Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

August 2015

In this issue

Use First Coast's Web tools to keep your provider group moving forward

Shirley Knoll knows Medicare billing like the back of hand. She's the State Director of Billing for Therapy Management Corporation, a large national rehabilitation services provider. Knoll leads a team of 10 billing professionals who handle claims for 16 provider locations in central Florida.

Her provider group recently made the transition to Internet-based PECOS from paper in the management of provider enrollment applications and revalidations. "In the change to PECOS, we encountered some challenges with our revalidations."

PECOS (The Internet-based Provider Enrollment, Chain, and Ownership System) simplifies the enrollment process for applicants by verifying provider information online and electronically transmitting enrollment data directly to the Medicare contractor responsible for processing it.

Knoll recommends the revalidation and provider enrollment animations on the First Coast website as a way of preparing for the transition to PECOS. "The provider enrollment animations were tremendously helpful. This to me was huge. If you are new to Medicare, I would definitely review those pages. In fact, if anyone were to establish a new provider practice in Florida, I would recommend starting off with the First Coast website."

For her practice, the move to PECOS also facilitated address changes when their group relocated several practices to different locations. "This process can get really confusing when you open new providers sites. With the relocations, we had to re-credential to ensure compliance with the 30-mile rule. We completed the application process within 15-20 minutes using PECOS and we received approval within 60 days. When we did this on paper the entire process took up to nine months, and in one case almost a full year."

One of the tips she offers for anyone using the online provider enrollment tools is to keep helpful notes of the information you will need to enter once you open the online

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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
Sofia Lennie
Martin Smith
Kathleen Storey
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.

New and revised place of service codes for outpatient hospitals

Provider types affected

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

Provider action needed

Change request (CR) 9231, from which this article is taken, updates the *Medicare Claims Processing Manual* by:

- Revising the current place of service (POS) code set by adding new POS code 19 for "off campus-outpatient hospital" and revising POS code 22 from "outpatient hospital" to "on campus-outpatient hospital;" and
- Making minor corrections to POS codes 17 (walk-in retail health clinic) and 26 (military treatment facility).

You should ensure that your billing staffs are aware of these POS code changes.

Background

As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with HIPAA's standards and their implementation guides. The currently adopted professional implementation guide for the Accredited Standards Committee (ASC) X12N 837 standard requires that each electronic claim transaction include a POS code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains.

The POS code set provides care-setting information necessary to appropriately pay Medicare and Medicaid claims. At times, Medicaid has had a greater need for code specificity than Medicare, and many of the past years' new codes that have been developed to meet Medicaid's needs.

While Medicare does not always need this greater specificity in order to appropriately pay claims; it nevertheless adjudicates claims with the new codes to ease coordination of benefits, and to give Medicaid and other payers the setting information that they require. Therefore, as a payer, Medicare must be able to recognize any valid code from the POS code set that appears on the HIPAA standard claim transaction.

Therefore, in response to the discussion in the 2015 physician fee schedule (PFS) final rule with comment period published November 13, 2014 (79 FR 67572); in order to differentiate between on-campus and off-campus provider-based hospital departments, CMS is creating a new POS code (POS 19) and revising the current POS code description for outpatient hospital (POS 22).

CR 9231, from which this article is taken, provides this POS code update, effective January 1, 2016. Specifically, CR 9231 updates the current POS code set by adding new POS code 19 for "off campus-outpatient hospital" and revising POS code 22 from "outpatient hospital" to "on campus-outpatient hospital" as described in the following table.

New and revised POS codes effective January 1, 2016

Code	Descriptor
POS 19 Off campus-outpatient hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
POS 22 On campus-outpatient hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization

CR 9231 also:

- Implements the systems and local contractor level changes needed for Medicare to adjudicate claims with the new and revised codes (your B MAC or DME MAC will develop policies as needed to edit and adjudicate claims that contain these new/revised codes according to Medicare national policy); and
- Makes minor corrections to POS codes 17 (walk-in retail health clinic) and 26 (military treatment facility) by adding those two codes back into the POS list in the *Medicare Claims Processing Manual*. Those two codes were removed inadvertently from a prior version of that manual.

Additional information related to POS codes 19 and 22

Payments for services provided to outpatients who are later admitted as inpatients within three days (or, in the case of non-IPPS hospitals, one day) are bundled when the patient is seen in a wholly owned or wholly operated

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physician practice. The three-day payment window applies to diagnostic and nondiagnostic services that are clinically related to the reason for the patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same. The three-day payment rule will also apply to services billed with POS code 19.

Claims for covered services rendered in an off campus-outpatient hospital setting (or in an on campus-outpatient hospital setting, if payable by Medicare) will be paid at the facility rate. The payment policies that currently apply to POS 22 will continue to apply to this POS, and will now also apply to POS 19 unless otherwise stated.

- Reporting outpatient hospital POS code 19 or 22 is a minimum requirement to trigger the facility payment amount under the PFS when services are provided to a registered outpatient. Therefore, you should use POS code 19 or POS code 22 when you furnish services to a hospital outpatient regardless of where the face-to-face encounter occurs.
- Your MACs will allow POS 19 to be billed for G0447 (Face-to-face behavioral counseling for obesity, 15 minutes) and G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes) in the same way as services billed with POS code 22.

Additional information

The official instruction, CR 9231, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3315CP.pdf.*

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

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Related CR Transmittal #: R3315CP
Implementation Date: January 4, 2016

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.

Limiting the scope of review on redeterminations and reconsiderations of certain claims

Provider types affected

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

What you need to know

This special edition article is being published by the Centers for Medicare & Medicaid Services (CMS) to inform providers of the clarification CMS has given to the MACs and qualified independent contractors (QICs) regarding the scope of review for redeterminations (technical direction letter 150407). This updated instruction applies to redetermination requests received by a MAC or QIC on or after August 1, 2015, and will not be applied retroactively.

Background

CMS recently provided direction to MACs and QICs regarding the applicable scope of review for redeterminations and reconsiderations for certain claims. Generally, MACs and QICs have discretion while conducting appeals to develop new issues and review all aspects of coverage and payment related to a claim or line item. As a result, in some cases where the original denial reason is cured, this expanded review of additional evidence or issues results in an unfavorable appeal decision for a different reason.

For redeterminations and reconsiderations of claims denied following a post-payment review or audit, CMS has instructed MACs and QICs to limit their review to the reason(s) the claim or line item at issue was initially denied. Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a zone program integrity contractor (ZPIC), recovery auditor, MAC, or comprehensive error rate testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment. If an appeal involves a claim or line item denied on a pre-payment basis, MACs and QICs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

Please note that contractors will continue to follow existing procedures regarding claim adjustments resulting from

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favorable appeal decisions. These adjustments will process through CMS systems and may suspend due to system edits. Claim adjustments that do not process to payment because of additional system imposed payment limitations, conditions or restrictions (for example, frequency limits or correct coding initiative edits) will result in new denials with full appeal rights. In addition, if a MAC or QIC conducts an appeal of a claim or line item that was denied on post-payment review because a provider, supplier, or beneficiary failed to submit requested documentation, the contractor will review all applicable coverage and payment requirements for the item or service at issue, including whether the item or service was medically reasonable and necessary. As a result, claims initially denied for insufficient documentation may be denied on appeal if additional documentation is submitted and it does not support medical necessity.

