198
Related CR Release Date: May 3, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1213OTN
Implementation Date: October 7, 2013

General Coverage

ICD-10 conversion / coding infrastructure revisions / ICD-9 updates to - 2nd maintenance CR

Provider types affected

***Note**: This article was revised May 22, 2015, to reflect a revised change request. That revision changed C8681 to L8681 in spreadsheet NCD 160.18 and added a requirement to change the provider query eligibility screens for bone density to support CWF updates to NCD 150.3. The transmittal number, CR release date and link to the CR also changed. All other information remains the same. This information was previously published in the March 2015 Medicare B Connection, Pages 34-35.*

Provider types affected

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

Provider action needed

This article is based on CR 9087 which is the second maintenance update of ICD-10 conversions and coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, and CR 8691. Links to related *MLN Matters*® articles MM7818, MM8109, MM8197, and MM8691 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these spreadsheets attached to CR 9087 for the following 13 NCDs:

NCD	NCD title
20.29	Hyperbaric oxygen therapy
20.9.1	Ventricular assist devices
50.3	Cochlear implantation
80.2	Photodynamic therapy
80.2.1	Ocular photodynamic therapy (OPT)
80.3	Photosensitive drugs
80.3.1	Verteporfin
110.10	Intravenous iron therapy
150.3	Bone (mineral) density studies
160.18	Vagus nerve stimulation
180.1	Medical nutrition therapy
210.2	Screening Pap smears and pelvic examinations for early detection of cervical or vaginal cancer
250.3	Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases

Background

CR 9087's purpose is to create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, plus all associated coding infrastructure such as and so forth. The requirements described in CR 9087 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the attached Medicare NCD spreadsheets.

Please note that there are 10 spreadsheets attached to CR 9087. These spreadsheets relate to 13 NCDs, and provide pertinent policy/coding information necessary to implement ICD-10. Further, you should be aware that NCD policies may contain specific covered, non-covered and/or discretionary diagnosis coding. These spreadsheets are designated as such and are based on current NCD policies and their corresponding edits. Nationally covered and non-covered diagnosis code editing is finite and cannot be revised without subsequent discussions with CMS. Discretionary code lists are to be regarded as CMS' compilation of discretionary codes based on current analysis/interpretation. Local MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions. Nothing contained in CR 9087 should be construed as new policy.

Some coding details are as follows:

1. The ICD-10 diagnosis/procedure codes associated with the NCDs attached to CR 9087 are not to be implemented until October 1, 2015, or until ICD-10 is implemented.
2. Your MAC will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages, where appropriate:
   - **Remittance advice remark code (RARC) N386**: (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered), along with Claim Adjustment Reason Code (CARC) 50 (These are noncovered services because this is not deemed a "medical necessity" by the payer), CARC 96 (Non-covered charge(s). 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]),

See **ICD-10**, next page

ICD-10

From previous page

and/or CARC 119 (Benefit maximum for this time period or occurrence has been reached).

3. When denying claims associated with the attached NCDs, except where otherwise indicated, your MACs will use:

   - **Group code PR** (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 (Advance Beneficiary Notice), or with occurrence code 32 and a GA modifier (The provider or supplier has provided an Advance Beneficiary Notice (ABN) to the patient), indicating a signed ABN is on file).
   - **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier (The provider or supplier expects a medical necessity denial; however, did not provide an Advance Beneficiary Notice (ABN) to the patient), indicating no signed ABN is on file).

Note: For modifier GZ, use CARC 50 and MSN 8.81 (If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/supplier).

Additional information

The official instruction, CR 9087 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1504OTN.pdf*. The spreadsheet attachments to CR 9087 are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1478OTN.zip*.

MM7818 is available for review at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7818.pdf*.

MM8109 is available for review at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8109.pdf*.

MM8197 is available for review at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8197.pdf*.

MM8691 is available for review at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.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: MM9087 *Revised*
Related Change Request (CR) #: CR 9087
Effective Date: April 6, 2015 - For designated ICD-9 updates and all local system edits (ICD-9 and ICD-10); July 1, 2015 - For all ICD-9 shared system edits; October 1, 2015 - For all ICD-10 shared system edits (or whenever ICD-10 is implemented)
Related CR Release Date: May 20, 2015
Implementation Date: April 6, 2015 - For designated ICD-9 updates and all local system edits; July 6, 2015 - For ICD-9 and ICD-10 shared system edits
Related CR Transmittal #: R1504OTN

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.