This clarification and instruction applies to redetermination and reconsideration requests received by a MAC or QIC on or after August 1, 2015. It will not be applied retroactively. Appellants will not be entitled to request a reopening of a previously issued redetermination or reconsideration for the purpose of applying this clarification on the scope of review. CMS encourages providers and suppliers to include any audit or review results letters with their appeal request. This will help alert contractors to appeals where this instruction applies.

Additional information

You can find out more about appealing claims decisions in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 29 (Appeals of Claims Decisions), Section 310.4.C.1. (Conducting the Redetermination (Overview)) at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf*.

You can also find out more about 1) conducting a redetermination in 42 CFR 405.948, at *http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1948*; and 2) conducting a reconsideration in 42 CFR 405.968 at *http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1968*.

MLN Matters® Number: SE1521
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Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

ICD-10 Quick Start Guide ICD-10 Quick Start Guide

The Small Physician Practice's Route to ICD-10

Ambulance

Common payment errors for ambulance emergency transport HCPCS code A0427

Provider types affected

One of the top contributors to First Coast Service Options' (First Coast's) claims payment error rate, as measured by the comprehensive error rate testing (CERT) program, is improper billing of Healthcare Common Procedure Coding System (HCPCS) code A0427. HCPCS code A0427 is defined as an ambulance service, advanced life support (ALS), emergency transport, level 1.

Recent CERT error findings demonstrate the beneficiary did not meet coverage guidelines for the following reasons:

- Insufficient documentation to support medical necessity of the service or the level of service billed;
- Documentation did not include the beneficiary's signature (or the signature of his or her authorized representative).

Ambulance suppliers are encouraged to review the following article regarding Medicare's ambulance benefit and ensure that they meet documentation requirements for services that are medically reasonable and necessary.

Medical necessity

One common CERT error for HCPCS code A0427 is the clinical documentation submitted for review did not support the level of emergency ambulance transport billed. For example, submitted documentation for one claim indicated that the beneficiary was "weak, having nausea/vomiting, and severe back pain from surgery. Beneficiary was able to walk to stretcher for transportation."

To be covered, ambulance services must be medically necessary and reasonable. According to *CMS Publication 100-02, Chapter 10 Ambulance Services, Section 10.2.1 Necessity for the Service*, medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services.

The manual also states that the reasons for the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service, or to return from such a service.

Furthermore, *Section 10.2.2 Reasonableness of the Ambulance Trip* states that under the fee schedule (FS), payment is made according to the level of medically necessary services actually furnished. That is, payment is based on the level of service furnished (provided they were medically necessary), not simply on the vehicle used. Even if a local government requires an ALS response for all calls, payment under the FS is made only for the level of service furnished, and then only when the service is medically necessary.

Other common CERT errors is that although an ICD-9 code(s) was submitted on the claim, the clinical documentation submitted regarding the beneficiary's condition was either insufficient or missing. According to *CMS Publication 100-04, Chapter 15 Ambulance, Section 40 Medical Conditions and Instructions*, Medicare contractors will rely on medical record documentation to justify coverage, not simply the HCPCS code or the condition code by themselves.

Documentation

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier/intermediary. Appropriate documentation includes:

- Dispatch instructions;
- Patient's condition;
- Other on-scene information; and
- Details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled)
- Proper and legible signatures

Missing signatures

Another common CERT error for HCPCS code A0427 is the documentation submitted did not include the beneficiary's signature or the signature of his or her authorized representative. As outlined in *CMS Publication 100-02, Chapter 10, Section 20.1.2*, Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare.

If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:

- The beneficiary's legal guardian.
- A relative or other person who receives Social Security or other governmental benefits on behalf of the beneficiary.
- A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs.
- A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary.
- A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in

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Drugs & Biologicals

October 2015 update of Healthcare Common Procedure Coding System

Provider types affected

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

Provider action needed

Change request (CR) 9273 informs the MACs that, effective for claims with dates of service on or after October 1, 2015, new Healthcare Common Procedure Coding System (HCPCS) code Q9979 (Injection, alemtuzumab, 1 MG) will be payable for Medicare. Make sure that your billing staff is aware of these changes.

Background

The Healthcare Common Procedure Coding System (HCPCS) code set is updated on a quarterly basis. Change request (CR) 9273 instructs that, effective for claims with dates of service on or after October 1, 2015, HCPCS code Q9979 will be established for alemtuzumab (Lemtrada) and payable by Medicare. See the following table for details regarding this temporary HCPCS code:

HCPCS code	Short description	Long description	TOS	Status indicator
Q9979	Injection,	Injection,	1, P	E

Additional information

The official instruction, CR 9273, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3304CP.pdf*.

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

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Implementation Date: October 5, 2015

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accordance with 42 CFR 424.36(b) (1-4)

- A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least four years from the date of service. A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purpose of accepting assignment of Medicare payment for ambulance benefits. When a provider/supplier is unable to obtain the signature of the beneficiary, or that of his or her representative, at the time of transport, it may obtain this signature any time prior to submitting the claim to Medicare for payment.

Additional educational resources

CMS Ambulance Service Center

http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html

First Coast checklist for ambulance transports documentation at

http://medicare.fcso.com/Medical_documentation/192607.pdf

July 2015 Healthcare Common Procedure Coding System drug/biological code changes - update

***Note**: This article was revised July 20 to reflect the revised change request (CR) 9167 issued July 10. In the article, language has been modified to clarify the use of Q9977. Also, the CR release date, transmittal number, and the Web address for accessing CR 9167 are revised. On July 22, 2015, the article was revised further to include additional language from the revised CR 9167. This additional language is in the "Please note" box of this article. All other information remains the same. This information was previously published in the May 2015 Medicare B Connection, Page 6.*

Provider types affected

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

Provider action needed

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

Background

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

Summary of new HCPCS codes in CR 9167

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

Table 1 – New HCPCS codes in CR 9167

Effective for claims with DOS on/after:	Code	Long descrip-tion	Short descrip-tion	TOS
3/6/15	Q5101	Injection, Filgrastim (GCSF), Biosimilar, 1 microgram	Inj filgrastim g-csf biosim	1, P
7/1/15	Q9976	Injection, Ferric	Inj Ferric	1,L
7/1/15	Q9978	Netupitant 300 mg and	Netupitant	1
7/1/15	Q9977	Compound-ed drug, not otherwise classified	Compound-ed drug NOC	1, P

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

CR 9167 also updates Section 20.1.2 Average Sales Price (ASP) Payment Methodology in Chapter 17 of the *Medicare Claims Processing Manual* to address the use of compounded drug NOC code on claim for compounded drugs.

Please note: The new compounded drug code, Q9977 (Compounded drug, not otherwise classified), is not a replacement for existing codes. It is intended to distinguish compounded drugs (which may include biologicals) from other "not otherwise classified" codes such as J3490, J3590, J7799, J9999 and existing specific codes for compounded nebulized drugs. The implementation of Q9977 as a means of identifying compounded drug claims does not affect existing payment policy for compounded drugs as outlined in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.2.