Your feedback matters

Your opinion is important to us. If you haven't already completed the MAC Satisfaction Indicator (MSI) survey, please take a moment to complete it now. Share your experience with the services we provide. It will take about 10 minutes. You can access the survey by clicking here.

Information and resources for submitting correct ICD-10 codes to Medicare

Provider types affected

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

Provider action needed

This *MLN Matters*® special edition article is intended to assist physicians, providers, and suppliers by offering information and resources for submitting correct International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes to Medicare.

Background

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2015, for all Health Insurance Portability and Accountability Act-covered entities. ICD-10-CM, including the "ICD-10-CM Official Guidelines for Coding and Reporting," will replace International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after October 1, 2015. ICD-10-PCS, including the "ICD-10-PCS Official Guidelines for Coding and Reporting," will replace ICD-9-CM procedure codes.

Use of external cause and unspecified codes in ICD-10-CM

Similar to ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless you are subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, you are not required to report ICD-10-CM codes found in Chapter 20 of the ICD-10-CM, External Causes of Morbidity.

If you have not been reporting ICD-9-CM external cause codes, you will not be required to report ICD-10-CM codes found in Chapter 20 unless a new state or payer-based requirement about the reporting of these codes is instituted. If such a requirement is instituted, it would be independent of ICD-10-CM implementation. In the absence of a mandatory reporting requirement, you are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While you should report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. You should code each health care encounter to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient's condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code.

All the Medicare claims audit programs will use the same approach under ICD-10 as is used under ICD-9. Physicians, like all providers, are expected to code correctly and have sufficient documentation to support the codes selected. For example, if a physician is treating a patient for diabetes, there should be an ICD-10 code on the claim for diabetes. The level of specificity of the diabetes code selected will not change the coverage and payment of services in most cases.

Information and resources

Visit the following Web pages to find information and resources that will assist you in submitting correct ICD-10 codes to Medicare:

General ICD-10-CM/PCS information

http://www.cms.gov/Medicare/Coding/ICD10/index.html

ICD-10 fee-for-service educational resources, including *MLN Matters*® articles, MLN products, *MLN Connects*® videos, and CMS resources

http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html

"Coding for ICD-10-CM: More of the Basics" *MLN Connects*® video

See **RESOURCES**, next page

CMS conducts second successful Medicare FFS ICD-10 end-to-end testing week in April

From April 27 through May 1, 2015, Medicare fee-for-service (FFS) health care providers, clearinghouses, and billing agencies participated in a second successful ICD-10 end-to-end testing week with all Medicare administrative contractors (MACs) and the durable medical equipment (DME) MAC common electronic data interchange (CEDI) contractor. CMS was able to accommodate most volunteers, representing a broad cross-section of provider, claim, and submitter types.

This second end-to-end testing week demonstrated that CMS systems are ready to accept ICD-10 claims. Approximately 875 providers and billing companies participated, and testers submitted over 23,000 test claims. View the *results file.*

Overall, participants in the April end-to-end testing week were able to successfully submit ICD-10 test claims and have them processed through Medicare billing systems. The acceptance rate for April was higher *than January*, with an increase in test claims submitted and a decrease in the percentage of errors related to diagnosis codes. Most of the claim rejections that occurred were due to errors unrelated to ICD-9 or ICD-10.

In addition to acknowledgement testing, which may be completed at any time, a final end-to-end testing week will be held on July 20 through 24, 2015. The opportunity to volunteer for this testing week has closed. Testers who participated in the January and April end-to-end testing weeks are automatically eligible to test again in July.

Prepare now for ICD-10 implementation

Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015; or accept claims that contain both ICD-9 and ICD-10 codes.

There is still time to get ready

Even though the October 1, 2015, mandatory implementation date is quickly approaching, providers still have time to prepare for ICD-10, and CMS has created a number of tools and resources to help you succeed. One tool is the *Road to 10*, aimed specifically at smaller physician practices with primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help you with implementation.

For more information

- *MLN Matters® article MM8867*, "ICD-10 Limited End-to-End Testing with Submitters for 2015
- *MLN Matters® special edition article SE1435*, "FAQs – ICD-10 End-to-End Testing"
- *MLN Matters® special edition article #SE1409*, "Medicare FFS ICD-10 Testing Approach"

RESOURCES

From previous page

http://www.cms.gov/Medicare/Coding/ICD10/CMS-Sponsored-ICD-10-Teleconferences-Items/2014-12-02-ICD-10-Basics.html

General equivalence mappings

http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html

ICD-10 National coverage determinations

http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html

Additional information

If you have any questions, please contact your MAC at their toll-free number. To find MAC toll-free numbers, please refer to the review contractor interactive map located at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html*.