Additional information

The official instruction, CR 9167 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3292CP.pdf*.

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

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Durable Medical Equipment

October update to DMEPOS fee schedule

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health and hospice MACs and durable medical equipment (DME MACs), for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider action needed

Change request (CR) 9279 alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2015. Make sure your billing staffs are aware of the changes.

Background

The DMEPOS fee schedule 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 Pub.100-04, *Medicare Claims Processing Manual*, Chapter 23, Section 60, found here *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

The recurring update notification provides instructions regarding the October quarterly update for the 2015 DMEPOS fee schedule. Payment on a fee schedule basis is required for DME, prosthetic devices, orthotics, prosthetics and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

As part of the October 2015 update, fee schedules are established for the following two Healthcare Common Procedure Coding System (HCPCS) codes added to the HCPCS file effective January 1, 2005:

- **E0639** – Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories, and
- **E0640** – Patient lift, fixed system includes all components/accessories.

The fee schedule amounts for both codes were established using fees for comparable items in accordance with the instructions found in the *Medicare Claims Processing Manual*, Chapter 23, Section 60.3. An average of the existing hydraulic or mechanical patient lift code E0630 and the electric patient code E0635 were used to establish the fee schedules for the hydraulic or electric patient lifts described under E0639 and E0640. The fee schedules for E0639 and E0640 are effective for dates of service on or after January 1, 2015. This update also revises the type of service code for HCPCS codes E0639 and E0640 from "9" to type of service code "R".

CR 9279 also provides revised fee schedules for speech generating device (SGD) HCPCS codes E2500, E2502, E2504, E2506, E2508, E2510 and E2351 per the recent amendments to Section 1834(a)(2)(A) of the Social Security Act. The "Steve Gleason Act of 2015" was signed by the President on July 30, 2015, and changes the DME payment category for SGDs and accessories essential for the effective use of the SGD furnished between October 1, 2015, and September 30, 2018, from capped rental (CR) to inexpensive or routinely purchased (IN). Instructions relating to the implementation of the SGD amendments to Section 1834(a)(2)(A) were issued in CR 9179, dated June 12, 2015. The NU, UE, and RR fee schedule amounts for codes E2500, E2502, E2504, E2506, E2508, E2510 and E2351 are being added to the fee schedule file as part of this update.

The *MLN Matters*® article related to CR 9179 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9179.pdf*.

Additional information

The official instruction, CR 9279, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3323CP.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: MM9279
Related CR Release Date: August 14, 2015
Related Transmittal #: R3323CP
Change Request (CR) #: CR 9279
Effective Date: January 1, 2015 (for implementation of fee schedule amounts for codes in effect on January 1, 2015; October 1, 2015 for all other changes)
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.

Attention physicians: Are you ordering oxygen for your patient?

Your medical record documentation determines whether your patient can receive the oxygen equipment and supplies you have prescribed and the amount of the patient's out of pocket expenses.

Your medical record documentation must show that other alternative treatments (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried or considered and deemed clinically ineffective. The documentation must show the patient was seen within 30 days prior to the start of oxygen therapy. The medical record must show the medical condition necessitating the home use of oxygen therapy. The medical record and/or prescription would indicate the oxygen flow rate (e.g., two liters per minute) and the estimation of the frequency (10 minutes per hour), duration of use (12 hours per day), and duration of need (six months). You must specify the type of oxygen deliver system to be used (i.e. portable/stationary concentrator, compressed gas portable/stationary, liquid portable/stationary).

Medicare can make payment for home oxygen supplies and equipment when the patient's medical record shows the patient has significant hypoxemia and meets medical documentation, test results, and health conditions as specified in the *CMS Internet-Only Manual (IOM) Publication 100-03, Section 240.2*.

You must complete and sign Form CMS-484 (Certificate of Medical Necessity [CMN]: Oxygen) at *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms484.pdf*. However, the CMN itself is not considered part of the medical record. All information included in the CMN must be supported by the contemporaneous medical record. You can find instructions on completing this form in the *CMS IOM Publication 100-08, Chapter 5*.

The comprehensive error rate testing (CERT) contractor has identified multiple errors in the claims received for oxygen equipment and supplies. These errors include missing physician clinical records showing the patient's condition and the continued need for oxygen, missing signed and dated order from the physician when changing the oxygen liter flow rate, missing copy of the oxygen saturation testing, and missing treating physician's re-evaluation for recertification CMN.

Help your patients and the Medicare program by verifying you have the medical record documentation to support the order and supply of oxygen for your patients. This allows Medicare to pay claims appropriately.

End-Stage Renal Disease

End-stage renal (ESRD) home-dialysis policy

Provider types affected

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

Provider action needed

CR 9265 instructs that the monthly capitation payment (MCP) physician or practitioner should bill for the age appropriate home dialysis MCP service, as described by Healthcare Common Procedure Coding System (HCPCS) codes *90963* through *90966*, for the home dialysis (less than a full month) scenario if the MCP practitioner furnishes a complete monthly assessment of the ESRD beneficiary and at least one face-to-face patient visit during the month.

Background

In the 2005 physician fee schedule (PFS) final rule with comment period (69 FR 66357 through 66359) (see *http://www.gpo.gov/fdsys/pkg/FR-2004-11-15/html/04-24758.htm*), the Centers for Medicare & Medicaid Services (CMS) established criteria for furnishing outpatient per diem ESRD-related services in partial month scenarios. CMS specified that use of per diem ESRD-related services is intended to accommodate unusual circumstances when the outpatient ESRD-related services would not be paid under the MCP and that use of the per diem services are limited to the following circumstances:

- Transient patients – Patients traveling away from home (less than full month);
- Home-dialysis patients (less than full month);
- Partial month where there were one or more face-to-face visits without the comprehensive visit and either the patient was hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient received a kidney transplant; or
- Patients who have a permanent change in their MCP physician during the month.

For center-based patients, CMS specified that if the MCP practitioner furnishes a complete assessment of the ESRD beneficiary, the MCP practitioner should bill for the full MCP service that reflects the number of visits furnished during the month.

However, CMS did not extend this policy to home dialysis (less than one full month) because the home dialysis MCP service did not include a specific frequency of required patient visits. Unlike the ESRD MCP service for center-based patients, a visit was not required for the home dialysis MCP service as a condition of payment.

In the 2011 PFS final rule with comment period (75 FR

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73295 through 73296; see *http://www.gpo.gov/fdsys/pkg/FR-2010-11-29/html/2010-27969.htm*), CMS changed the policy for the home dialysis MCP service to require that the MCP practitioner furnish at least one face-to-face patient visit per month as a condition of payment.

However, CMS inadvertently did not modify billing guidelines for home dialysis (less than a full month) to be consistent with partial month scenarios for center-based dialysis patients. Stakeholders subsequently brought this inconsistency to the attention of CMS as part of the 2015 PFS rulemaking cycle.