MLN Matters® Number: SE1518
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: October 1, 2015
Related CR Transmittal #: N/A
Implementation Date: N/A

FAQs – ICD-10 end-to-end testing

***Note**: This article was revised June 9, 2015, to provide updated information for physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing. This information was previously published in the December 2014 Medicare B Connection, Pages 24-25.*

Provider types affected

This *MLN Matters*® special edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

Provider action needed

Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

What to know prior to testing

1. How is ICD-10 end-to-end testing different from acknowledgement testing?

   The goal of acknowledgement testing is for testers to submit claims with ICD-10 codes to the Medicare fee-for-service claims systems and receive acknowledgements to confirm that their claims were accepted or rejected.

   End-to-end testing takes that a step further, processing claims through all Medicare system edits to produce and return an accurate electronic remittance advice (ERA). While acknowledgement testing is open to all electronic submitters, end-to-end testing is limited to a smaller sample of submitters who volunteer and are selected for testing.

2. What constitutes a testing slot for this testing?

   A testing slot is the ability to submit 50 claims to a particular Medicare administrative contractor (MAC) who selected you for testing.

3. What data must I provide to the MAC before testing?

   For each testing slot, you must provide the MAC the following:

   - Up to two submitter identifiers (IDs);
   - Up to five national provider identifiers (NPIs)/ provider transaction access numbers (PTANs), and
   - Up to 10 health insurance claim numbers (HICNs).

   You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

   If you want to change your selected submitter IDs, NPIs, PTANs, or HICNs, you must contact the MAC. If the MAC is not aware of these changes, claims submitted will not be processed.

4. What should I consider when choosing HICNs for testing?

   The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information and other documentation such as certificates of medical necessity (CMNs). The HICNs you provide must be real beneficiaries and may not have a date of death on file. If you previously submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.

5. If I was selected for the January 2015 or April 2015 end-to-end testing, do I need to reapply for July 2015 testing?

   No, once you are selected for testing, you are automatically registered for the later rounds of testing.

6. Can I submit additional NPIs, PTANs, and HICNs for the later rounds of testing?

   Yes, while you do not need to re-apply for the later rounds of testing, you may choose to submit up to two additional submitter IDs, up to five additional NPIs/ PTANs, and up to 10 additional HICNs. You may also still use the information you submitted for the previous testing round. The MAC will provide the form you must use to submit this new information, and the information must be received by the due date on the form to be considered for the next round of testing.

What to know during testing

1. Is it safe to submit test claims with protected health information (PHI)?

   The test claims you submit are accepted into the system using the same secure method used for production claims on a daily basis. They will be processed by the same MACs who process production claims, and all the same security protocols will be followed. Therefore, using real data for this test does not cause any additional risk of release of PHI.

2. What dates of service can be used on test claims?

   Professional claims with an ICD-10 code must have a date of service on or after October 1, 2015.

   Inpatient claims with an ICD-10 code must have a discharge date on or after October 1, 2015.

   Supplier claims with an ICD-10 code must have a date of service between October 1, 2015, and October 15, 2015.

   For professional and institutional claims, you may use dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

3. Can both ICD-9 and ICD-10 codes be submitted on the same claim?

See **FAQs**, next page

FAQs

From previous page

ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later), please refer to the following *MLN Matters*® articles:

- SE1325, "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims That Span the ICD-10 Implementation Date," located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf*;
- SE1408, "Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492," located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf*
- SE1410, "Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition (ICD-10-CM) Coding on Home Health Episodes that Span October 1, 2015," located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf*

4. Do returned to provider (RTP) claims count toward the 50 claims submitted? Can RTP'd claims be re-submitted for testing?

   Institutional claims that fail RTP editing count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the ERA, and they will not be available through direct data entry (DDE). If claims accepted by the front end edits do not appear on the ERA, please contact the MAC for further information.

   Claims that are rejected by front end editing do not count toward the 50 claim submission limit; therefore, they should be corrected and resubmitted.

5. Will a summary of test claims be provided at the conclusion of testing?

   Yes, the MAC will provide testers a summary of all accepted test claims after the April and July testing rounds. These reports will be delivered to testers approximately 4 weeks following the testing week. Reports for April 2015 testing were delivered by May 29.