As discussed in the 2015 PFS final rule (79 FR 67733; see *http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/html/2014-26183.htm*), CMS finalized a change to home dialysis (less than a full month) to provide consistency with the policy for partial month scenarios pertaining to patients dialyzing in a dialysis center.

CR 9265 instructs that the MCP physician or practitioner should bill for the age appropriate home dialysis MCP service (as described by HCPCS codes *90963* through *90966*) for the home dialysis (less than a full month) scenario if the MCP practitioner furnishes:

- A complete monthly assessment of the ESRD beneficiary; and
- At least one face-to-face patient visit during the month.

For example, if a home dialysis patient was hospitalized during the month and at least one face-to-face outpatient visit and complete monthly assessment was furnished, the MCP practitioner should bill for the full home dialysis MCP service.

Additional information

The official instruction, CR 9265, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3311CP.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?

However, CMS inadvertently did not modify billing guidelines for home dialysis (less than a full month) to be consistent with partial month scenarios for center-based dialysis patients. Stakeholders subsequently brought this inconsistency to the attention of CMS as part of the 2015 PFS rulemaking cycle.

MLN Matters® Number: MM9265
Related Change Request (CR) #: CR 9265
Related CR Release Date: August 6, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3311CP
Implementation Date: September 8, 2015

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Laboratory/Pathology

New waived tests approved by the FDA

Provider types affected

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

Provider action needed

Change request (CR) 9261 the MACs about the new Clinical Laboratory Improvement Amendments of 1988 (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) must notify its MACs of the new tests to allow MACs to accurately process claims.

CLIA regulations require a facility to be appropriately certified for each test it performs. The *Current Procedural Terminology* (*CPT*®) codes that CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. Make sure your billing staffs are aware of these changes.

Background

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

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 (CLIA waived test) to be recognized as a waived test. The *CPT*® code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- G0434QW, January 28, 2015, Healgen Amphetamine Test Cassette;
- G0434QW, January 28, 2015, Healgen Amphetamine Test Cup;

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- G0434QW, January 28, 2015, Healgen Amphetamine Test Dip Card;
- G0434QW, January 28, 2015, Healgen Amphetamine Test Strip;
- G0434QW, January 28, 2015, Healgen Oxycodone Test Cassette;
- G0434QW, January 28, 2015, Healgen Oxycodone Test Cup;
- G0434QW, January 28, 2015, Healgen Oxycodone Test Dip Card;
- G0434QW, January 28, 2015, Healgen Oxycodone Test Strip;
- G0434QW, March 4, 2015, Healgen Scientific LLC Healgen MDMA (Ecstasy) Test Cassette;
- G0434QW, March 4, 2015, Healgen Scientific LLC Healgen MDMA (Ecstasy)Test Cup;
- G0434QW March 4, 2015, Healgen Scientific LLC Healgen MDMA (Ecstasy) Test Dip Card;
- G0434QW, March 4, 2015, Healgen Scientific LLC Healgen MDMA (Ecstasy) Test Strip;
- G0434QW, March 4, 2015, Healgen Scientific LLC Healgen Phencyclidine Test Cassette;
- G0434QW, March 4, 2015, Healgen Scientific LLC Healgen Phencyclidine Test Cup;
- G0434QW March 4, 2015, Healgen Scientific LLC Healgen Phencyclidine Test Dip Card;
- G0434QW, March 4, 2015, Healgen Scientific LLC Healgen Phencyclidine Test Strip;
- G0434QW, March 31, 2015, Medical Distribution Group Inc., Identify Home Drug Testing Device Test Cards;
- G0434QW, March 31, 2015, Medical Distribution Group Inc., Identify Home Drug Testing Device Test Cups;
- G0434QW, April 20, 2015, Chemtron Biotech, Inc. Chemtrue Drug Screen Cup Tests;
- G0434QW, April 20, 2015, Chemtron Biotech, Inc. Chemtrue Drug Screen Cup Tests with OPI 2000;
- G0434QW, April 29, 2015, Quest Products, Inc. DrugHAWK MDMA and OPI Drug Test Cup (Urine) {Cup format};
- G0434QW, April 30, 2015, Quest Products, Inc. DrugHAWK Drug Test Cup;
- G0434QW, May 6, 2015, Quest Products, Inc. DrugHAWK Buprenorphine Drug Test Cup;
- *87651QW*, May 15, 2015, Roche Molecular, cobas Liat System;
- *87880QW*, May 26, 2015, Medline Strep A Test Strip) {Throat Swabs};

- *80061QW*, *82465QW*, *83718QW*, *84478QW*, May 28, 2015, Poylmer Technology Systems, Inc., CardioChek Plus Test Systems (PTS Panels Lipid Panel test strips);
- *80061QW*, *82465QW*, *83718QW*, *84478QW*, May 28, 2015, Poylmer Technology Systems, Inc., CardioChek Home Test Systems (CardioChek Home Lipid Panel test strips);
- *82947QW*, May 28, 2015, Poylmer Technology Systems, Inc., CardioChek Plus Test Systems (PTS Panels eGLU test strips);
- *82947QW*, May 28, 2015, Poylmer Technology Systems, Inc., CardioChek Plus Test Systems (PTS Panels Glucose test strips;
- *82947QW*, May 28, 2015, Poylmer Technology Systems, Inc., CardioChek Home Test Systems (CardioChek Home eGLU test strips);
- *82947QW*, May 28, 2015, Poylmer Technology Systems, Inc., CardioChek Home Test Systems (CardioChek Home Glucose test strips);
- G0434QW, June 3, 2015, Native Diagnostics International; DrugSmart Drug Screen Cup Tests with OPI 2000;
- G0434QW, June 3, 2015, Onsite Testing Specialists, Inc. On-site Testing Specialists Drug Screen Cup Tests;
- G0434QW, June 3, 2015, Onsite Testing Specialists, Inc. On-site Testing Specialists Drug Screen Cup Tests with OPI 2000;
- G0434QW, June 4, 2015, Transmetron, Inc. Invitro Pro Drug Test Cards; and
- *87651QW*, July 15, 2015, Alere i Instrument.

The new *CPT*® code *87651QW* has been assigned for the Streptococcus group A test performed on the Roche Molecular cobas Liat System and the Alere i Instrument. This test system utilizes nucleic acid amplification technology to detect Group A Streptococcus.

Please note that the *CPT*® codes for the following tests do not require a QW modifier to be recognized as a waived

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test, (These *CPT*® codes are found on page 1 of the attachment to CR 9261):

- *81002*, Dipstick or tablet reagent urinalysis – non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen;
- *81025*, Urine pregnancy tests by visual color comparison;
- *82270*, Fecal occult blood;
- *82272*, Fecal occult blood;
- *82962*, Blood glucose by glucose monitoring devices cleared by the FDA for home use;
- *83026*, Hemoglobin by copper sulfate – non-automated;
- *84830*, Ovulation tests by visual color comparison for human luteinizing hormone;
- *85013*, Blood count; spun microhematocrit; and
- *85651*, Erythrocyte sedimentation rate – non-automated.

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

Additional information

The official instruction, CR 9261, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3327CP.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: MM9261
Related Change Request (CR) #: CR 9261
Related CR Release Date: August 14, 2015
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Related CR Transmittal #: R3327CP
Implementation Date: October 5, 2015

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Quarterly provider update

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

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

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

Medicare Physician Fee Schedule

October 2015 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 subject to the Medicare physician fee schedule database (MPFSDB) that are provided to Medicare beneficiaries.

What you need to know

Changes included in the October update to the 2015 MPFSDB are effective for dates of service on and after January 1 (unless otherwise stated).

The key change is to the malpractice relative value units (RVU) of the following *CPT*®/HCPCS codes: *33471, 33606, 33611, 33619, 33676, 33677, 33692, 33737, 33755, 33762, 33764, 33768, 33770, 33771, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33783, 33786, 33803, 33813, 33822, 33840*, and *33851*. The RVU changes for these codes are retroactive to January 1, 2015.

Also, effective October 1, 2015, *CPT*®/HCPCS code Q9979 is assigned a procedure status indicator of E (Excluded from the PFS by regulation. These codes are for items and services that CMS has excluded from the PFS by regulation. No payment may be made under the PFS for these codes and generally, no RVUs are shown.).

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 issued to the MACs based upon the 2015 Medicare physician fee schedule (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.

Additional information

The official instruction, CR 9266 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3317CP.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: MM9266
Change Request (CR) #: CR 9266
Related CR Release Date: August 6, 2015
Implementation Date: January 1, 2015
Related Transmittal #: R3317CP
Effective Date: October 5, 2015

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Pulmonary procedures and evaluation & management services

***Note**: This article was rescinded July 27, 2015. This information was previously published in the July 2013 Medicare B Connection, Pages 9-10.*

MLN Matters® Number: SE1315 *Rescinded*
Related Change Request (CR) #: Not Applicable
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A

Implementation Date: N/A

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Preventive Services

Screening for hepatitis C – implementation of new edits

***Note**: This article was revised on August 10, 2015, to make clarifications regarding HCV services in rural health clinics, federally qualified health centers, and critical access hospitals. All other information remains the same. This article was previously published in the July edition of Medicare B Connection, Pages 7-8.*

Provider types affected

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

Provider action needed

Change request (CR) 9200 informs providers that beneficiaries born prior to 1945 or after 1965 with no risk factors for HCV are not eligible for HCV screening benefits as described in CR 8871, Transmittal 3215, dated March 11, 2015. Make sure that your billing staffs are aware of these changes.

Background

Effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) covers screening for HCV consistent with the grade B recommendations by the United States Preventive Services Task Force for the prevention or early detection of an illness or disability, and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. This policy was implemented in CR 8871.You may want to review the related *MLN Matters® article MM8871* for additional claims processing instructions.

As indicated in CR 8871, and replicated in CR 9200 for ease of reference only, CMS covers screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices), used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act regulations, when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

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

2. A single screening test is covered for adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965.

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

Key points

- For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk as defined in the policy, HCV screening is limited to once per lifetime. New HCPCS code G0472 (short descriptor - Hep C screen high risk/other, and long descriptor- Hepatitis C antibody screening for individual at high risk and other covered indication(s)) will be used.
- Beneficiaries born prior to 1945 or after 1965 with no risk factors are not eligible for this benefit.
- For those beneficiaries determined to be high-risk initially as defined in the policy, regardless of birth year, ICD-9 diagnosis code V69.8, "other problems related to life style" (when ICD-10 is implemented ICD-10 diagnosis code Z72.89, "other problems related to lifestyle") is required in addition to HCPCS G0472.
- Coverage of a subset of the above high risk beneficiaries may occur on an annual basis if appropriate as defined in the policy, regardless of birth year, denoted by the presence of HCPCS G0472, ICD diagnosis code V69.8/Z72.89, and ICD diagnosis code 304.91, "unspecified drug dependence continuous"/ F19.20, "other psychoactive substance abuse, uncomplicated" (once ICD-10 is implemented). Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

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- HCV screening, HCPCS code G0472, is a technical service only and there is no professional fee.
- CR 9200 also removes the following types of bill (TOBs) as valid TOBs for HCV screening services:
  - * RHC, TOB 71x;
  - * FQHC, TOB 77x; and
  - ** CAH Method II, professional services, TOB 85x when submitted with revenue code 096x, 097x, or 098x. * **Note**: While RHCs and FQHCs cannot bill for HCV screening services, this does not prevent HCV screening services from being provided to patients at RHCs and FQHCs.
  - ** **Note**: CAHs, TOB 85x, are valid facilities for HCV screening services. CR 9200 removes the professional payment to CAHs for HCV screening.
- MACs will line-item deny claims for HCV screening, HCPCS G0472, for beneficiaries born prior to 1945 and after 1965 who are not high risk with the following messages:
  - **CARC 96** - Non-covered charge(s). At least one remark code must be provided (may be comprised of either the NCPDP reject reason [sic] code, or 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;
  - **RARC N386** - This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp.* If you do not have web access, you may contact the contractor to request a copy of the NCD.; and
  - **Group code CO** – assigning financial liability to the provider.

Note: Only HCPCS G0472 as noted above should be reported for this new HCV screening benefit. *CPT*® code *86803*, HCV rapid antibody test, is not appropriate for reporting screening under this policy.

Additional information

The official instruction, CR 9200, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3285CP.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: MM9200 *Revised*
Related CR Release Date: June 19, 2015
Related Transmittal #: R3285CP
Change Request (CR) #: CR9200
Effective Date: June 2, 2014
Implementation Date: For FISS shared system edits, split between October 5, 2015, and January 4, 2016, releases; July 20, 2015, - For non-shared MAC edits; October 5, 2015 - For CWF shared systems edits.

Radiology interpretation furnished to emergency room patients

In 2012, First Coast Service Options Inc. (First Coast) implemented claim editing for radiology interpretation services billed on the same date of service by more than one provider in the emergency room setting (place of service 23) due to potential inappropriate billing. First Coast will pay for the first claim received and deny the claim billed with the second interpretation. Claims billed with the 77 modifier were initially excluded from the edit parameters. Edit parameters will be revised to also deny the second interpretation when billed with the 77 modifier.

Providers are encouraged to review the Medicare guidelines as outlined in the Centers for Medicare & Medicaid Services (CMS) IOM Publication 100-04, Chapter 13, Section 100.1 *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf*.

If you disagree with the determination made by Medicare, you have the right to appeal the decision. Please follow the current appeals process as outlined in the CMS IOM Publication 100-04, Chapter 29 *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf*.

Update of remittance advice remark and claims adjustment reason code lists

Provider types affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare administrative contractors (MACs), including home health and hospice MACs (HHH MACs), and durable medical equipment MACS (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your MAC for a *Current Procedural Terminology* (*CPT*®) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Caution – what you need to know

Change request (CR) 9278 updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists and also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software used by some providers.

Go – what you need to do

Make sure that your billing staffs are aware of these updates.