6. If a CMN or DME information form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?

   If the beneficiary has a valid CMN or DIF on file for that equipment/supply covered by the dates of service on your test claim (after October 1, 2015), you do not need to submit a new CMN/DIF.

   If the beneficiary's CMN/DIF has expired for the dates of service on your test claim (after 10/1/2015), you must submit a revised CMN/DIF to extend the end date for that CMN/DIF.

   If the beneficiary does not have a CMN or DIF for that equipment/supply, you must submit a new CMN/DIF.

7. For home health claims, how should I submit the Request for anticipated payment (RAP) and final claim for testing?

   Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the common working file (CWF). The RAP processing time will be short since the test beneficiaries are set up in advance.

   To get your results more quickly, you may also want to consider billing low utilization payment adjustment claims with four visits or less that do not require a RAP.

8. For Hospice claims, should I submit the notice of election (NOE) prior to testing?

   You will not need to provide NOEs to the MAC prior to the start of testing. MACs will set up NOEs for any hospice claims received during testing.

9. For an inpatient rehabilitation facility (IRF) or skilled nursing facility (SNF) stay, can the case-mix group (CMG) or resource utilization group (RUG) code be submitted on the claim even though the date of service is in the future?

   Yes, you can send the IRF claim with a valid CMG code on the claim and a SNF claim with a valid RUG code on the claim, even though the date is in the future. For testing purposes, only a claim with a valid health insurance prospective payment system (HIPPS) code will be required. You do not need to submit the supporting data sheets.

Additional information

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: SE1435 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A Related CR Transmittal #: N/A
Implementation Date: N/A

Medicare fee-for-service (FFS) International Classification of Diseases, 10th Edition (ICD-10) testing approach

***Note**: This article was revised on May 29, 2015, to show that the April I/OCE is available and that it contains ICD-9 and ICD-10 codes. It was previously published in the December 2014 Medicare B Connection, Pages 22-23.*

Provider types affected

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

Provider action needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA.

The HIPAA standard health care claim transactions are among those for which International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready. This *MLN Matters*® special edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2015, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS as well as the FFS provider community is ready.

When "you" is used in this publication, we are referring to the FFS provider community.

The four-pronged approach includes:

- CMS internal testing of its claims processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail below.

CMS internal testing of its claims processing systems

CMS has a very mature and rigorous testing program for its Medicare FFS claims processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for four weeks;
- Beta testing is performed by a separate integration contractor for eight weeks; and
- Acceptance testing is performed by each MAC for four weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claim processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-initiated beta testing tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as national coverage determination (NCD) and local coverage determination (LCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs and LCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*;
- The ICD-10 Medicare severity-diagnosis related groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the general equivalence mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at *http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html*.
  On this Web page, you can also find current versions of the ICD-10-CM MS-DRG grouper, Medicare code editor (available from National Technical Information Service), and MS-DRG definitions manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- The April 2015 version of the integrated outpatient code editor (I/OCE) now includes both ICD-9-CM and ICD-10-CM. The files are available at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html*. The July 2015 I/OCE release will also include both ICD-9-CM and ICD-10-CM. The final version of the I/OCE that utilizes ICD-10-CM is scheduled for release in August 2015.

Acknowledgement testing

Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, CMS will be highlighting this testing by offering three separate weeks of ICD-10 acknowledgement testing. These special acknowledgement testing weeks give submitters access to real-time help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events.

See **TESTING**, next page

TESTING

From previous page

All MACs and the DME MAC common electronic data interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A or a 999) that confirms whether the submitted test claims were accepted or rejected.

MACs and CEDI will be appropriately staffed to handle increased call volume on their electronic data interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during these testing weeks. The testing weeks will occur in November 2014, March 2015, and June 2015. For more information about acknowledgement testing, refer to the information on your MAC's website.

End-to-end testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods. End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider's receipt of a remittance advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. To facilitate this testing, CMS requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26 – 30, 2015, April 27 – May 1, 2015, and July 20 – 24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers to represent a broad cross-section of provider types, claims types, and submitter types. At least five, but not more than fifteen, of the testers will be a clearinghouse.
- MACs and CEDI will post a volunteer form to their website during the enrollment periods to collect volunteer information with which to select volunteers. Those interested in testing should review the minimum testing requirements on the form to ensure they qualify before volunteering.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate *MLN Matters*® article.