Background

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

The CARC and RARC changes that impact Medicare are usually requested by staff of the Centers for Medicare & Medicaid Services (CMS), in conjunction with a policy change. MACs are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. If any new or modified code has an effective date past the implementation date specified in CR 9278, MACs must implement on the effective date found at the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times per year and may not match the CMS release schedule. CR 9278 lists only the changes that have been approved since the last code update by CR 9125 (*https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3242CP.pdf*), issued April 13, 2015, and does not provide a complete list of codes for these two code sets.

The WPC website has four listings available for both CARC and RARC. Those listings are available at *http://www.wpc-edi.com/Reference*.

Changes in RARC list since CR 9125

New codes – RARC

Code	Modified narrative	Effective date
N753	Missing/Incomplete/Invalid Attachment Control Number.	7/1/15
N754	Missing/Incomplete/Invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.	7/1/15
N755	Missing/Incomplete/Invalid ICD Indicator on the 1500 Claim Form.	7/1/15
N756	Missing/Incomplete/Invalid point of drop-off address,	7/1/15
N757	Adjusted based on the Federal Indian Fees schedule (MLR).	7/1/15
N758	Adjusted based on the prior authorization decision.	7/1/15
N759	Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.	7/1/15

See **LISTS**, next page

LISTS

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Modified codes – RARC

Code	Modified narrative	Effective date
M47	Missing/Incomplete/Invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	7/1/15
MA74	**ALERT**: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	7/1/15
N432	**ALERT**: Adjustment based on a Recovery Audit.	7/1/15
N22	**ALERT**: This procedure code was added/changed because it more accurately describes the services rendered.	7/1/15
M39	**ALERT**: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	7/1/15
M109	**ALERT**: This claim/service was chosen for complex review.	7/1/15
M38	**ALERT**: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.	7/1/15
N381	**ALERT**: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	7/1/15
MA91	**ALERT**: This determination is the result of the appeal you filed.	7/1/15

Deactivated codes - RARC

Code	Current narrative	Effective date
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	7/1/16

***N735** - This RARC is not included in the list of deactivated codes because CMS did not add this code during the previous release when it was included on the WPC website. The RARC was previously added to the WPC website erroneously.

Changes in CARC list since CR 9125

New code – CARC

Code	Modified narrative	Effective date
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	7/1/15

Modified code – CARC

Code	Modified narrative	Effective date
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. **Note**: This must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability.)	11/1/15

There have been no deactivated CARC codes since CR 9125.

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

Additional information

The official instruction, CR 9278, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3298CP.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: MM9278
Related CR Release Date: August 6, 2015
Related Transmittal #: R3298CP
Change Request (CR) #: CR 9278
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

Medicare Remit Easy Print upgrade

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

This article is based on change request (CR) 9203. Medicare Remit Easy Print (MREP) software was developed by the Centers for Medicare & Medicaid Services (CMS) to help providers transition to electronic remittance advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CR 9203 instructs the developer of the MREP software to update it based on enhancement requests received through the MACs and the CMS website. This software is available free of charge from the CMS website and now offers a number of special reports that users can view and download in addition to the remittance advice. The key change in this latest version of the software is an enhancement to the MREP application to suppress the PR group code (patient responsibility) from the glossary of the "Entire Remittance" report when the only patient responsibility items on the claim are for claim adjustment reason code aware of these changes.

Additional information

The official instruction, CR 9203, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1524OTN.pdf*.

More details about the free software, including instructions for downloading the software, are available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html*.

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: MM9203
Related Change Request (CR) #: CR 9203
Related CR Release Date: August 6, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R1524OTN
Implementation Date: January 4, 2016

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.

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.

SPOT

From previous page

application. “Keep your cheat sheets beside your computer with the practice official’s name and other information and you can be done in 15 minutes versus two hours,” Knoll said.

Besides the provider enrollment functions, Knoll makes use of a wide-variety of resources available through the First Coast site. As she audits each month, Knoll often refers to the top reasons for claim denials page to diagnose any issues which pop up with her audit. “This page is so helpful. I find what I’m looking for within a few clicks.” Knoll said she uses so many different functions on the site because she spent the better part of a work day and devoted the time to exploring the site. “If you go on the First Coast site and take the better part of an afternoon, you will be amazed at what you will find. You will save so much more time by just learning and putting into practice what is available at your fingertips.”

Knoll says she stays on top of her education requirements also through the First Coast site. “The education courses on First Coast University are priceless. I found them to be tremendously helpful in keeping up with the changes in Medicare,” she said. The First Coast website is my first option when I need information. Nine out of ten times I will find exactly what I am look for. In some cases, we’ve even used it to research information for health plans other than Medicare.

First Coast Service Options Inc. (First Coast) offers online training courses for both Part A and Part B provider offices through First Coast University. Many of the courses offer continuing education hours. The instructor-led training classes and online training (OLT) courses give Medicare billers the opportunity to stay current with Medicare policies and options for training new employees with instruction on the basics of Medicare billing.

First Coast University also offers courses in how to use several of the First Coast Web tools including the Secure Online Provider Tool (SPOT), fee schedule lookup tool among others. “Predominantly, the two tools I used most are the fee schedule and LCD lookup tools. And, I’ve just started using SPOT, checking patient eligibility and claim status,” Knoll said.

“The provider enrollment animations were tremendously helpful. This to me was huge. If you are new to Medicare, I would definitely review those pages. In fact, if I were establishing a new provider practice in Florida, I would recommend starting off with the First Coast website.”

-Shirley Knoll MHA, CPC
Therapy Management Corporation
Director of Billing

Temporary moratoria extended on enrollment of home health agencies and ambulance suppliers

On July 28, 2015, CMS published a notice in the *Federal Register* (CMS-6059 N3) (*go.usa.gov/37m9W*) announcing that the temporary moratoria on the enrollment of new home health agencies, home health agency sub-units, and Part B ground ambulance suppliers is being extended for an additional six months in certain geographic areas in Florida, Illinois, Michigan, Texas, Pennsylvania, and New Jersey to prevent and combat fraud, waste, and abuse.

For more information see *MLN Matters*® article SE1425 (*go.usa.gov/37mnR*), “Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers.”

National site visit verification (NSV) initiative

Provider types affected

This *MLN Matters*® special edition article is intended for all providers and suppliers that enroll in the Medicare program and submit fee-for-service (FFS) claims to Medicare administrative contractors (MACs), including home health and hospice MACs, for services provided to Medicare beneficiaries.

What you need to know

This article provides the latest information about the Centers for Medicare & Medicaid Services (CMS) national site visit verification (NSV) initiative. The NSV initiative is part of CMS' National Fraud Prevention Program (NFPP) and assists CMS in its efforts to prevent fraud and abuse in the Medicare program starting with the enrollment process.

Key information

National Fraud Prevention Program (NFPP)

The NFPP is an integral part of the CMS Fraud Prevention Initiative. The NFPP enables CMS to proactively identify and respond to suspicious behavior, thus making the agency more effective at fighting health care fraud than ever before. The NFPP focuses on two key program integrity gateways: provider enrollment and claims payment. By integrating these steps into one program, CMS can better ensure that it enrolls only qualified providers and pays only valid claims. CMS' comprehensive program integrity strategy is designed to stop fraudsters at every step of the process by:

- Identifying and preventing bad actors from enrolling in Medicare;
- Identifying and removing bad actors that are already in the program; and
- Identifying and preventing payment of fraudulent claims by responding with quick administrative action (e.g. enrollment revocations or payment suspensions).

National site visit contractor: ensuring program integrity at the provider enrollment stage

In 2011, CMS implemented a site visit verification program using a national site visit contractor (NSVC). The site visit verification program is a screening mechanism to prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. The NSVC will conduct unannounced site visits for Medicare Part A/B providers and suppliers. Site visits for durable medical equipment (DMEPOS) suppliers and providers will continue to be conducted by the national supplier clearinghouse.

The NSVC may conduct either an observational site visit or a detailed review to verify enrollment related information and collect specific information based on pre-defined checklists and procedures determined by CMS.

During an observational visit, the inspector engages in minimal contact with the provider or supplier and does not inhibit the daily activities that occur at the facility. The inspector may take photographs of the facility as part of

the site visit. During a detailed review, the inspector will enter the facility, speak with staff, take photographs, and collect information to confirm the provider or supplier's compliance with CMS standards. MSM Security Services, LLC was awarded the national site visit contract December 20, 2011. MSM and its subcontractors, Computer Evidence Specialists, LLC (CES) and Health Integrity, LLC (HI) are authorized by CMS to conduct the provider and supplier site visits.

Inspectors performing the site visits will be employees of MSM, CES, or HI and shall possess a photo ID and a letter of authorization issued and signed by CMS that the provider or supplier may review.

If the provider and/or its staff want to verify that a site visit has been ordered by CMS, please contact the respective jurisdiction's Medicare administrative contactor (MAC). MAC contact information can be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf*.

If the provider and/or its staff wish to verify that an inspector is credentialed to complete site visit verification, please call MSM Security Services, Monday through Friday from 7:00 a.m. to 8:00 p.m. ET at 1-855-220-1071. After 8 p.m., you may leave a message and the call will be returned the next business day.

Additional information

To learn more about the CMS Fraud Prevention Initiative, visit the "Fraud Prevention Toolkit" Web page at *http://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp*.

MLN Matters® Number: SE1520
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

Extension of provider enrollment moratoria for home health agencies and Part B ambulance suppliers

***Note**: This article was revised July 27, 2015, to reflect an extension of the temporary moratoria for an additional six months, as noted in the article. It was previously published in the February 2015 Medicare B Connection, Pages 18-19.*

Provider types affected

This *MLN Matters*® article is intended for home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in certain geographic areas of Florida, Illinois, Michigan, Texas, Pennsylvania, and New Jersey that provide services to Medicare, Medicaid, and CHIP beneficiaries.

Provider action needed

Stop – impact to you

Effective July 29, 2015, the temporary moratoria on new home health agencies, home health agency sub-units, and Part B ground ambulance suppliers are being extended for an additional six months in certain geographic locations.

Caution – what you need to know

During the six-month temporary moratoria, initial provider enrollment applications and change of information applications to add additional practice locations, received from home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in the moratoria counties will be denied. Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

Go – what you need to do

Effective July 29, 2015, home health agencies, home health agency sub-units, and Part B ground ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the six-month moratoria has expired. CMS will announce in the *Federal Register* when the moratorium has been lifted, extended, or changed.

Background

In accordance with 42 CFR §424.570(c), the Centers for Medicare & Medicaid Services (CMS) may impose a moratorium on the enrollment of new Medicare providers and suppliers of a specific type or the establishment of new practice locations in a particular geographic area.

On July 28, 2015, CMS announced, in a *Federal Register* notice (*http://federalregister.gov/a/2015-18327*), the extension of temporary moratoria on the enrollment of new home health agencies, home health agency sub-units and Part B ambulance suppliers in designated geographic locations.

The moratoria initially became effective July 30, 2013, and the implementation was announced in the *Federal Register* which may be accessed on the Internet at: *https://federalregister.gov/a/2013-18394*. The moratoria were expanded January 30, 2014, and the expansion was announced in the *Federal Register* which may be accessed at: *https://federalregister.gov/a/2014-02166*.

Moratoria extension

Effective July 29, 2015, the temporary moratorium on new home health agencies and home health agency sub-units is being extended for an additional six months in the areas stated in Table 1.

Table 1: Home health agencies and home health agency sub-units under temporary moratorium

City and state	Counties
Fort Lauderdale, FL	Broward
Miami, FL	Miami-Dade Monroe
Detroit, MI	Macomb Monroe Oakland Washtenaw Wayne
Dallas, TX	Collin Dallas Denton Ellis Kaufman Rockwall Tarrant
Houston, TX	Brazoria Chambers Fort Bend Galveston Harris Liberty Montgomery Waller
Chicago, IL	Cook DuPage Kane Lake McHenry Will

In addition, the temporary moratorium on new Part B ground ambulance suppliers is being extended for an additional six months in the areas stated in Table 2,

Table 2: Part B Ambulance suppliers under six-month temporary moratorium

City and State	Counties
Houston, TX	Harris Brazoria Chambers Fort Bend Galveston Liberty Montgomery Waller

See **MORATORIA**, next page

MORATORIA

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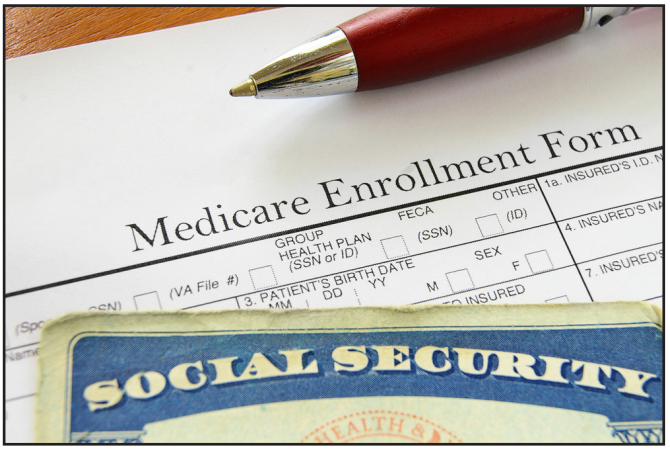
City and State	Counties
Philadelphia, PA	Bucks (PA) Delaware (PA) Montgomery (PA) Philadelphia (PA) Burlington (NJ) Camden (NJ) Gloucester (NJ)

Initial provider enrollment applications and change of information applications to add additional practice locations received from home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in the above listed counties will be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

Additional information

For more information regarding CMS' use of temporary moratoria, please review *MLN Matters*® article MM7350 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.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: SE1425
Related Change Request (CR) #: N/A
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Related CR Transmittal #: N/A|
Implementation Date: N/A

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Register for free, hands-on Internet-based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. The date is October 8, 2015, so register soon!

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.

"We are aware of the changes in medical policies via First Coast eNews we receive every week. We are continuously monitoring to identify changes and thus prevent claims to be denied."