Claims submission alternatives

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2015, you should investigate downloading the free billing software that CMS offers via their MAC websites. The software has been updated to support ICD-10 codes and requires an Internet connection. This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Alternatively, all MACs offer provider internet portals, and a subset of these MAC portals offer claims submission; providers submitting to this subset of MACs may choose to use the portal for submission of ICD-10 compliant claims. Register in the portals that offer claims submission to ensure that you have the flexibility to submit professional claims this way as a contingency. More information may be found on your MAC's website.

Additional information

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*?

In addition to showing the toll-free numbers, you will find your MAC's website address at this site in the event you want more information on the free billing software or the MAC's provider Internet portals mentioned above.

MLN Matters® Number: SE1409 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: October 1, 2015
Related CR Transmittal #: N/A
Implementation Date: N/A
Implementation Date: October 5, 2015

Claim status category and claim status codes update

Provider types affected

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

Provider action needed

Change request (CR) 9141 informs MACs about the changes to the claim status category and claim status codes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the Accredited Standards Committee (ASC) X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*.

All code changes approved during the June 2015 committee meeting shall be posted on those sites on or about July 1, 2015. MACs must complete entry of all applicable code text changes, add new codes, and terminate use of deactivated codes by the implementation date of CR 9141.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC

X12 277 transactions issued on and after the date of implementation of CR 9141.

Additional information

The official instruction, CR 9141, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3272CP.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: MM9141
Related Change Request (CR) #: CR 9141
Related CR Release Date: May 29, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3272CP
Implementation Date: October 5, 2015

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association.

Your feedback matters

Your opinion is important to us. If you haven't already completed the MAC Satisfaction Indicator (MSI) survey, please take a moment to complete it now. Share your experience with the services we provide. It will take about 10 minutes. You can access the survey by clicking here.

Implement operating rules - phase III ERA EFT: CORE 360 uniform use of CARC and RARC codes

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9138 which instructs MACs and Medicare's shared system maintainers (SSMs) to update their systems based on the Council for Affordable Quality Healthcare (CAQH) 360 Uniform Use of CARC and RARC (835) rule set. These system updates are based on the committee on operating rules for information exchange (CORE) code combination list to be published on or about June 1, 2015. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that was under the Affordable Care Act.

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

More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to electronic data interchange (EDI) from paper has been slow and disappointing. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CR 9138 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) rule.

CAQH CORE will publish the next version of the code combination list on or about June 1, 2015. This update is based on March 1, 2015 claim adjustment reason code (CARC) and remittance advice remark code (RARC) updates as posted at the WPC website. Please go to *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

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

Additional information

The official instruction, *CR 9138* issued to your MAC regarding this change is available on the CMS website.

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: MM9138
Related Change Request (CR) #: CR 9138
Related CR Release Date: May 29, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3270CP
Implementation Date: October 5, 2015

Non-specific procedure code description requirement for HIPAA version 5010 claims

Provider types affected

***Note**: This article was revised June 8, 2015, to delete a reference to a Web address for the NOC code set. That code set is no longer available on the CMS website. All other information remains the same. This information was previously published in the January 2012 Medicare B Connection, Pages 36-37.*

Provider types affected

This *MLN Matters*® special edition article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), home health and hospice MACs (HH+H MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What you need to know

The Office of E-Health Standards and Services (OESS) announced on November 17, 2011, that although the 5010/D.0 compliance date of January 1, 2012 will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012.

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required. Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when non-specific procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all non-specific procedure codes.

Background

The HIPAA version 5010 implementation guide describes non-specific procedure codes as codes that may include, in their descriptor, terms such as: “not otherwise classified (NOC); unlisted; unspecified; unclassified; other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name”. If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant. Note that the non-specific procedure code’s descriptor terms as listed above do not constitute a description of the procedure, drug, or service. For example, simply using not otherwise classified as the description does not pass editing and the claim will be rejected.

Additional information

For 5010/D.O implementation information and deadlines, refer to *MLN Matters*® special edition article SE1131, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1131.pdf*.

If you are not ready, consider contacting your Medicare contractor to receive the free version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

If you are billing Part B and DME claims, you may download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at *http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp*.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines. Part A billers may download the free PC-Print software to view and print a compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Please note, change request (CR) 7392, “Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates,” dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR 7392 was implemented by Medicare contractors on October 1, 2011, and does not override any previous claim processing instructions.

MLN Matters® Number: SE1138 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

TOOLS

From front page

level was chosen by the provider and compare it with the results on the E/M worksheet. It is very effective."

Liscombe uses a full array of tools in addition to those provided by First Coast Service Options and the UF technology team.