– Luis Rodríguez Félix,
Billing manager, Ashford Presbyterian Community Hospital

Revisions to LCDs

Luteinizing hormone-releasing hormone (LHRH) analogs – revision to the Part B LCD

LCD ID number: L29215 (Florida)
LCD ID number: L29360 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for luteinizing hormone-releasing hormone (LHRH) analogs was revised to add the following off-labeled indication for leuprolide acetate: malignant neoplasm of male breast. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was updated to include malignant neoplasm of male breast as an off-labeled indication for leuprolide acetate. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis codes 175.0-175.9 and descriptors were added for HCPCS code J1950. In addition, the "Sources of Information and Basis for Decision" section of the LCD has also been updated.

Effective date

This LCD revision is effective for services rendered **on or after July 30, 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*.

Spinal cord stimulation for chronic pain – revision to the Part B LCD

LCD ID number: L35648 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for spinal cord stimulation for chronic pain was revised based on a reconsideration request to include diagnosis codes that support medical necessity for *CPT®* codes *63661-63664*, *63685*, and *63688* when the device has complications and requires removal, revision, or replacement. The "ICD-9 Codes that Support Medical Necessity" section was updated to add ICD-9 diagnosis codes 996.2, 996.63, and 996.75.

Effective date

This LCD revision is effective for services provided **on or after August 13, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

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.

Upcoming provider outreach and educational events

ICD-10: We're almost there

When: Wednesday, September 2
Time: Time: 11:00 a.m.-12:30 p.m. **Type of event:** Webcast

http://medicare.fcso.com/Events/0297181.asp

Medicare Speaks 2015 Tampa

When: Tuesday-Wednesday, September 15-16
Time: 7:30 a.m.-4:15 p.m.

http://medicare.fcso.com/Medicare_Speaks/278356.pdf

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

Two easy ways to register

Online – Visit our provider training website at *http://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 July 23, 2015

MLN Connects® Provider eNews for July 23, 2015
View this edition as a PDF

In this edition:

Countdown to ICD-10

- ICD-10 Is Less than 70 Days Away: Get Ready
- Are Non-HIPPA Covered Entities Required to Transition to ICD-10?
- MLN Connects National Provider Call: Countdown to ICD-10
- Video: 10 Facts about ICD-10

MLN Connects® National Provider Calls and Events

- ESRD QIP: Proposed Rule for Payment Year 2019 Call – Last Chance to Register
- Proposed Reform of Requirements for Long-Term Care Facilities Call – Registration Now Open
- Hospital Compare Overall Star Ratings Methodology Call – Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts
- Associations and Organizations Providing Credit for MLN Connects Events

Announcements

- CMS Releases First Round of Home Health Compare Quality of Patient Care Star Ratings
- CMS Announces Medicare Care Choices Model Awards
- LTCH QRP Data Submission Deadline: August 15
- IRF QRP Data Submission Deadline: August 15
- Updated Open Payments CME Guidance
- eCQM: 2016 QRDA Implementation Guide Now Available

Claims, Pricers, and Codes

- July 2015 OPPS Pricer File Update

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 4]" Educational Tool – Released
- "Home Oxygen Therapy" Booklet – Released
- "The Basics of DMEPOS Accreditation" Fact Sheet – Revised
- "Medical Privacy of Protected Health Information" Fact Sheet – Reminder
- "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians" Web-Based Training Course – Reminder
- Medicare Learning Network Products Available In Electronic Publication Format
    - New Continuing Education Organization Now Accepting Medicare Learning Network Web-Based Training Courses

Medicare Learning Network®

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

Medicare Learning Network®
Official Information Health Care Professionals Can Trust
http://go.cms.gov/MLNGenInfo

MLN Connects® Provider eNews for July 30, 2015

MLN Connects® Provider eNews for July 30, 2015
View this edition as a PDF

In this edition:

Countdown to ICD-10

- Clarifying Questions and Answers Related to CMS/ AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities
- MLN Connects National Provider Call: Countdown to ICD-10
- List of Valid ICD-10-CM Codes
- Use of Unspecified Codes in ICD-10-CM
- Coding for ICD-10-CM: Continue to Report CPT/ HCPCS Modifiers for Laterality
- Transition to ICD-10 for Home Health
- Claims that Span the ICD-10 Implementation Date

MLN Connects® National Provider Calls and Events

- Proposed Reform of Requirements for Long-Term Care Facilities Call – Register Now
- Hospital Compare Overall Star Ratings Methodology Call – Register Now
- New MLN Connects National Provider Call Audio Recording and Transcript

Announcements

- On Its 50th Anniversary, More than 55 Million Americans Covered by Medicare
- Temporary Moratoria Extended on Enrollment of Home Health Agencies and Ambulance Suppliers
- eCQM: Version 2 Schematron Rules for 2016 QRDA Implementation Guide Now Available

Medicare Learning Network® Educational Products

- July 2015 Version of the Medicare Learning Network Catalog – Released
- "Medicare Claim Review Programs" Booklet – Revised
- Medicare Learning Network Products Available in Electronic Publication Format
- New Medicare Learning Network Educational Web Guides Fast Fact

MLN Connects® Provider eNews for August 6, 2015

MLN Connects® Provider eNews for August 6, 2015
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In this edition:

Countdown to ICD-10

- Clarifying Questions and Answers Related to CMS/ AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities – Update
- MLN Connects National Provider Call: Countdown to ICD-10
- Prepare for ICD-10 with MLN Connects Videos

MLN Connects® National Provider Calls and Events

- Proposed Reform of Requirements for Long-Term Care Facilities Call – Last Chance to Register
- Hospital Compare Overall Star Ratings Methodology Call – Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI Call – Registration Now Open
- New MLN Connects National Provider Event Audio Recording and Transcript

MLN Connects Videos

- New Videos on HIS Manual for Hospice Quality Reporting Program

Announcements

- Inpatient and Long-term Care Hospital PPS: Final FY 2016 Payment and Policy Changes
- Skilled Nursing Facilities: Final FY 2016 Payment and Policy Changes
- Inpatient Rehabilitation Facilities: Final FY 2016 Payment and Policy Changes
- Inpatient Psychiatric Facilities: Final FY 2016 Payment and Policy Changes
- Hospice: Final FY 2016 Payment Rates
- Immunizations – Not Just for Kids
- Technical Correction to ESRD PPS Proposed Rule
- Decision Memorandum and Revised Scope of Benefit NCD for Speech Generating Devices
- Hospice Providers: Review HIS Reports to Confirm Successful Submission
- PEPPERs Available for SNFs, HHAs, Hospices, CAHs, LTCHs, IPFs, IRFs, and PHPs
- Antipsychotic Drug use in Nursing Homes: Trend Update
- EHR Incentive Programs: Determine Broadband Speed in Your Area

Claims, Pricers, and Codes

- FY 2015 Inpatient PPS PC Pricer Update Available

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MLN Connects® Provider eNews for August 13, 2015

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ENEWS

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Medicare Learning Network® Educational Products

- Upgraded Learning Management and Product Ordering System – Going Live August 12
- "HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules" Fact Sheet – Released
- "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" MLN Matters® Article – Revised
- Medicare Learning Network Products Available in Electronic Publication Format

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