"I track the coding patterns and the Medicare standards for their type of practice. We will work with the E/M bell-curve for primary care in reviewing their charts," she said. "If they are consistently off 10 percent or higher, then we will bring the resident back for more education in coding."

At this point in the resident training process, Liscombe also turns to First Coast's *local coverage determination (LCD) lookup* and *fee schedule tools*. She reviews a LCD with the resident to show documentation requirements and possible diagnosis codes associated with a procedure or treatment. Liscombe says the fee schedule look-up tool helps identify what the costs are to the practice when there's a variance between what is documented and what is coded on the chart.

"The review is critical. Using the tools like the fee schedule look up, we can see the potential costs to our facility and to Medicare if they undercode or overcode," Liscombe says.

"The E/M worksheet is an excellent audit tool for all providers to use in their coding. If I were to hire additional staff, the E/M worksheet would be an important part of their orientation."

-Najwa Liscombe,
Department of Community Health and Family Medicine
University of Florida, College of Medicine

In explaining her role with educating the residents, Liscombe is as thorough as any patient would want their doctor to be in providing medical care.

"I subscribe to all of the listserves from CMS and First Coast. I keep tabs on all of the changes in Medicare," Liscombe said, adding that the information is critical for her to do her job well.

Potential assignment violations by clinical laboratories in U.S. Virgin Islands

It has come to the attention of First Coast Service Options by the State Health Insurance Assistance Program (SHIP) in the U.S. Virgin Islands that some laboratories are charging patients upfront to perform services. This would not be appropriate as, typically, beneficiaries are not held financially responsible for lab services.

As a reminder, providers of laboratory services should be aware of the following Medicare regulations:

- By law, a provider must submit Part B claims for all Medicare beneficiaries.
- Additionally, a provider must accept assignment for laboratory tests paid on the laboratory fee schedule. Otherwise, a Part B Medicare administrative contractor (MAC) cannot make payment for laboratory tests. Furthermore, no payment may be made for clinical diagnostic laboratory tests furnished by a physician or medical group unless the physician or medical group accepts assignment or claims payment under the indirect payment procedure for the laboratory services.
- For all clinical laboratory tests, specimen collection fees or travel allowance related to laboratory tests performed by a physician, laboratory, or other entity paid on assigned basis, neither the annual deductible nor the 20 percent coinsurance apply; the MAC will pay the lesser of the actual charge or 100 percent of the clinical laboratory fee schedule.
    - By law, the basic allowable charges for a beneficiary are the remaining deductible and 20 percent of the customary (or reasonable) charges in excess of the deductible. If the provider collects any monies from the beneficiary, the provider must inform the MAC of any amounts collected from them or from other persons on his or her behalf by completing Item 29 of the CMS-1500 claim form (or electronic equivalent).
    - **Note**: Please review "*When not to show patient paid amounts on claims*" article before collecting payments from patients.

Potential penalties for assignment violations

Providers that knowingly and willfully bill patients on an unassigned basis may be subject to sanctions, civil money penalties (up to $2,000 per violation), and/or exclusion from the Medicare program for a period of up to five years imposed.

Beneficiaries are encouraged to report possible assignment violations to 1-800-MEDICARE.

Source: *Pub. 100-04, Chapter 1, Section 30.3.6 and 30.3.9*; *Pub. 100-04, Chapter 16, Section 30.1 and 30.2*; Social Security Act (SSA) Act, Section 1848(g)(4); *Medicare Learning Network (MLN) Matters® special edition article SE0908 Mandatory Claims Submission and its Enforcement*; *Code of Federal Regulations* (CFR) Title 42, *Section 489.30(b)* and *489.35*

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

Revisions to LCDs

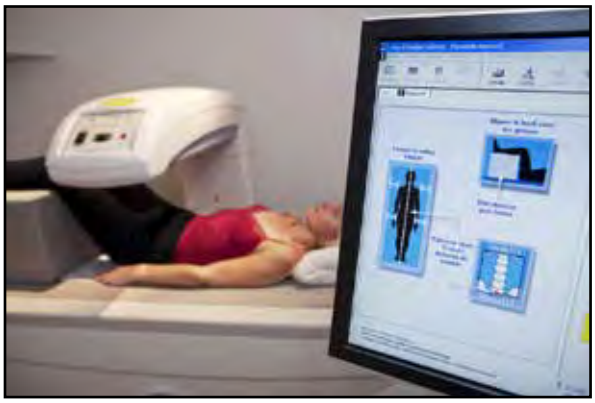
Bone mineral density studies – revision to the Part B LCD

LCD ID number: L29086 (Florida)
LCD ID number: L29101 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was revised based on change request (CR) 9087 related to ICD-9-CM updates to national coverage determination (NCD) 150.3 and *Current Procedural Terminology* (*CPT*®) code *77085* . The "Indications", "Limitations" and "*CPT*®/HCPCS Codes" sections of the LCD were updated.

Effective date

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

Carboplatin, (Paraplatin®, Paraplatin-AQ®) – revision to the Part B LCD

LCD ID number: L29089 (Florida)
LCD ID number: L29104 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for carboplatin (Paraplatin®, Paraplatin-AQ®) was revised to include the off-label indication of malignant poorly differentiated neuroendocrine carcinoma. The "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD was revised to include this off-label indication, and the "ICD-9 Codes that Support Medical Necessity" section was updated to add the correlating diagnosis code 209.30. In addition, the "Sources of Information and Basis of Decision" section was updated.

Effective date

This LCD revision is effective for services rendered **on or after June 4, 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*.

Viscosupplementation therapy for knee – revision to the Part B LCD

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

The local coverage determination (LCD) for viscosupplementation therapy for knee has been revised. In the "Limitations" section of the LCD, the following language has been added: "Per the Food and Drug Administration (FDA) package insert, the effectiveness of Monovisc™ has not been established for more than one course of treatment." Also, a list of the imaging procedures that are not covered when performed routinely for the purpose of visualization of the knee to provide guidance for needle placement have been added. Additionally, in the "Utilization Guidelines" section of the LCD, the "Duration of Treatment" has been revised to reflect, "One time/single injection (the effectiveness of Monovisc™ has not been established for more than one course of treatment)."

Effective date

This LCD revision is effective for claims processed **on or after June 11, 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*.

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

Upcoming provider outreach and educational events

Medicare Speaks 2015 Jacksonville

When: Thursday-Friday, July 16-17
Time: 7:30 a.m-4:15 p.m. **Type of event:** Face-to-face

http://medicare.fcso.com/Medicare_Speaks/278355.pdf

Internet-based PECOS class

When: Thursday, August 13
Time: 1:00 p.m.-5:00 p.m. **Type of event:** Face-to-face

http://medicare.fcso.com/Events/0293487.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 May 21, 2015

MLN Connects® Provider eNews for May 21, 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 – Register Now
- National Partnership to Improve Dementia Care and QAPI – Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 – Registration Now Open
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X – Register Now

MLN Connects® Videos

- New Video on PQRS and the Value-Based Payment Modifier

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

Announcements

- 2014 Mid-Year QRURs Available
- EHR Proposed Rules Available for Comment: Stage 3 Comments Due by May 29
- Call for TEP Nominations: Closing Date June 1
- CMS to Release Comparative Billing Report on CT Scans of the Abdomen and Pelvis in June
- EHR Incentive Program: Deadline for Eligible Professional Hardship Exception is July 1

- PQRS: IACS Transitioning to EIDM on July 13
- CMS is Accepting Suggestions for Potential PQRS Measures

Medicare Learning Network® Educational Products

- "Chronic Care Management (CCM) Services Frequently Asked Questions (FAQs)" *MLN Matters®* Article – Released
- "Power Mobility Pearls for the Practicing Physician" Web-Based Training Course – Released
- "Clarification of the Use of Modifiers When Billing Wrong Surgery on a Patient" Podcast – Released
- "Co-Surgery Not Billed with Modifier 62" Podcast – Released
- "Chronic Care Management Services" Fact Sheet – Reminder
- New Medicare Learning Network® Educational Web Guides Fast Fact
- Medicare Learning Network Product® Available In Electronic Publication Format

Medicare billing certificate programs

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

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

MLN Connects® Provider eNews for May 28, 2015

MLN Connects® Provider eNews for May 28, 2015
View this edition as a PDF

In this edition:

MLN Connects® National Provider Calls

- 2014 Mid-Year QRURs – Last Chance to Register
- Medicare Shared Savings Program ACO: Application Review – Register Now
- National Partnership to Improve Dementia Care and QAPI – Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 – Register Now
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X – Register Now
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data – Registration Now Open
- ESRD QIP: Proposed Rule for Payment Year 2019 – Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Quality Reporting Requirements
- Physician Compare Virtual Office Hour Session
- EHR Proposed Rules: Recordings and Presentations from Webinars

Announcements

- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- 2015 PQRS GPRO: 4 Weeks Left to Register by June 30 Deadline
- HHS Awards $112 Million to Help 5,000 Primary Care Professionals Advance Heart Health
- Guidance on Beneficiary Disenrollments by Long Term Care Facilities

Claims, Pricers, and Codes

- ICD-10 FAQs: CMNs and Prescriptions
- Transition to ICD-10 for Home Health
- April 2015 IOCE Updated with ICD-10-CM Codes
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Mass Adjustment of FQHC PPS Claims

Medicare Learning Network® Educational Products

- "Medically Unlikely Edits Compliant" Podcast – Released
- "Electronic Prescribing (eRx) Incentive Program - A Compilation of 2013 Educational Resources" Booklet – Released
- "Medicare Appeals Process" Fact Sheet – Revised

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.*

MLN Connects® Provider eNews for June 4, 2015

MLN Connects® Provider eNews for June 4, 2015
View this edition as a PDF

In this edition:

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Application Review – Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI – Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 – Register Now
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X – Register Now
- Hospital Compare Overall Star Ratings Methodology – Save the Date
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data – Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 – Register Now

MLN Connects® Videos

- Prepare for ICD-10 with MLN Connects® Videos

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week through June 5
- Webinar for Comparative Billing Report on CT of the Abdomen and Pelvis

Announcements

- New Affordable Care Act Payment Model Seeks to Reduce Cardiovascular Disease
- New Medicare Data Available to Increase Transparency on Hospital and Physician Utilization

- Entrepreneurs and Innovators to Access Medicare Data
- DMEPOS Competitive Bidding Round 1 2017 – Get Licensed
- Quality Reporting Programs: 2014 eCQM Updates for 2016 Reporting

Claims, pricers, and codes

- July 2015 Average Sales Price Files Now Available

Medicare Learning Network® Educational Products

- "Home Health Change of Care Notice (HHCCN) and Advance Beneficiary Notice of Noncoverage (ABN)" Web-Based Training Course – Released
- "Anesthesiologist Services with a Modifier GC in a Method II Critical Access Hospital (CAH)" Podcast – Released
- "ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets" Educational Tool – Revised
- "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet – Revised

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 June 11, 2015

MLN Connects® Provider eNews for June 11, 2015
View this edition as a PDF

In this edition:

MLN Connects® National Provider Calls

- National Partnership to Improve Dementia Care and QAPI – Last Chance to Register
- Hospice Quality and Hospice Item Set Manual V1.02 – Last Chance to Register
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X – Last Chance to Register
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data – Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 – Register Now

CMS Events

- Medicare Learning Network® Webinar: Medicare Basics for New Providers Part Two: Billing, Reimbursement, and Appeals
- PERM Cycle 1 Provider Education Sessions

Announcements

- Updated Results for ICD-10 End-to-End Testing Week in April
- Recognizing Men's Health Month and Men's Health Week
- CMS Finalizes Rules for Medicare Shared Savings Program
- Comprehensive Prevention Program Effectively Reduces Falls among Older People
- EHR Incentive Programs: Comments on Meaningful Use Proposed Rule Due June 15
- 2015 PQRS GPRO: 2 Weeks Left to Register by June 30 Deadline
- EHR Incentive Program: Deadline for Eligible Professionals Hardship Exception is July 1
- ICD-10 Resources for Medicare Providers

Medicare Learning Network® Educational Products

- "Information and Resources for Submitting Correct ICD-10 Codes to Medicare" MLN Matters® Article – Released
- "Transcatheter Aortic Valve Replacement (TAVR) Hospital Program Volume Requirements" MLN Matters® Special Edition Article — Released
- "Revised and Clarified Place of Service (POS) Coding Instructions" Podcast — Released
- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" *MLN Matters®* Article – Revised
- "Skilled Nursing Facility (SNF) Billing Reference" Fact Sheet – Reminder
- *Medicare Learning Network Product®* Available In Electronic Publication Format
- Subscribe to the *Medicare Learning Network®* Educational Products and MLN Matters® Electronic Mailing Lists

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)

Education event registration hotline
904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)
888-670-0940

Electronic funds transfers (EFT) (CMS-588)
866-454-9007
877-660-1759 (TTY)

Fax number (for general inquiries)
904-361-0696

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

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

The SPOT help desk
855-416-4199
email: *FCSOSPOTHelp@FCSO.com*

Addresses

Claims
Medicare Part B Claims
P.O. Box 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

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

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. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:
First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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